April 2024

Chiropractic Physicians' Guide to Oregon On-the-Job Injuries

WCD | Workers' Compensation Division
Department of Consumer and Business Services

Chiropractic Physicians' Guide to Oregon On-the-Job Injuries

Quick reference for chart notes

Chart notes should be used to supplement the information provided on Form 827. Your chart notes should be legible and include the following:

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

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

Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7606

Table of contents

Before treating workers' compensation patients

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

If treating patients for Oregon on-the-job injuries, you need to certify to the director of the Department of Consumer and Business Services that you have reviewed the materials supplied in this guide.

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

Certification

You must review the Chiropractic Handbook, which is also available on WCD's website at www.wcd.oregon.gov. You must certify to the director that you are a licensed chiropractic physician and that you have reviewed the handbook.

To certify to the director using our easy online process, visit WCD's website at www.wcd.oregon.gov and select "Health Care Providers" under "Industry Services."

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

Responsibilities as the attending physician

As the attending physician, you are primarily responsible for treatment and authorizing time loss.

The Oregon workers' compensation system places considerable responsibility on attending physicians for all of the following:

- 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

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

You must sign a copy of the treatment plan and send it to the insurer within 30 days of the start of ancillary treatment.

As the attending physician, you can also refer your patient to a specialist physician for a consultation or specialized treatment and still continue to serve as the patient's attending physician (you are responsible for authorizing any time loss).

Attending physicians' time frames

As a chiropractic physician, you may treat the patient as the attending physician up to 60 consecutive days or 18 visits (whichever occurs first) from the date of the initial visit. As a chiropractic physician, you may authorize time loss for up to 30 days from the date of the initial visit.

If you have authorized time loss for 30 days and the patient continues to need time loss authorized, the patient must choose a new attending physician or authorized nurse practitioner. However, if you have authorized time loss for 30 days and the patient no longer needs time loss authorized, you may continue to treat as the attending physician up to the limit of 60 days or 18 visits.

✓ **Tip**: As a chiropractic physician, you need to find out if the patient has already been treated by a naturopathic physician or another chiropractic physician because the 60-day/18 visits clock starts when the patient chooses one of these providers as their attending physician.

Stay at work/return to work

As the attending physician, you have the primary responsibility to determine whether the patient is able to continue regular employment or whether there are any limits on the patient's ability to perform work activities. Keep in mind, you can only authorize time loss for 30 days from the initial visit. If you determine that the patient is unable to continue regular work duties, WCD strongly encourages you to contact the employer or insurer and discuss potential modified work duties the patient is able to perform.

If you place, modify, or lift any work modifications, you must immediately inform the patient and notify the insurer in writing within five consecutive calendar days. Prompt notification to the insurer will reduce insurer inquiries and promote timely payment of benefits to the patient.

When you release a patient to return to work, you must do so in writing and specify work restrictions, if any. You may use Form 3245, "Return-to-Work Status"; however, you are not required to use this form unless the insurer requests it.

✓ **Tip**: You are allowed to communicate with the employer regarding what type of work the patient is able to perform.

Treatment after the patient is medically stationary

Once the patient becomes medically stationary, you can no longer be the attending physician. However, you may continue to provide compensable medical services as an ancillary provider if authorized by the attending physician.

Providing care as the ancillary care provider

When you are not the attending physician or no longer qualify to be the attending physician, you are considered an ancillary care provider. As an ancillary care provider, you may provide treatment only upon referral from the attending physician, authorized nurse practitioner, or specialist physician.

As the ancillary care provider, you must send a treatment plan containing the following four elements to the referring provider and insurer within seven days of beginning treatment:

- Objectives (e.g., decreased pain, increased range of motion)
- Modalities (e.g., chiropractic manipulation, ultrasound)

- Frequency of treatment (e.g., once per week)
- Duration (e.g., four weeks)

✓ **Tip**: Fax the treatment plan to the insurer and keep a copy of the confirmation page in the patient's file.

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

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

At any time, insurers may enroll patients into a managed care organization (MCO). You should ask the patient or the insurer if the patient has become enrolled in an MCO because if you are not a panel provider for that MCO, the insurer will not have to pay for your services.

First visit

The patient may file a workers' compensation claim two ways:

- When the employer completes and submits Form 801, "Report of Job Injury or Illness."
- When you complete and submit Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims."

Form 827 – Worker's and Health Care Provider's Report for Workers' Compensation Claims

Have the patient complete and sign the worker portion of this form ONLY if:

- You are the very first health care provider the patient has seen for their injury. In this case, send Form 827 to the insurer within three days.
- If you become the new attending physician and become primarily responsible for treating the patient. In this case, send Form 827, to the insurer within five days.
- The patient wants to file a new or omitted medical condition. In this case, send Form 827 to the insurer within five days.

