



Claims Examiner's Guide for Interaction with Independent Medical Exam Providers

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The Workers' Compensation Division (WCD) developed this guide for claims examiners who want training to fulfill the one-hour requirement related to interactions with independent medical exam (IME) providers. Oregon's workers' compensation system is designed to:

- Ensure that workers receive timely and accurate benefits.
- Prevent or reduce workers' injuries and illnesses.
- Provide appropriate medical treatment to help workers recover and return to work as soon as possible.
- Resolve disputes quickly and fairly.
- Be the exclusive liability for employers and the exclusive remedy for workers with injuries, diseases, symptom complexes, and similar conditions arising out of and in the course of employment, whether or not they are determined to be compensable under workers' compensation law. Oregon Revised Statute (ORS) 656.018.

Types of exams and the differences between them

Independent medical exam (IME)

An objective and impartial medical exam of a worker by a health care provider other than the worker's attending physician at the request of the insurer. Insurers must choose from the director's list of authorized IME providers. ORS 656.325. A health care provider other than the worker's attending physician conducts the exam in an office or through an IME company. An exam performed by more than one health care provider, in one or more locations within a 72-hour period, is called a panel exam.

IME exams may be performed to determine the compensability or cause of the injury itself; if the treatment the worker is receiving is appropriate; and whether the worker has a measurable impairment. This does not include a consultation arranged by a managed care organization (MCO) for an enrolled worker or a second surgical opinion. A physical exam by an attending physician is performed primarily for the purposes of determining a diagnosis and documenting the clinical course over time.

The IME physical exam objectively documents the worker's status. Specific measurements according to accepted protocols may be used to provide the basis for impairment ratings. In an IME, there is usually only one opportunity for examination. The IME provider needs to provide a complete, comprehensive, and objective description of the worker's condition at that time. The IME provider needs to take into context prior health, physical and vocational capabilities, and social functioning. In contrast, the attending physician's evaluations are based on multiple, shorter encounters over the course of time. Unlike the medical consultation that ends only with treatment recommendations, the IME is broader in scope. The IME provider will answer specific questions posed by the insurer.





Worker-requested medical exam (WRME)

An objective and impartial exam available to a worker whose claim has been denied based on an independent medical exam in which the worker's attending physician did not concur with the findings and the worker requests a hearing on the denial. ORS 656.325. If the WRME is approved, the director chooses the provider from the authorized list of IME providers. The worker or the worker's attorney schedules the exam. The insurer is required to send the medical records to the health care provider conducting the exam. The WRME provider answers the questions asked during the original IME and any additional questions from the worker or the worker's attorney.

Medical arbiter exam

The director selects a health care provider to perform an impartial exam about a disagreement over impairment findings at claim closure. This exam helps the division's appellate reviewer resolve the disagreement. The reviewer asks specific questions about the worker's impairment and may ask about the portion of the worker's impairment that is due to the accepted conditions. Claim closure disputes do not review for compensability. ORS 656.268.

Physician review exam

The director selects a health care provider to perform an exam or file review for a dispute about appropriateness of a proposed or provided treatment. This exam helps the division's medical reviewer resolve the dispute. The reviewer asks specific questions about if the treatment is appropriate given the worker's accepted condition. Treatment disputes do not review for compensability. ORS 656.327.

Who can perform an IME?

Health care providers on the [director's list of authorized IME providers](#).

A physical therapist or occupational therapist may be asked to perform physical capacity evaluations (PCE) or work capacity evaluations (WCE), along with an IME. In this case, the claims examiner must use the director's list of authorized IME providers to select the physical therapist or occupational therapist. If the attending physician asks the claims examiner to arrange the PCE or WCE, or if an attending physician initiates the PCE or WCE, the attending physician or the claims examiner do not need to use the director's list when choosing the physical therapist or occupational therapist.



IME standards

Below are the IME Requirements and Standards of Professional Conduct that the authorized IME provider agrees to abide by when signing the IME provider application.

