What happens if I'm hurt on the job?

A guide to Oregon's workers' compensation benefits, rights, and responsibilities

January 2026

WCD Workers' Compensation Division

Department of Consumer and Business Services

In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternative formats. Call the Workers' Compensation Division: 503-947-7810.

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Claim Information Record

Insurer:	Phone:
Insurer representative:	
Claim no.:	Date of injury:
Attending physician:	
Employer's name:	

Please complete the above claim information for your own records.

Protect your rights

Stay in touch with your insurer, the health care provider you chose, and your attorney (if you have one). You can get the name and phone number of your workers' compensation insurer from your employer.

Workers' Compensation Division

The Workers' Compensation Division (WCD) can tell you about workers' compensation rights and responsibilities. For more information, call 800-452-0288 (toll-free) or go to wcd.oregon.gov.

Third-party claim

If your workplace injury or illness was caused by a third party (other than your employer), you may take legal action against the third party or assign the right to take action to the workers' compensation insurer.

Some examples of third parties are:

- The driver of the car that hit you.
- A manufacturer of the defective product that injured you.
- A property owner who failed to properly maintain the building where you were working when you were hurt.

- The owner of an animal that bit you.

A third-party claim can be a complex process, and we encourage legal representation.

Ombuds Office for Oregon Workers

The Ombuds Office for Oregon Workers is the state office that serves as an independent advocate for workers by acting to resolve complaints and helping workers understand their rights, protections, and responsibilities related to the workers' compensation system and safety in the workplace. For more information, call 800-927-1271 (toll-free) or go to www.oregon.gov/DCBS/OOW.

Oregon State Bar

You may want to consult with an attorney. The Oregon State Bar has a referral service to provide referrals to people who are looking for an Oregon licensed attorney. For more information, contact the Oregon State Bar referral service at 800-452-7636 (toll-free) or go to www.oregonstatebar.org. See Page 28 for more information about how to find legal help.

Spanish, Russian Publications

To obtain a copy of this publication in Spanish, call the Workers' Compensation Division: 503-947-7627.

Para obtener una copia de esta publicación en español, llame la División de Compensación para Trabajadores: 503-947-7627.

To obtain a copy of this publication in Russian, call the Workers' Compensation Division: 503-947-7627.

Чтобы приобрести копию публикации на русском языке, пожалуйста, позвоните в Отдел Компенсаций Рабочих (Workers' Compensation Division): 503-947-7627.

The Oregon Workers' Compensation Division provides this booklet to Oregon workers with disabling claims. For more information, contact the WCD at 800-452-0288 or email workcomp.questions@dcbs.oregon.gov.

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Important information

- Throughout this booklet, we use the general term **health care provider** to describe a person or entity licensed to practice one of the healing arts, such as a medical service provider, hospital, medical clinic, or vendor of medical services.
- **Health care providers may be limited in how long they can 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 you have questions, you may contact the insurer, the Ombuds Office for Oregon Workers, or the Workers' Compensation Division. Contact information is in the back of this booklet..

First steps

How do I file a claim?

- If you believe you were injured at work or suffer from an illness because of your job, tell your employer as soon as possible.
- Ask your employer to give you Form 801, "Report of Job Injury or Illness," complete the "worker" portion of the form, and give it back to your employer. If you have more than one job, be sure to indicate that on the 801 Form. You may be eligible for additional time-loss benefits.
- Your employer will complete its portion and send the form to the workers' compensation insurance company. Your employer will also give you a copy to keep for your records.
- Get the name and phone number of the workers' compensation insurer from your employer. Your insurer is your primary contact, so stay in contact with them.
- Get medical treatment from a **health care provider of your choice** and tell your provider that you were injured on the job. Remember: Your employer cannot choose your health care provider for you.
- At your first visit, your health care provider should ask you to complete Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims." The provider will send the form to the insurer and give you a copy for your records.

Questions?
Ombuds Office for Oregon Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

How do I get medical treatment?

- You may receive medical treatment from a **health care provider of your choice** on the initial claim, including:
  - Authorized nurse practitioner
  - Chiropractic physician
  - Medical doctor
  - Naturopathic physician
  - Oral surgeon
  - Osteopathic physician
  - Physician associate
  - Podiatric physician
  - Other health care providers
- The health care provider will bill the workers' compensation insurer. If your claim is accepted, the insurer will pay for medical treatment related to the work injury, with some limitations.
- If your claim is denied, or the insurer determines the services are not related to your work injury, you may have to pay for your medical treatment.
- The insurance company may enroll you in a **managed care organization (MCO)** at any time. If you are enrolled in an MCO, contact the insurer for more information about your medical treatment options.

How do I get interpreter service?

- You can choose any person to help you communicate with a health care provider if you and the provider speak different languages, languages; however, a sign language interpreter must be licensed by the Oregon Health Licensing Office. The insurer may pay for the interpretive

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services when the interpretation is for an accepted claim or condition; however, the insurer does not have to pay for the service if you choose to use a family member or friend.