Give the patient a copy of the completed Form 827. To learn how to use Form 827, check out the short video at https://www.youtube.com/watch?v=HMnsmhj403k.

✓ **Tip**: Order multiple copies of Form 827 at https://wcd.oregon.gov/forms/Pages/ordering.aspx.

On the first visit, you must notify the patient, preferably in writing, that the patient may have to pay for medical services that are not covered. This may include:

- If the patient seeks treatment for conditions that are not related to the accepted compensable injury or illness. You can contact the insurer to find out what the accepted conditions are.
- If the patient has been enrolled in an MCO and seeks treatment from you and you are not a panel provider for that MCO.
- If the patient seeks treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven.

Stay at work/return to work

All parties benefit when the patient stays at work or returns to work as quickly as possible after an on-the-job injury. Physicians who regularly treat workers' compensation patients have said that setting stay-at-work or return-to-work expectations at the patient's first visit is a vital part of the treatment program and key to the healing of their on-the-job injury.

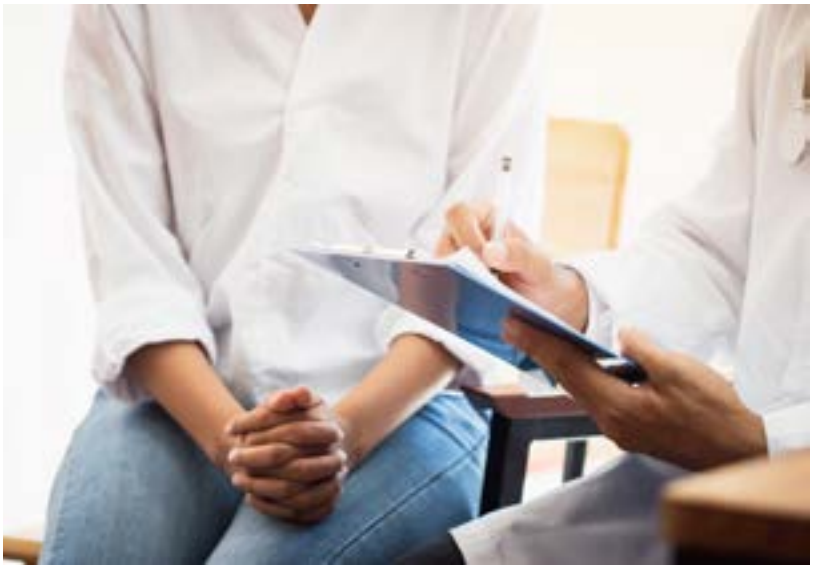

Chart notes

It is crucial that your chart notes are clear and fully document a comprehensive diagnostic workup. You must submit a legend when submitting coded or semi-coded chart notes. The insurer uses the information in your chart notes to determine what conditions to accept for the claim. The patient is entitled only to medical services that are related to the accepted conditions.

✓ **Tip**: It is important that you report a specific diagnosis rather than a symptom.

Managed care organization (MCO)

At every visit, ask if the patient is enrolled in an MCO. You also may contact the insurer to find out if the patient is enrolled in an MCO. If you treat an MCO-enrolled patient and you or the referring physician are not on that MCO's panel, the insurer will not have to pay you.

Your rights and duties as an MCO-panel provider may differ from those described in this guide. Many MCOs require pre-certification of medical services for enrolled patients. Therefore, if you are an MCO-panel provider, you should refer to your MCO provider participation agreements or contracts for specific requirements in addition to this guide.

✓ **Tip**: Remind your patient at each visit to bring in any paperwork from the insurer or MCO.

Come-along provider

If you are not an MCO-panel provider, but you have a history of treating the patient before the work-related injury or disease, you may continue to treat the patient as a come-along provider. As a come-along provider, you must abide by the MCO's terms and conditions to remain a come-along provider. To become a come-along provider, have your patient contact the MCO or insurer.

Pre-authorization

If a patient is enrolled in a certified MCO, the MCO may require pre-authorization of certain services. Please check with each MCO. Generally, for patients not enrolled in an MCO, insurers do not have to issue pre-authorization for any treatment. An exception is for imaging studies other than plain film X-rays. The request must be separate from chart notes and clearly state that it is a request for pre-authorization of diagnostic imaging studies.

Pre-authorization is not a guarantee of payment. The insurer must respond to your request in writing whether the service is pre-authorized or not pre-authorized within 14 days of receipt of the request.