1. IME providers must maintain effective communication, which includes but is not limited to:
 - a. Taking steps to avoid personal conflicts during the IME and, to the extent they arise, an IME provider must be prepared to address the conflict in a professional and constructive manner and adapt to situations by changing strategy or communication style when appropriate.
 - b. Maintaining the confidentiality of the parties involved in the exam subject to applicable laws.
 - c. Allowing the worker to express themselves fully without unnecessary interruption. If the IME provider needs more information after a worker has answered a question, the IME provider must rephrase the question and explain why they are asking again.
2. IME providers must conduct an objective and impartial examination, which includes but is not limited to:
 - a. Conducting the IME without any preconceived notions or premature conclusions.
 - b. Not sharing personal feelings or personal opinions.
 - c. Remaining objective and impartial, both in reporting and during the examination.
 - d. Basing findings and opinions only on established medical fact, practice, and theory, and not on an accepted fee for services.
 - e. Recusing themselves prior to the IME if there is any sort of preexisting conflict, whether apparent or actual.
 - f. Being fair, truthful, and forthright in interactions with the worker and insurers whether through written documentation or oral communication.
3. IME providers must maintain dignity and respect for the parties involved, which includes but is not limited to:
 - a. Treating the worker with dignity and respect and listening attentively.
 - b. Giving the worker appropriate empathy for pain, discomfort, and anxiety.
 - c. Using an appropriate tone and being aware of the worker's demeanor and body language when conducting the IME.
 - d. Being courteous and polite to the worker.
 - e. Being respectful of the worker's scheduled time for the IME and minimizing the necessary preparation for the IME while the worker waits.
 - f. Refraining from making disparaging or insulting comments to the worker about any party to the claim.
 - g. Refraining from criticizing or degrading the worker about their behavior or the history they provide.



h. Respecting a worker's answer of "no" if the IME provider asks for permission to allow someone other than a scribe or chaperone to sit in on the IME without further questioning or encouraging a worker to provide permission.

4. Before the IME starts, the IME provider must:

- a. Identify themselves to the worker as an IME provider.
- b. Verify the worker's identity.
- c. Tell the worker who requested the IME.
- d. Tell the worker that an ongoing physician-patient relationship will not be sought or established.
- e. Tell the worker that any information provided during the IME will be documented in a report.
- f. Let the worker know that the IME provider cannot share opinions with them but will document findings in the report.
- g. Explain the procedures that will be used during the IME.
- h. Tell the worker that they may terminate a procedure if the worker feels the activity is beyond the worker's physical capacity or when pain occurs.
- i. Ask the worker if they have any questions about the IME process.

5. During the IME, the IME provider must:

- a. Ensure the worker has privacy to disrobe.
- b. Sufficiently examine the conditions being evaluated to answer the requesting party's questions.
- c. Let the worker know when the exam has concluded and ask if the worker wants to provide more information or has questions.

Appropriate communications and interactions with IME providers

Claims examiners should be honest in all communications with the IME provider.

Claims examiners should never offer a fee for services dependent upon the IME provider writing a report favorable to the insurer.

Claims examiners should phrase questions to the IME provider in a way that will not lead the IME provider to make a conclusion. The IME provider's role is to provide an independent, unbiased, and objective evaluation to establish medical facts about a worker's physical condition. Do not ask leading questions.

Example: If there are work restrictions, and they are permanent, wouldn't the worker be considered medically stationary?

Instead: If there are work restrictions, and they are permanent, is the worker medically stationary?

Example: If the worker is not medically stationary at this time, do you believe it is because of preexisting conditions?

Instead: If the worker is not medically stationary at this time, please explain.

Example: It appears that the prior radiographs were essentially normal and the current MRI scan shows unrelated changes.

Instead: Prior radiographs were reported to be essentially normal, and the current MRI scan shows unrelated changes.

Example: Do you agree that all the loss of range of motion is due to an unrelated condition?

Instead: Describe the range-of-motion findings due to the accepted condition.

Claims examiners should not ask the IME provider to reword or rephrase the report. Claims examiners should not attempt to influence the IME report.

Claims examiners should not tell the IME provider not to write or send the report. The rules require the provider to send the insurer a report.

If the claims examiner needs clarification, it is fine to ask follow-up questions.

Claims examiners should not discuss the worker's history or medical treatment with the IME provider.



Insurer responsibilities

The insurer may obtain three IMEs for each opening of the claim without director approval. These exams may be obtained before or after claim closure. Exams after claim closure are subject to the limitations in ORS 656.268(8). The insurer must choose the medical service providers from the director's list of authorized IME providers under ORS 656.328.

For the purpose of determining the number of IMEs, any IME scheduled but not completed does not count as a statutory IME.