- To schedule interpretive services, you may contact an interpreter service company, your doctor, or your insurer to arrange the service. The health care provider may disapprove of your choice of interpreter if they feel the interpretation is not complete or accurate.
- The interpreter services company should bill the workers' compensation insurer. If the insurer determines the services are not related to your work injury, you may be responsible for payment.
- For more information about interpreter services and your options, contact Medical Resolution at 503-947-7840 or visit the Workers' Compensation Division's website at wcd.oregon.gov.

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

- Your health care provider must authorize your absence from work. You should provide a copy of your off-work authorization to your insurer and employer as soon as possible. If you have more than one job, you may also be eligible for additional time loss if your doctor authorizes time off or modified work from your secondary jobs.
- You will not be paid for the first three calendar days for your time off work unless you are off work for 14 days in a row or hospitalized overnight as an inpatient within the first 14 days.
- If your claim is denied within the first 14 days from the date you reported it to the employer, you will not be paid for any lost wages.

Questions?
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Helpful tips

- Pay attention to information about medical appointments and time limits.
- If you fail to take action or if you miss a deadline to appeal claim decisions, you may lose your right to workers' compensation benefits. If you have questions about your claim or the documents you receive, call the insurer.
- Read all letters and notices about your claim, and keep copies of all letters you send and receive.
- Attend all medical appointments.
- Contact your employer immediately when your health care provider releases you back to work.
- Keep in contact with your doctor and inform your employer about your work restrictions. If your employer offers you a modified job or light duty, you must cooperate with your employer's efforts to return you to work.

Claim status

What is acceptance or denial of a claim?

The insurer must accept or deny your claim within 60 days of the day your employer has notice or knowledge of the claim. This is referred to as the interim period.

- If your claim is accepted, the insurer will send you a "Notice of Acceptance" that lists the specific medical conditions accepted.
- If you believe the insurer has not listed all the conditions caused by your injury, you must request, in writing, that the insurer add the missing conditions to your notice. If you believe that the notice is incomplete or incorrect, you must notify the insurer in writing of the error.

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- If your claim is denied, the insurer must send you a letter specifying the reasons for denying your claim and notify you of your appeal rights.

What if the insurer denies my claim based on an independent medical examination (IME)?

If the insurer denies your claim based on an **independent medical examination (IME)**, you may be eligible for a **worker-requested medical examination (WRME)**, paid for by the insurer. To qualify for a WRME all of the following must be met:

- The denial is based on an IME
- Your attending physician does not concur with the IME report
- You have timely requested a hearing to appeal the claim denial.

If you meet these conditions and want to request a WRME, or need more information, contact the Workers' Compensation Division at 800-452-0288 (toll-free).

Medical treatment

Do I have privacy rights at medical examinations?

You have the right to privacy at medical examinations. Your employer or the insurer cannot send a representative to your medical examinations without your written consent. If you do not consent, your benefits cannot be stopped or reduced.

What are interim medical benefits?

Interim medical benefits are payments for medical services from the start of your claim to when the insurer accepts or denies your claim and you have private health insurance. However, if the insurer denies your

claim within 14 days, you are not entitled to interim medical benefits. Be sure to give your provider your private health insurance information, even if you are seeking care for a work-related injury or illness. Note: The Oregon Health Plan is *not* considered private health insurance.

During this time, you do not have to pay any private health insurance co-pays, co-insurance, or deductibles; however, if the workers' compensation insurer accepts your claim and you paid the provider any co-pays, co-insurance, or deductibles, the provider must reimburse you.

If the workers' compensation insurer denies your claim, you may be responsible for any private health insurance co-pays, co-insurance, or deductibles.

If you have any questions about your benefits during the interim period, call the workers' compensation insurer for more information.

If my claim is accepted, what medical bills will the insurer pay?

If your claim is accepted, the insurer should pay for all of the following:

- Medical treatment related to your on-the-job injury
- Prescription drugs
- Transportation, meals, and lodging necessary to attend medical appointments, with some limitations

Your health care provider should not bill you for medical services. Your provider should directly bill the workers' compensation insurer.

The pharmacy may be able to directly bill the insurer for prescriptions.

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If you are required to pay for your prescriptions out of pocket, you have up to two years from the date the expenses were incurred to send a written request for reimbursement with proof of expenses (copies of receipts) to the insurer. The insurer has 30 days to request more information or reimburse you for your out-of-pocket expenses.

What happens if my claim is denied and my health care provider sends me bills?

If your claim is denied, your health care provider is allowed to send you a copy of the bills.

If you appeal your denial, the provider may make no further attempt to collect payment from you until either of the following happens:

- All your appeals are completed
- You settle the claim

If you do not appeal your denial, then your health care provider can bill you.

If you have health insurance, the health care provider is required to bill your health insurer.

Who can be my attending physician?