Another exception is after a patient becomes medically stationary. The attending physician needs to request approval from the insurer for palliative care (e.g., physical therapy).

You must notify the insurer in writing of your intent to perform elective surgery at least seven days before the date of the surgery. The insurer must respond within seven days of receiving the notice of intent to perform surgery that the proposed surgery is either approved; not approved and a consultation is requested; or is disapproved. Emergency surgery to preserve life, function, or health is excluded from notification requirements.

Referrals

Referral to an ancillary care provider

As the attending physician, you may refer the patient to an ancillary care provider, such as a massage therapist or acupuncturist. The ancillary care

provider must send you a treatment plan containing the following four elements within seven days of beginning treatment:

- Objectives (e.g., decreased pain, increased range of motion)
- Modalities (e.g., acupuncture, massage)
- Frequency of treatment (e.g., once per week)
- Duration (e.g., four weeks)

Once you receive the treatment plan from the ancillary care provider, you must sign and send the plan to the insurer within 30 days of the beginning of the ancillary care.

✓ **Tip**: Fax the treatment plan to the insurer and keep a copy of the confirmation page in the patient's file.

At any time, insurers may enroll patients into an MCO. You should ask the patient or insurer if the patient has become enrolled in an MCO. If you refer an MCO-enrolled patient to an ancillary care provider, that provider must be on that MCO's panel.

Referral to a specialist physician

As the attending physician, you can refer your patient to a specialist physician for a consultation or specialized treatment, and you will continue to serve as the patient's attending physician (you are responsible for authorizing any time loss).

✓ **Tip**: When chiropractic physicians are not providing treatment as the attending physician, they are considered an ancillary care provider and may not refer the patient to a specialist and must follow the guidelines above regarding the treatment plan.

Billing

Here is useful information for an efficient billing process:

- An employer may not pay you directly unless the employer is self-insured. Therefore, you must always bill the workers' compensation insurer and not the employer.
- Send your bills to the insurer on a CMS-1500 form no later than 60 days after the date of service – even if the worker's claim has not yet been accepted.
- Charge the usual fees that you charge to the general public.
- Use CPT and Oregon-specific codes. If there is no CPT and Oregon-specific code, use the appropriate HCPCS code.
- All your billings must include legible chart notes describing the services provided and identify the person performing the service.
- You may not charge a fee for providing the chart notes with your bills. However, if the insurer requests additional copies, you may bill for the copies using Oregon specific code R0001 or, if electronically, R0002.
- If you are asked to prepare a report or review records other than your own, use CPT code 99080 and indicate the actual time spent. If the request comes from the insurer, the insurer must pay you, even if the claim is denied.
- Before the claim is accepted or denied and if the patient has private health insurance, you should bill as described under interim medical benefits.

✓ **Tip**: You may bill electronically. See the electronic medical billing rules OAR 436-008 or contact the insurer.

Interim medical benefits

WCD has published administrative rules implementing House Bill 4104 affecting interim medical benefits. Effective Jan. 1, 2015, the following applies to interim medical benefits.

- Interim medical benefits apply only when a patient initially files for workers' compensation benefits and has a health benefit plan. Interim medical benefits

cover services from the start of the claim to the date the insurer accepts or denies the claim.

- Interim medical benefits do not include treatments listed under OAR 436-009-0010(12).
- The provider must bill the workers' compensation insurer within 60 days and the health benefit plan according to the plan's requirements.
- The provider should submit a pre-authorization request to the health benefit plan according to the plan's requirements before claim acceptance or denial.
- The provider may not collect any health benefit plan copay, coinsurance, or deductible from the patient during the interim period.
- If the insurer accepts the claim, the workers' compensation insurer must pay providers for services according to the medical fee and payment rules (OAR 436-009). When the provider receives the insurer's payment, the provider must reimburse the patient and the health benefit plan for any medical expenses, copays, coinsurance, or deductibles paid by the patient or the health benefit plan.
- If the insurer denies the claim, the workers' compensation insurer must notify the medical provider that the claim has been denied. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Billing the workers' compensation patient

When you provide medical services to a workers' compensation patient, you should not bill the patient for any services related to an accepted compensable injury or illness unless:

- The patient seeks treatment for conditions not related to the accepted compensable injury or illness.
- 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 the insurer or the director has disapproved it.
- The MCO-enrolled patient seeks treatment from a non-panel provider.
- The patient seeks excluded treatment after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

Finding the workers' compensation insurer

If your patient does not know who the workers' compensation insurer is, call the WCD Employer Index at 503-947-7814 or visit the WCD Employer Proof of Coverage search page.