An IME panel exam is an exam conducted by one or more providers of different specialties. The insurer is responsible to ensure panel exams are completed within a 72-hour period, even when providers are not located in the same location, and that IME locations are reasonably convenient to the worker.

Under OAR 436-010-0265(1)(b), the following circumstances allow for a new series of three IMEs:

- A claim for aggravation.
- Board's own motion (reopening a claim after aggravation rights have expired for a worsening, new, or omitted medical condition claim).
- Reopening of a claim when the worker becomes enrolled or actively engaged in training under OAR 436-120.

IME appointment notice

If an exam is scheduled, the appointment notice must be mailed at least 10 calendar days before the exam. The worker's attorney must be given prior or simultaneous written notice of the scheduled IME under ORS 656.331. The appointment notice must be sent on the insurer's stationery.

The appointment notice must contain all of the following:

- The name of the examiner or facility.
- A statement of the specific purpose for the exam and identification of the medical specialties of the examiners.
- The date, time, and place of the exam.
- The first and last name of the attending physician or authorized nurse practitioner, and verification that the attending physician or authorized nurse practitioner was informed of the exam by, at least, a copy of the appointment notice or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate.
- If applicable, confirmation that the director has approved the exam.
- A statement that the reasonable cost of public transportation or use of a private vehicle will be reimbursed. When necessary, reasonable cost of child care, meals, lodging, and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt, or other evidence necessary to support the request. If an advance of these costs is necessary to attend the exam, a request

for advancement must be made in sufficient time to ensure attendance.

- A statement that an amount will be paid equal to net lost wages for the period during which it is necessary to be absent from work to attend the exam if benefits are not received under ORS 656.210(4) during the absence.
- A statement that the worker has the right to have an observer present at the exam, but the observer may not be compensated in any way for attending the exam.
- However, for a psychological exam, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer.
- Required notice language as directed by [OAR 436-060-0095\(3\)\(e\)\(I\)](#).

With each appointment notice it sends the worker, the insurer must include the following:

- Form [440-3921](#), "Request for Reimbursement of Expenses," or a similar form for requesting reimbursement.
- Form [440-3923](#), "Important Information about Independent Medical Exams."

Reimbursement of costs

The insurer must reimburse the worker for a reasonable cost of public transportation or use of a private vehicle and, when necessary, a reasonable cost of child care, meals, lodging, and other related services. The worker must submit a request for reimbursement, accompanied by a sales slip, receipt, or other evidence necessary to support the request. Child care costs reimbursed at the rate prescribed by the Oregon Department of Human Services are considered to be reasonable under this rule.

If an advance of these costs is necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance.

Worker did not attend an IME

The insurer should verify if the worker did not attend the IME. The insurer may request suspension of benefits and a \$100 penalty against the worker's future benefits if the worker fails to attend an IME without notifying the insurer before the date of the exam or without a good reason for not attending the exam. Also, the \$100 penalty may not be assessed against a worker receiving temporary disability benefits.

Requests for suspension

The director will consider requests to authorize suspension of benefits on accepted claims, deferred claims, and denied claims in which the worker has appealed the insurer's denial. The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service in the same manner as a summons.

The request must include all of the following:

- That the insurer requests suspension of compensation under ORS 656.325 and OAR 436-060-0095.
- The claim status and any accepted or newly claimed conditions.
- The specific actions of the worker that prompted the request.



- The dates of any prior IMEs the worker attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate.
- A copy of any approvals given by the director for more than three IMEs, or a statement that no approval was necessary, whichever is appropriate.
- Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate.
- The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's attorney will be sufficient documentation with which to request suspension.
- A copy of the appointment notice and a copy of any written verification.
- Any other information that supports the request.
- Required notice language as directed by [OAR 436-060-0095\(6\)\(j\)](#).

The insurer must help the worker meet requirements necessary to continue compensation payments. When the worker has undergone the IME, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the mailing date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(8).

Worker's rights and responsibilities

Recording the exam

A worker may use a video camera or other device to record the exam only if the IME provider approves.

Observers in IME exams

A worker may choose to have an observer present during the IME. An observer is not allowed to be present during a psychological examination unless the IME provider approves.