The term **attending physician** is used in the workers' compensation system to designate the physician who is responsible for authorizing time-loss benefits and for overseeing the medical care you receive for your work injury. This could include overseeing care from other health care providers, such as physical therapists or other medical specialists, you may have to see to recover from the work injury. Under Oregon law, the following health care providers can be attending physicians:

- Medical doctors
- Podiatric physicians
- Osteopathic physicians

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- Oral or maxillofacial surgeons
- Chiropractic physicians, naturopathic physicians, and physician associates who have certified to the Department of Consumer and Business Services director
- Medical providers designated to be attending physicians by a managed care organization

What are the responsibilities of the health care provider?

Attending physicians can do the following:

- Authorize time-loss payments if you cannot work
- Authorize reduced work hours or duties
- Release you to go back to work
- Decide when you are **medically stationary**

Emergency room physicians who do not serve as attending physicians may authorize time loss for only 14 days.

Even though chiropractic physicians and naturopathic physicians can be an attending physician, they:

- May be your attending physician for only up to 60 consecutive calendar days or 18 visits, whichever occurs first
- May authorize time-loss payments for only 30 days from your first visit

Chiropractic physicians may make impairment findings, however, naturopathic physicians may not make those findings.

Physician associates can also be an attending physician, but they:

- May be your attending physician for only up to 180 consecutive calendar days
- May authorize time-loss payments for only 180 days from your first visit

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- May not make **impairment findings**

Although **authorized nurse practitioners** are not designated as attending physicians, they:

- May treat you independently for up to 180 days
- May authorize time-loss payments for up to 180 days
- May authorize reduced work hours or duties for up to 180 days
- May release you to go back to work within 180 days
- May decide when you are medically stationary for up to 180 days
- Must refer you to an attending physician for a closing examination if you appear to have permanent impairment

Providers who do not qualify to be an attending physician or an authorized nurse practitioner:

- May treat you independently for only 30 days or 12 visits, whichever occurs first
- Are not allowed to authorize time-loss payments or to modify work
- Must be authorized by an attending physician or authorized nurse practitioner to provide additional treatment after 30 days or 12 visits

What if I want to change my attending physician?

Since an attending physician is **primarily** responsible for your treatment, you may have only one attending physician at a time.

After your initial choice of an attending physician, you may change attending physicians two more times by choice. Any more attending physician changes need approval from the insurer.

To change your attending physician, fill out Form 827 at your new attending physician's office, and the attending

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physician will send the completed form to the insurer.

If the insurer does not approve the attending physician change, you may request approval from the Workers' Compensation Division.

The following are not considered a change of attending physician:

- A health care provider treats you in an emergency or as an "on-call" physician.
- Your attending physician sends you to a specialist, but remains primarily responsible for your care.
- You change health care providers due to a reason beyond your control, such as:
  - Provider's treatment limitations
  - You or your health care provider move out of the area
  - You become enrolled in a managed care organization

If you are enrolled in a managed care organization, your rights may differ. Contact the insurer to find out more information.

What if my health care provider recommends elective surgery?

Elective surgery is surgery other than emergency surgery. Before scheduling elective surgery, the health care provider must notify the insurer, which may request a second opinion (managed care organization procedures may differ).

If the insurer disagrees about the need for surgery, the insurer must ask the Workers' Compensation Division to review the request for surgery to determine whether the surgery is appropriate.

What if the insurer enrolls me in a managed care organization?

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If your employer is covered by a managed care organization contract, the insurer may enroll you with the managed care organization at any time after your injury. You may be required to select a managed care organization health care provider from a list of providers the insurer sends with your enrollment notice.

Until you are enrolled, any health care provider may provide medical treatment to you up to any treatment limitations the provider may have.

If you have a regular primary care physician who is a family practitioner, general practitioner, internal medicine specialist, chiropractic physician, or authorized nurse practitioner, they may be able to continue to provide treatment if they agree to treat you according to the managed care organization contract.

What is an independent medical examination (IME)?

An IME is an examination scheduled by the insurer processing your claim. This doesn't include a consultation arranged by a managed care organization for an enrolled worker.

The insurer will choose the IME provider and pay for the exam. The insurer may require you to attend up to three IMEs. Some exams may be scheduled with more than one health care provider at more than one location, but count only as one of the three IMEs. This is called a panel exam. If your claim is closed and later reopened, the insurer may require you to attend up to three more IMEs.

You may be charged a $100 penalty if you do not attend without a good reason or if you do not notify the insurer before the examination. The penalty would be taken out of your future benefits.

The IME providers:

- Will not provide treatment

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- May perform a physical- or work-capacity evaluation
- Will prepare a report to document their findings and opinions, and to answer questions asked by the insurer related to your claim
- Will send a copy of the report to the insurer

If the IME provider intends to perform an invasive procedure (an invasive procedure is one in which the body is entered by a needle, tube, scope, or scalpel):

- They must explain the risks
- They must obtain your written agreement for this procedure
- Your benefits cannot be reduced or stopped if you decline an invasive procedure

The insurer must pay all costs for the medical examination and will reimburse expenses necessary for you to attend the exam.