Payment

Once the claim is accepted, the insurer must issue payment within 45 days of receiving your bills and chart notes. If the insurer fails to pay timely, you may charge a reasonable monthly service fee for the period that the payment was delayed, but only if you charge such a fee to the general public.

✓ **Tip**: When the insurer does not issue a notice of acceptance or denial within 60 days of employer notice then the workers' compensation claim is considered denied (de facto denial). The patient may appeal the de facto denial with the Oregon Workers' Compensation Board.

If you do not receive payment within 45 days or you disagree with the payment amount, first contact the insurer to try to resolve the issue. If you are unable to resolve the issue with the insurer you can file a dispute with WCD, but you must do so within 90 days of the mailing date on the explanation of benefits (EOB).

An employer may not pay you directly unless the employer is self-insured. Therefore, you must always bill the workers' compensation insurer and not the employer.

Unless you have an MCO contract or a fee discount agreement, you should get paid the amount you billed or the amount of the Oregon workers' compensation fee schedule, whichever is less.

Insurers do not have to pay providers for the following:

- Treating conditions that are not accepted by the insurer
- Completing forms 827 and 4909
- Providing chart notes with the original bill
- Preparing a written treatment plan
- Supplying progress notes that document the services billed
- Completing a work release form or a physical capacity evaluation (PCE) form, when no tests are performed
- A missed appointment "no show"
- Dietary supplements

Note: There are excluded treatments that insurers don't have to pay for. Read OAR 436-009-0010(12).

If an insurer reduces a fee stating that the service is included in another service billed (bundling), you may want to verify that either the CPT or the Division 009 rules allow that specific bundling.

Note: WCD has not adopted the National Correct Coding Initiative (NCCI) edits, and the insurer should not apply any NCCI edits.

Payment disputes

Some insurers may ask you to file an appeal to answer your payment question or resolve your dispute; however, you are not required to file an appeal with the insurer. If you are unable to informally resolve your payment issue with the insurer, you may file a dispute with WCD.

However, you must request dispute resolution with WCD within 90 days of the mailing date of the most recent explanation of benefits or a similar notification.

✓ **Tip**: Even if you are working with the insurer to resolve your issue during the 90 days, don't let the 90-day time frame pass before requesting dispute resolution with WCD.

To file a dispute, use a copy of Form 2842, "Request for Dispute Resolution of Medical Issues and Medical Fees." To identify specific services in dispute, you may use worksheet 2842a, "Medical Fee Dispute Resolution Request and Worksheet," in addition to Form 2842.

Alternatively, if you have an explanation of benefits (EOB), you can file a dispute by doing all of the following:

- Signing and dating the EOB.
- Attaching copies of chart notes, original bills, or additional supporting documentation.
- Providing a cover letter outlining the steps you have taken to try to resolve the dispute and describing the specific issue in dispute.

Fee schedule

The rules regarding the application of the fee schedules are located in the Division 009 rules, specifically:

- Physician fee schedule in OAR 436-009-0040
- Ambulatory surgery center in OAR 436-009-0023
- Hospital fee schedule in OAR 436-009-0020
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule in OAR 436-009-0080
- Pharmaceutical fee schedule in OAR 436-009-0090

Fee schedule amounts:

- WCD publishes the following fee schedules:
- Physician fee schedule (Appendix B or calculator)
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule (Appendix E or calculator)
- Ambulatory surgery center fee schedule (Appendices C and D or calculator)

Discounts and contracts:

Insurers are allowed to apply a discount to the fee schedule amounts only if the services are covered by an MCO contract or you and the insurer have a fee discount agreement registered with the division.

If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may apply the discount only under the MCO's contract.

Excluded treatment

The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

- Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis
- Intradiscal electrothermal therapy (IDET)
- Surface electromyography (EMG) tests
- Rolfing
- Prolotherapy
- Platelet rich plasma (PRP) injections
- Thermography
- Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:
  - The single level artificial disc replacement is between L3 and S1
  - The patient is 16 to 60 years old
  - The patient underwent a minimum of six months unsuccessful exercise-based rehabilitation
  - The procedure is not found inappropriate under OAR 436-010-0230
- Cervical artificial disc replacement, unless the procedure is a single level or a two level contiguous cervical artificial disc replacement with a device that has Food and Drug Administration approval for the procedure

Interpreter services

The patient may choose an interpreter; however, you may disapprove the patient's choice if the interpreter does not improve communication with the patient.

Only a sign language interpreter licensed by the Health Licensing Office may provide signed language interpretation services in a medical setting.