The worker must sign an IME Observer Form, included in Form 3923 "Important Information about Independent Medical Exams for Injured Workers." By signing Form 3923, the worker is stating that they understand the following:

- The IME provider may ask sensitive questions during the exam in front of the observer.
- If the observer interferes with the exam, the IME provider may stop the exam, which could affect the worker's benefits.
- The observer must not be paid to attend the exam.

An IME observer cannot:

- Participate in or obstruct the exam.
- Be the worker's attorney or any representative of the worker's attorney.

Invasive procedures

An invasive procedure is one that breaks the skin or penetrates, pierces, or enters the body using a surgical or exploratory procedure (e.g., by a needle, tube, scope, or scalpel). If an IME provider intends to perform an invasive procedure, the provider must explain to the worker the risks involved in the procedure and the worker's right to refuse the procedure. The worker must fill out and sign Form 3227 "Invasive Medical Procedure Authorization," and check the applicable box either agreeing to or declining the procedure. The IME provider must make a copy of the signed Form 3227 for the worker and send the original to the insurer.

Interpreters

A worker may choose a person to communicate with the IME provider when the IME provider and the worker speak different languages, including sign language. The worker may ask the claims examiner to help arrange for an interpreter. The worker may use a family member, friend, an employee of the medical provider, or a professional interpreter to assist with interpreting. However, only a licensed sign language interpreter under Oregon Laws 2023, chapter 414, section 6 may provide sign language interpretation.

The IME provider may disapprove of the worker's choice of interpreter at any time the provider thinks the interpreter's services are not improving communication with the worker or thinks the interpretation is not complete or accurate. The insurer will not pay a medical provider, medical provider's employee, or a family member or friend of the worker who provides interpreter services.

Worker objects to IME location

If the worker objects to the location of an IME, the worker may request review by the director within six business days of the mailing date of the appointment notice. OAR 436-010-0265(8). The worker's request must be made in person or by phone, fax, email, or mail. The director may facilitate an agreement between parties regarding the location of the IME.

The director may conduct an expedited review to determine the reasonableness of the location. The director will determine if travel is medically contraindicated or unreasonable because of the following issues:

- The travel exceeds limits imposed by the attending physician or authorized nurse practitioner or any medical conditions.
- Alternative methods of travel will not overcome the limitations.
- The travel will impose undue hardship for the worker that outweighs the right of the insurer to select an IME location of its choice.

IME report

If the worker requests a copy of the IME report, the insurer must provide it.

If the worker finds inaccuracies in the IME report, the worker may write a letter to the claims examiner to address these inaccuracies and ask that the letter be added to the worker's official claim file.

WCD survey and complaint process

The worker may file a complaint or provide feedback about the IME experience online at www.wcdimesurvey.info. If the worker has already taken the survey and wants to file a complaint, the worker can email wcd.policyquestions@dcbs.oregon.gov or call 503-947-7537. The Workers' Compensation Division reviews IME complaints to determine the appropriate action under the director's jurisdiction.

The Workers' Compensation Division has received the following worker complaints regarding unprofessional behavior by some IME providers:

- Asking the same questions multiple times after the worker has already answered.
- Trying to convince or persuade the worker of the provider's opinions or conclusions.
- Using a position of power to manipulate the worker's response to fit the provider's expectation.
- Minimizing the worker's pain complaints to achieve a better range of motion measurement.
- Not recognizing the worker's fears and anxiety and not giving the appropriate empathy.
- Not actively listening and appropriately responding to the worker's concerns and questions.

The Workers' Compensation Division investigates worker complaints of this nature and will determine the appropriate action, which may include removal of the IME provider from the director's IME list.

The division may contact any person who may have information or view any documents or items regarding the IME or complaint.

IME reports

The IME provider must send a copy of the IME report to the insurer and include a quality assurance statement at the end of the report acknowledging that the IME provider made no false statements and verifying who performed the exam, who dictated the report, and the accuracy of the report content. If there is an Observer Form or an Invasive Procedure Form, the IME provider should send copies to the insurer. The IME report should answer all of the questions the claims examiner asks. The reader of an IME report may not have extensive medical background, therefore, the IME provider should write the report so that it is understandable to the lay reader. If an error is found after the report is sent to the insurer, the IME provider may correct the report.

If, after reviewing the report, the claims examiner needs more information from the IME provider, the claims examiner may request a supplemental report.

The IME provider must communicate with the insurer if the IME provider is unable to provide the report within the insurer's requested time period and provide a date when the report will be sent.