If you need advance payment in order to attend, or if you believe you need help attending the appointment because of your work-related injury, contact the insurer as soon as possible.

You may have a family member or friend accompany you to the examination, but the insurer is not required to pay that person's expenses. Furthermore, a family member or friend is not allowed to be present during a psychological examination unless the IME provider approves.

To have a friend or family member present during the exam, you must complete, sign, and submit an "IME Observer Form" (440-3923A) to the independent medical provider. In addition, if you undergo a psychological examination, the IME provider must approve the attendance of your family member or friend in order for them to be present.

What medical care am I entitled to

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after I become medically stationary?

When your health care provider determines that neither time nor treatment will improve your condition, you are considered medically stationary.

Medical benefits after you are found to be medically stationary may be limited to the following:

- Prescription drugs
- Prosthetic devices, braces, supports
- Diagnostic care
- Curative care to stabilize your condition
- Life preserving treatment

Contact the insurer or the Workers' Compensation Division if you have questions about covered services.

Palliative care, a medical service that makes you feel better but does not heal your condition, is covered if you are working and need the care to continue working or attend vocational training. The care is covered only if approved by the insurer or the Workers' Compensation Division.

What is a new or omitted medical condition?

A new condition is a condition that arises from the original injury. An omitted condition is a condition that was always there since the injury, but was not accepted by the insurer. A worker may request the insurer to accept either a new or omitted condition at any time after the injury. That right continues even after your **aggravation rights** expire.

Time-loss (temporary disability) payments

If I miss time from work, will I get paid?

Questions?
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Time-loss

- If your health care provider authorizes you to take time off work or to do modified work that causes you to lose wages, you may receive time-loss payments from the insurer.
- Your first check will be mailed within 14 days from the date of the employer's notice or knowledge of the claim and of your disability, if time-loss has been authorized. If time-loss is not authorized until after this 14-day period, your first check will be mailed within 14 days from the date you receive a valid time-loss authorization.
- No payment is due for time missed from work that has not been authorized by your health care provider.

If you are unable to work, remind your health care provider each time you see them to send your time-loss authorization to the insurer. You can help ensure timely payments by contacting your employer and the insurer as soon as you begin to miss work.

Time-loss benefits will **stop** if one of the following happens:

- Your health care provider fails to provide time-loss authorization
- Your claim is denied
- Your health care provider gives you a release to return to regular work
- You return to regular work at full wages
- A Notice of Closure closes your claim
- You are incarcerated (incarcerated means in pretrial detention or in jail or prison following conviction for a crime)
- You remove yourself from the workforce

Time-loss benefits will also be **reduced or stopped** if one of the following happens:

- Your health care provider approves a written offer of modified work and you refuse to take the job

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- Your health care provider approves work with your employer and your employer fires you (with cause)
- Your health care provider releases you to work, but you are unable to work because you are in the United States in violation of federal immigration laws

Is there a waiting period for time-loss benefits?

Oregon has a three-day waiting period for time-loss benefits. You will not be paid for the first three calendar days for your time off work unless you are off work 14 days in a row or you are hospitalized overnight as an inpatient within the first 14 days.

The first day you lose time or wages will be the first day of the three-day waiting period.

If you are released for modified duty during the first 14 days, you will not be paid for the three-day waiting period.

How do you calculate wages to determine payments?

Payment for time lost from work is called **temporary total disability** or **temporary partial disability** and is based on your average weekly wage at the time of injury. The insurer may calculate your average weekly wage by averaging the wages you earned, with your employer at injury, over the 52 weeks before your injury.

- Time-loss payments will equal two-thirds of your gross average weekly wage.
- Oregon has a minimum and maximum amount payable to an injured worker that is adjusted every year.
- If your doctor returns you to modified or light-duty work and you earn less money, you may be eligible to receive partial time-loss payments.

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- Your average weekly wage is an important factor in calculating your time-loss benefits and it is important to verify your proper wage is being used in these calculations.

What happens if I have more than one job?

You may be eligible to receive additional payments for time lost from other jobs; these payments are called supplemental disability. You must have had more than one Oregon subject job at the time of injury to be eligible for supplemental disability benefits.

- You must let the insurer know about your other jobs within 30 days of the day you filed the claim.
- To receive payment for any time lost from those other jobs, you must provide documentation of wages (check stubs or payroll records).
- You must provide the documentation within 60 days of the insurer's request or you may be found ineligible for supplemental disability.

Returning to work

What are my rights when returning to work?

Most Oregon employers with more than 20 workers are required to return an injured worker to the worker's job or another suitable job after the worker is released to work.

- The insurer will send you written notice when your health care provider releases you to go back to work.
- When you receive this notice, you must ask your employer for your job or another suitable job within **seven calendar days** (sooner if your union contract or employer's personnel policies require it) or you will lose your right to be reinstated with

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your employer.