You may not bill for interpreter services if one of your employees provides those services.

Closing exams

Once a patient reaches maximum recovery, the patient becomes medically stationary, meaning no further material improvement would be reasonably expected from medical treatment or the passage of time. When the patient is medically stationary, the patient's attending physician should conduct a closing exam to measure impairment.

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

Closing reports must be submitted to the insurer within 14 days of the date the patient is declared medically stationary.

✓ **Tip**: You can find the requirements for performing a closing exam in Bulletin 239.

Treatment after medically stationary

Once the patient becomes medically stationary, you are allowed to treat the patient only as an ancillary care provider if authorized by the attending physician and under a treatment plan.

Curative care is care provided to a patient to stabilize a temporary and acute waxing and waning of symptoms. Treatment plan requirements are the same as described under providing care as the ancillary provider.

Palliative care is treatment aimed at temporarily reducing or moderating the intensity of an otherwise stable medical condition and is necessary to enable the patient to continue current employment or a vocational training program. The palliative care request that the attending physician sends to the insurer contains a treatment plan. Therefore, the ancillary care providers do not need to submit a separate treatment plan when providing palliative care. The attending physician's palliative care request must contain the following elements:

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

The insurer does not have to pay you for palliative care you provide if the attending physician fails to complete and send the completed palliative care request to the insurer for approval.

✓ **Tip**: Ask for a copy of the palliative care request from the attending physician. Make sure the palliative care request contains all the required elements. If not, talk to the attending physician.

Aggravation:

To qualify as an aggravation, the patient's accepted condition must have pathologically worsened. A patient may make a claim for aggravation by filing Form 827 anytime within five years after first closure or five years after the date of injury on a nondisabling claim. The attending physician must include medical evidence supported by objective findings of an actual worsening of the accepted claim and file Form 827 on the patient's behalf.

Timeline summary

File Form 827 for the first report of injury or disease within **3 days**.

File Form 827 for change of attending physician or authorized nurse practitioner within **5 days**.

Refer worker for a closing exam within **7 days**.

When providing ancillary care, send treatment plan to insurer and prescribing provider within **7 days**.

Respond to records request from insurer or director within **14 days**.

Complete an insurer-requested physical capacity evaluation (PCE) or work capacity evaluation (WCE) within 20 days.

Sign copy of treatment plan when you are the attending physician and send to insurer within 30 days.

Medical records – what to release

When your patient signs Form 801 or Form 827 to file a workers' compensation claim, the patient authorizes you to release relevant medical records to the insurer, self-insured employer, or WCD. Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. However, you are not authorized to release information regarding the following without a separate authorization:

- Federally funded alcohol and drug-abuse treatment programs.
- HIV-related information unless the patient makes a claim for HIV or AIDS or when such information is directly relevant to the claimed condition.

The privacy rule of the Health Insurance Portability and Accountability Act allows health care providers to disclose protected health information to regulatory agencies, insurers, and employers as authorized and necessary to comply with the laws relating to workers' compensation.

Note: Any disclosures to employers are limited to work-related purposes, such as return to work or modified work.

Timeline summary

Action/Status	Days
File Form 827 for new injury or disease	3 days
File Form 827 for change of attending physician	5 days
Submit treatment plan when ancillary care provider	7 days
Refer worker for a closing examination	8 days
Respond to records request from insurer or director	14 days
Complete an insurer-requested PCE or WCE	20 days
Sign copy of treatment plan when attending physician	30 days
Authorize time loss	*30 days
Attending physician status	*60 days/18 visits

Note: Remember, as a chiropractic physician you can be an attending physician for up to 60 calendar days or 18 visits (whichever comes first) and authorize time-loss benefits for up to 30 calendar days from the first day the patient sees you or any chiropractic physician, naturopathic physician, or physician associate on the initial claim.

How to find workers' compensation coverage information

First – Call the employer for information about insurance coverage.

If you need more help – Contact the Employer Compliance Unit of WCD by phone, fax, email, or Internet.

- Phone: 503-947-7815
- Fax: 503-947-7718
- Email: wcd.employerinfo@dcbs.oregon.gov
- Internet: www.wcd.oregon.gov, under "Industry services," select "Look up an employer's coverage."

Provide this information to WCD:

- Employer's legal business name, street address, city, and phone number.
- Coverage inquiry date.
- Worker's name.

If necessary, the Employer Compliance Unit will conduct further research.

Please send a copy of Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," or Form 801, "Report of Job Injury or Illness" to:

Workers' Compensation Division Employer Compliance Unit
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

440-3656 (5/24/COM)