The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within three business days of the insurer's receipt of the report.



Terms used in workers' compensation

accepted condition

A medical condition for which an insurer accepts responsibility for the payment of benefits on a claim filed by an injured worker. The insurer provides written notice of accepted conditions. ORS 656.262. Generally, the insurer will accept specific conditions based on the diagnosis by the physician or nurse practitioner. It is important that the health care provider report a diagnosis rather than a symptom.

aggravation claim

A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. An aggravation is established by medical evidence supported by objective findings observed or measured by the physician. Aggravation rights expire five years after first closure on disabling claims or five years from date of injury on nondisabling claims. ORS 656.273. The insurer has 60 days to accept or deny a claim for an aggravation.

apportionment of impairment

A description of the current total overall findings of impairment and those findings that are due to the compensable injury.

Describes specific findings that are partially attributable to the compensable injury, as well as any superimposed or preexisting conditions.

Example: Seventy-five percent of the decreased range of motion is due to the accepted condition and any direct medical sequela, and the remaining percentage is due to preexisting degenerative joint disease.

attending physician (AP)

A health care provider primarily responsible for the treatment of an injured worker. ORS 656.005.

claim

A written request by the worker or on the worker's behalf for compensation. ORS 656.006. The

insurer has 60 consecutive calendar days from the employer's date of knowledge to accept or deny the claim. (Also, refer to [disabling claim](#) and [nondisabling claim](#).)

claim disposition agreement (CDA and C&R)

An agreement between the parties to a workers' compensation claim. The worker agrees to sell back their rights (e.g., rights to compensation, attorney fees, and expenses), except medical and preferred worker benefits on an accepted claim. Also known as a "C&R" or a "compromise and release." ORS 656.236.

closing exam

A medical exam to measure impairment that occurs when the worker is medically stationary.

combined condition

A combined condition occurs when a preexisting condition combines with a compensable injury to cause or prolong disability or need for treatment. However, a combined condition is compensable only if the compensable injury is the major contributing cause of the disability or the need for prolonged treatment.

Example: A worker has arthritis of the knee and then sustains a job-related injury to the same knee. The acute condition is diagnosed as a sprain. Both conditions contribute to the worker's disability. The combined condition is compensable only if the compensable injury contributes more than 50 percent to the worker's disability or need for treatment.

compensable injury

An accidental injury to a person or prosthetic appliance, arising out of and in the course of employment that requires medical services or results in disability or death. ORS 656.005.

consequential condition or disease

A condition arising after a compensable injury of

which the major contributing cause is the injury or treatment rendered that increases either disability or need for treatment. ORS 656.005. A consequential condition is compensable only if the compensable injury or disease contributes more than 50 percent of the worker's disability or need for treatment.

Example: Use of crutches due to a compensable knee condition may cause a consequential shoulder condition that requires treatment or leads to disability.

consulting physician

A physician who advises the attending physician or authorized nurse practitioner regarding the treatment of a worker's injury. A consulting physician is not considered an attending physician, and, therefore, the worker should not complete Form 827 for the consultation.

curative care

In the workers' compensation system, treatment to stabilize a temporary waxing and waning of symptoms after a worker is medically stationary. ORS 656.245.

denied claim (denial)

A written refusal by an insurer to accept compensability or responsibility for a worker's claim of injury. ORS 656.262. On accepted claims, the insurer may deny only certain conditions; this is known as a partial denial. Only a worker can appeal a denial of a claim.

disabling claim

A worker's compensation claim that results in temporary disability (time loss), permanent disability or an expectation of it, or death.

Form 801 — "Report of Job Injury or Illness"

Official state form for use by workers and employers to report occupational injury or disease.

Form 827 — "Worker's and Physician's Report for Workers' Compensation Claims"

Form used by workers and physicians to report a work-related injury or illness to insurers. Includes first report of injury, report of aggravation, notice of change of attending physician, progress report, closing report, and palliative care request.

health care provider

A person duly licensed to practice one or more of the healing arts.

impairment findings

A permanent loss of use or function of a body part or system as measured by a physician. OAR 436-035-0005.

initial claim

The first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared medically stationary by an attending physician or authorized nurse practitioner.

major contributing cause

A cause deemed to have contributed more than 50 percent to an injured worker's disability or need for treatment.

managed care organization (MCO)

An organization that may contract with an insurer to provide medical services to injured workers. OAR 436-015, ORS 656.260.

material cause

A fact of consequence regarding the need for medical services, up to 50 percent, compared to all other causes combined.

medical sequela

Also known as direct medical sequela, it is a condition that is clearly established medically and originates or stems from an accepted condition.