- When you receive any release for work, take it to your employer as soon as possible, as work may be available that is physically appropriate for you.

If you have questions about your rights or believe your employer has treated you unfairly because of your injury, call the Bureau of Labor and Industries at 971-673-0761.

Are there benefits to staying at work or returning to work?

Research shows that injured workers benefit from returning to work **at the earliest possible time** after an on-the-job injury.

Staying at work or returning to work as quickly as possible helps you prevent financial loss. When your health care provider manages your return to work, it can also help you recover from your injury faster.

What is modified work?

If your employer offers you modified work, contact your health care provider to find out if you are physically able to do the job. If your health care provider says you can do the modified job offered by your employer, you must accept the job or your time-loss benefits may be reduced or stopped. If you find after returning to work that you cannot do the job because of your injury, immediately contact your health care provider.

If you return to modified or light-duty work at a lower rate of pay or fewer hours, you will receive time-loss payments for the part of your wages you are missing. You may refuse a modified job without ending your time-loss benefits if **any** of the following is true:

- The job is **not** with the employer at injury or at a jobsite of the employer at injury (exception for home care workers or personal support workers).
- Your health care provider says you are physically

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unable to commute to the jobsite. (Your commute is the distance from your residence to your job at injury or to the job you are offered as modified work.)

- The jobsite is more than 50 miles from where you were injured or customarily worked before your injury, unless that jobsite is less than 50 miles from your home. However, greater distance may be appropriate if your job at the time of injury involved multiple or mobile work sites and you could have been assigned to any such site.
- The job's work schedule (shift) differs from the employer's written policy for changing work schedules, the common practice of the employer, or collective bargaining agreement.

What re-employment assistance is available from the Workers' Compensation Division?

The Employer-at-Injury Program helps workers stay on the job or get back to work with the employer at injury. Because of your injury, your employer may be eligible for benefits to help return you to light-duty work while your claim is open.

The Preferred Worker Program helps injured workers get back to work by providing benefits to the employer at injury or any other Oregon employer. If you have permanent disability due to your injury, and your health care provider says you cannot return to your regular job, you may qualify as a preferred worker.

If you are eligible for the Preferred Worker Program, you will receive an identification card and program materials shortly after your claim is closed.

If you think you should be eligible for Preferred Worker Program benefits and don't get an identification card soon after your claim is closed, call 800-445-3948 (toll-

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free) or 503-947-7588.

If you have questions or want to learn more about the Preferred Worker Program, call 800-445-3948 (toll-free) or 503-947-7588.

Do I qualify for vocational assistance?

Vocational assistance includes help with job placement and training. You may qualify for assistance if **all** of the following are true:

- You have permanent disability, caused by the on-the-job injury
- Your doctor did not release you to your regular job and you were not able to return to a suitable job that pays at least 80 percent of the wage you were earning

The insurer will determine if you are eligible for vocational assistance within 35 days of when you become medically stationary and notify you of its decision in writing. Contact the insurer if you need help getting back to work.

If you have questions, call 800-452-0288 (toll-free) or 503-947-7840.

Claim closure

What is a Notice of Closure?

Disabling claims are "open" or "active" while you are recovering from your injury and "closed" or "inactive" when you are medically stationary.

Your claim will also be closed if your injury is no longer the major cause of your disability or need for treatment, or if you fail to attend medical appointments. The insurer will send you the following important documents when your claim is closed:

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Claim closure

A legal document called a "Notice of Closure" that closes your claim. It lists the periods for which time-loss benefits were authorized and tells you how much permanent disability you may have. This document also tells you how to appeal the closure of your claim.

- An "Updated Notice of Acceptance at Closure" that lists the medical conditions the insurer has accepted. If the updated notice is incomplete or incorrect, notify the insurer in writing.
- A brochure, "Understanding Claim Closure and Your Rights," explaining your appeal rights and the types of care covered by the insurer after claim closure.

After your time-loss payments end, you may be entitled to unemployment benefits (even if it would ordinarily be too late to qualify). You must apply within four weeks of the date of the Notice of Closure to see if you qualify for a special "base-year extension" available to some injured workers. Contact the Oregon Employment Department office in your area for more information.

What is permanent partial disability?

If the Notice of Closure shows you have **permanent partial disability**, this means your injury resulted in a condition that has not returned to its normal or preinjury status. You may be entitled to receive payment from the insurer for your disability. Permanent disability payments are based on a formula set by law. The amount will depend on the severity of the disability and whether you received overpayment of benefits. If the insurer overpaid you for benefits while your claim was open, the insurer may recover the overpayment by reducing your permanent disability payment or by reducing future benefits. Here are some things to keep in mind about permanent partial disability benefits:

- Permanent disability award payments are due to

Note: Words that are in **bold** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services directory, Page 36.

start 30 days from the mailing date of the closure.

- If your award is $6,000 or less, the insurer will pay you a lump sum.
- If your permanent partial disability award is more than $6,000, the insurer will make monthly payments to you until the award is paid. Your monthly award payments are paid at 4.35 times the weekly temporary total disability rate at the time of closure.
- You may ask the insurer to pay you a lump sum. However, if you or the insurer appeal the Notice of Closure that awarded permanent partial disability, you cannot receive a lump-sum payment until the appeal process is finished and the order is final. **If you apply for a lump-sum payment for any part of your permanent disability award and waive your right to request reconsideration of the Notice of Closure, you give up the right to appeal the Notice of Closure (including the amount of the award).** You are not eligible to receive a work disability payment in a lump sum if you are taking part in a vocational training program.

What is permanent total disability?

If the Notice of Closure shows you have **permanent total disability**, it means you are permanently unable to perform gainful and suitable employment. You will receive monthly disability payments as long as you remain totally disabled. The insurer will re-examine your claim at least every two years to see if you remain unable to work.

What are fatality benefits?

When a worker dies due to an on-the-job injury or occupational disease or illness, and the insurer accepts the claim, Oregon law requires insurers to make

Questions?
Ombuds Office for Oregon Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

monthly payments to the worker's spouse, children, and other eligible beneficiaries. The insurer will pay for disposition and funeral expenses subject to a maximum amount. If you die while receiving permanent total disability benefits, your spouse or other eligible beneficiaries may be entitled to continuing benefits.

What do I do if I disagree with the Notice of Closure?

If you disagree with the Notice of Closure, you must write to the Workers' Compensation Division within 60 days of the mailing date printed on the Notice of Closure. Your appeal rights and the address to send your appeal are printed on the back of the Notice of Closure.

You may also fill out and send the form "Worker's Request for Reconsideration" to the Workers' Compensation Division. You can obtain the form by contacting the division and asking for a copy of the form to be mailed to you or going to the division's website, wcd.oregon.gov. Under the "Workers" section, click on "Reporting an injury and filing a claim." Click on "Appealing a closed claim" on the left-hand side of the webpage. Finally, click on "Request for Reconsideration."

For more information, call WCD at 800-452-0288 (toll-free) and ask to speak to an appellate reviewer.

What if my accepted condition gets worse?

If your accepted condition gets worse after your claim is closed, you have the right to seek medical care. You may ask the insurer to reopen your claim by filing a Form 827 at your attending physician's office. The health care provider will submit the paperwork to the insurer on your behalf.

Aggravation rights on disabling claims expire five years from the first closure date of the claim. Aggravation rights on a nondisabling claim expire five years from the

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date of injury.

After the five-year rights expire, you may still have some rights to additional benefits. If you need hospitalization, surgery, or other curative treatment in lieu of hospitalization, the insurer may reopen the claim and pay time-loss benefits that are authorized by the attending physician until your conditions are again declared medically stationary.

If you request acceptance of a new or omitted medical condition after your aggravation rights expire, you may also be eligible to receive a permanent disability award if your condition has permanently worsened more than when your claim was last closed.

Appeal rights and claim settlements

What if I disagree with a decision?

You can appeal any decision made about your claim. An appeal is a request by an injured worker, an insurer, or another party to a claim for a review of a decision made about the claim. If you receive a notice that your claim or benefits are denied or ended, the document you receive will have instructions on how to appeal if you disagree with the decision. **There are time limits for most appeals. You will lose your appeal rights if you don't appeal within the limits as printed in the letter or notice you received.** Benefits that are the subject of the appeal are usually not paid until the appeal process **(litigation)** is completed.

How can I find legal help?

An attorney can help you understand your rights and obligations. To find an attorney who handles workers' compensation cases, call the Oregon State Bar Lawyer Referral Service at 800-452-7636 (toll-free) or check the Yellow Pages or the Internet. Workers' compensation

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Workers' Compensation Division: 800-452-0288

attorneys are paid on a "contingent fee" basis. This means that you do not have to pay an attorney unless the attorney wins your case or settles your case for you.

What is a disputed-claim settlement?

If you and the insurer disagree about whether you have a valid workers' compensation claim or condition, you and the insurer may resolve the disagreement by a **disputed-claim settlement**.

A disputed-claim settlement (DCS) is settlement of a claim when there is a disagreement about compensability. In a DCS, you release all rights and benefits associated with the claim (for an agreed upon sum of money). This means your claim will remain denied, and you will give up all rights to future benefits for the denied medical conditions of the claim.

Health care providers may bill you for services not paid by the insurer, so be sure to know what your obligations will be under the agreement before you agree to a settlement.

What is a claim disposition agreement?

If you have an accepted claim, you may exchange your rights to the claim for money through a **claim disposition agreement**. In such an agreement, you may give up your rights to one or more of the following claim benefits:

- Present and future time-loss benefits
- Present and future permanent partial disability awards
- Monthly payments for permanent total disability
- Vocational assistance benefits
- Aggravation rights to reopen your claim
- Survivor benefits

Note: Words that are in **bold** are defined in the Glossary, Page 30. Agency phone numbers are listed in the Services directory, Page 36.

You cannot give up your right to medical benefits or your eligibility for the Preferred Worker Program.

The Workers' Compensation Board must approve all claim disposition agreements unless the settlement was negotiated during a mediation. In this instance, the administrative law judge who mediated the dispute can approve the settlement document. If you have a question about the claim disposition agreement, you may contact the Ombuds Office for Oregon Workers at 800-927-1271 (toll-free).

What are penalties for late payment?

If you believe that the insurer delayed accepting or denying your claim or delayed payment of benefits past their due date, you may write to the Workers' Compensation Division and request that the insurer be penalized. If the Workers' Compensation Division finds that a penalty is appropriate, the insurer will pay the penalty amount to you and your attorney, if you are represented.

Are my records confidential?

Claim information on file with the Workers' Compensation Division and medical and vocational claim records on file with the insurer may be released only in limited circumstances, such as the following:

- When you or your attorney requests copies
- When necessary for the insurer to process your claim
- When necessary for government agencies to carry out their duties
- When otherwise required or allowed by law

Employers may not legally consider workers' compensation injuries in making their hiring decisions, and they should not receive medical records beyond work releases.

Questions?
Ombuds Office for Oregon Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Glossary of workers' compensation terms

In this booklet, you will find the following terms:

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. An attending physician who is a licensed medical doctor, osteopathic physician, a podiatric physician, or oral and maxillofacial surgeon, must file a Form 827 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. ORS 656.273

attending physician (AP): A doctor or physician who is primarily responsible for the medical care of a worker by either directly treating the worker or by approving and directing care provided by others. The attending physician must be a licensed medical doctor, osteopathic physician, a podiatric physician, oral and maxillofacial surgeon, or medical provider designated to be an attending physician by the managed care organization (MCO). A chiropractic physician or a naturopathic physician on the WCD health care provider certification list can be an attending physician on the initial claim for up to 60 calendar days or 18 visits (whichever occurs first). They may also authorize time-loss benefits for up to 30 calendar days from the first day the patient sees any chiropractic physician or naturopathic physician. A physician associate on the WCD health care provider certification list can be an attending physician on the initial claim for up to 180 calendar days and authorize time-loss benefits for up to 180 calendar days from the first day the patient sees any physician associate. Naturopathic physicians and physician associates

cannot make impairment findings. Physician associates authorized to treat by managed care organizations may treat longer than 180 days. ORS 656.245; ORS 656.005

authorized nurse practitioner: A nurse practitioner authorized by the Workers' Compensation Division may provide compensable medical services to an injured worker for a period of 180 consecutive calendar days from the date of the first nurse practitioner visit on the initial claim. A nurse practitioner may also authorize the payment of temporary-disability benefits for a maximum of 180 calendar days from the date of the first nurse practitioner visit on the initial claim. Authorized nurse practitioners cannot make impairment findings. Nurse practitioners authorized to treat by managed care organizations may treat longer than 180 days. ORS 656.245

claim disposition agreement (CDA and C&R): An agreement between the parties to a workers' compensation claim. The worker agrees to sell back their 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."

disabling compensable injury: An on-the-job injury that entitles the worker to disability compensation or death benefits. ORS 656.005

disputed-claim settlement (DCS): Settlement of a claim when there is disagreement about compensability. For an agreed upon sum of money, the worker releases all rights and benefits associated with the claim.

health care provider: A person or organization licensed to practice one of the healing arts such as a medical service provider, a hospital, medical clinic, or vendor of medical services.

impairment findings: A measurement by a physician of loss of use or function of a body part or system.

independent medical examination (IME): Any medical examination, including a physical capacity or work capacity evaluation, or consultation requested by the insurer and completed by a medical service provider

other than the worker's attending physician.

injury: An on-the-job injury or occupational disease.

insurer: An insurance company, self-insured employer, or self-insured employer group that provides workers' compensation coverage to employers and benefits to injured workers.

litigation: A process that usually results in a judge deciding the resolution of the dispute based on the facts and the law.

lump sum: The payment of a permanent partial disability award in one check (for awards that are more than $6,000), usually upon request of the worker. Awards that are less than $6,000 are always paid in a lump sum.

managed care organization (MCO): An organization that contracts with an insurer to coordinate medical services to injured workers. ORS 656.260

medically stationary: An injured worker is considered medically stationary when the attending physician determines no further significant improvement to the worker's condition that resulted from the injury or illness can reasonably be expected either from medical treatment or the passage of time. ORS 656.005

nondisabling injury: Any injury that requires only medical services with no inability to work beyond the first three days and does not result in any measurable permanent disability. ORS 656.005

occupational disease: A disease or infection resulting from a worker's job. It is caused by substances or activities an employee is exposed to at work and results in medical services, disability, or death. ORS 656.802

Ombuds Office for Oregon Workers: The state office that serves as an independent advocate for workers by acting to resolve complaints and helping workers understand their rights, protections, and responsibilities related to the workers' compensation system and safety in the workplace. ORS 656.709

permanent partial disability (PPD): The permanent

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

permanent total disability (PTD): The loss of use or function of any portion of the body in combination with any pre-existing disability that permanently prevents the worker from regularly performing gainful and suitable work. ORS 656.206

supplemental disability: The increase of disability payments due a worker employed in more than one Oregon subject job at the time of injury.

temporary partial disability benefits (TPD): Payment for partial loss of wages when a worker can work only part time or light duty after an injury. ORS 656.212

temporary total disability benefits (TTD): Payment for loss of all wages after an injury when the worker cannot return to any work. ORS 656.210

time-loss payments: Payments to an injured worker who loses time or wages because of a compensable injury. ORS 656.210

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 within the Oregon Department of Consumer and Business Services that administers the state's workers' compensation laws.

worker-requested medical exam (WRME): An examination available to a worker whose claim has been denied based on an independent medical exam where the injured worker's physician does not agree with the findings.

Workers' compensation claim process

From injury through acceptance or denial:

On-the-job injury or occupational disease claim

Worker notifies employer and completes Form 801.

Worker goes to a health care provider and completes worker section of Form 827.

Employer reports claim to insurer within 5 days.

Health care provider reports claim to insurer within 3 days.

If claim is disabling, time-loss payments, if authorized by the health care provider, begin and continue every 14 days unless the claim is denied.

Insurer must accept or deny the claim within 60 days.

Interim medical benefits may be paid if the worker has health insurance.

If the claim is accepted – time-loss payments, if any, continue every 14 days for as long as the attending physician or authorized nurse practitioner authorizes the worker to be off work or the claim closes.

Medical and other services are provided to help the worker recover and return to work.

If the claim is denied – insurer issues denial letter.

Time-loss payments stop.

Worker has 60 days (up to 180 days with cause) to appeal the denial.

In some cases, workers may request medical exam by a doctor selected by WCD.

From acceptance through closure and beyond:

Worker and insurer may make a claim disposition agreement (at any time after claim acceptance), subject to approval by the Workers' Compensation Board.

The claim will be closed when the worker is medically stationary.

The claim is closed and a decision is made about the amount of worker's disability, including permanent partial disability (PPD), if any. A Notice of Closure is issued by the insurer.

Vocational assistance is provided if worker is eligible (at any time after claim acceptance).

If worker cannot return to regular work and has permanent disability, WCD issues a preferred worker card, which allows worker to offer hiring incentives to Oregon employers.

Insurer (within 30 days of the Notice of Closure) must begin payment of PPD, if any. However, if the claim closure is appealed, payment may be stayed (not paid) until the litigation is completed.

Insurer, within seven days, or worker, within 60 days of claim closure, may request reconsideration by the WCD's Appellate Review.

After the claim is closed, worker remains eligible for certain medical and vocational services. If the accepted condition worsens, the claim may be reopened for additional disability and other benefits.

Services directory

Workers' Compensation Division

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
wcd.oregon.gov
workcomp.questions@dcbs.oregon.gov

Workers' compensation infoline.....800-452-0288
Central reception.....503-947-7810
Benefit consultation 503-947-7840

WCD Employer Index
(to verify employer's insurance) 888-877-5670

Managed care organization 503-947-7650

Medical resolution 503-947-7606

Reconsideration of claim closures.....503-947-7816
Re-employment assistance 503-947-7588
Toll-free 800-445-3948

Vocational assistance, disputes.....503-947-7812
Toll-free.....800-696-7161
Medford..... 541-776-6032

Ombuds Office for Oregon Workers

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
www.oregon.gov/DCBS/OOW
oow.questions@dcbs.oregon.gov

General information 503-378-3351
Toll-free 800-927-1271

Workers' Compensation Board (and Hearings Division)

2601 25th St. SE, Suite 150
Salem, OR 97302-1280
www.oregon.gov/wcb

General information 503-378-3308
Salem (toll-free) 877-311-8061
Portland (toll-free) 866-880-2078

Other resources

This booklet explains workers' compensation benefits. Even if your claim has been denied or you have exhausted your workers' compensation benefits, you may be eligible for some other types of assistance.

- Contact the Oregon Employment Department to find out if you are eligible for unemployment benefits.
  www.employment.oregon.gov
- Contact the Social Security Administration to find out if you are eligible for disability benefits.
- Contact the Oregon Office of Vocational Rehabilitation Services to find out if you are eligible for rehabilitation services.
  www.oregon.gov/odhs/vr
- Contact the Oregon State Bar for lawyer referral services information.
  www.oregonstatebar.org

If you have questions about injured workers' employments rights, contact the **Civil Rights Division, Bureau of Labor and Industries** (workers' compensation discrimination issues):
www.oregon.gov/BOLI/CRD
971-673-0764

800-452-0288 (toll-free)
503-947-7630 (fax)
workcomp.questions@dcbs.oregon.gov
wcd.oregon.gov

440-1138 (07/26/COM)