Example: The accepted condition is low-back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a direct medical sequela.

medical service

Medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, drug, prosthetic, or other physical restorative services. ORS 656.245.

medically stationary

The point at which no further material improvement would reasonably be expected from medical

treatment or the passage of time. ORS 656.005.

new medical condition claim

A worker's written request that the insurer accept a new medical condition related to the original occupational injury or disease. Medical services for new conditions are not compensable unless conditions are accepted.

Example: An initial diagnosis of low-back sprain or strain results in the acceptance of that condition. After further diagnostic studies, a herniated disk is diagnosed, and the injured worker makes a new condition claim in writing for that herniated disk.

nondisabling claim

A worker's compensation claim that does not result in time loss or permanent disability but requires only medical treatment. (Also called "medical only.")

objective findings

Indications of an injury or disease that are measurable, observable, and reproducible; used to establish compensability and determine permanent impairment. ORS 656.005.

Examples: Range of motion, atrophy, muscle strength, palpable muscle spasm, etc.

occupational disease

A disease or infection arising out of and occurring in the course and scope of employment. It is caused by substances or activities that an employee is not ordinarily subjected or exposed to other than during employment and requires medical services or results in disability or death. ORS 656.802. A mental disorder, or physical disorder caused or worsened by job-related mental stress, also may be an occupational disease. If an occupational disease claim is based on a worsening of a preexisting disease or condition, the employment conditions must be the major contributing cause of the combined condition and pathological worsening of the disease.

omitted medical condition

A worker's written request that the insurer accept a medical condition the worker believes was incorrectly omitted from the Notice of Acceptance.

Medical services for omitted conditions are not compensable unless conditions are accepted.

palliative care

Medical services rendered to reduce or temporarily moderate the intensity of an otherwise stable condition to enable the worker to continue employment or training. ORS 656.005, 656.245. (Also, refer to the back of the Form 827.)

partial denial

Denial by the insurer of one or more conditions of a worker's claim, leaving some conditions of the claim accepted as compensable.

permanent partial disability (PPD)

The permanent loss of use or function of any portion of the body as defined by ORS 656.214 and OAR 436-035.

physical capacity evaluation (PCE)

The measurements of a worker's ability to perform a variety of physical tasks.

preexisting condition

A medical condition that existed before the compensable injury or disease.

regular work

The job the worker held at the time of injury or a substantially similar job.

release of medical records

Filing a workers' compensation claim authorizes health care providers to release relevant medical records to the insurer, self-insured employer, or the Department of Consumer and Business Services. The privacy rule of the Health Insurance Portability and Accountability Act (HIPAA) allows health care providers to disclose protected health information to regulatory agencies, insurers, and employers as authorized and necessary to comply with the laws relating to workers' compensation. However, this authorization does not authorize the release of information regarding the following:

- Federally funded alcohol and drug abuse treatment programs.
- HIV-related information.
- HIV-related information should be released

only when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition.

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

specialist physician

A specialist physician is a physician who qualifies as an attending physician but does not assume the role of attending physician. A specialist physician examines the worker or provides specialized treatment, such as surgery or pain management, at the request of the attending physician or authorized nurse practitioner. During the time a physician provides specialized treatment, the attending physician continues to monitor the worker and authorizes any time loss.

temporary partial disability benefits (TPD)

Payment for wages lost based on the worker's ability to perform temporary modified or part-time work due to a compensable injury. (ORS 656.212). (Also, refer to [time-loss benefits](#).)

temporary total disability benefits (TTD)

Payment for wages lost based on the worker's temporary inability to work due to a compensable injury. ORS 656.210. (Also, refer to [time-loss benefits](#).)

time-loss authorization

When an attending physician authorizes time loss, the insurer may request periodic progress reports. Form 827 is not required if the chart notes provide the information requested.

time-loss benefits

Compensation due to a worker who loses time or wages because of a compensable injury. Time-loss benefits include temporary partial disability and temporary total disability (ORS 656.212, 656.210, 656.262). A worker who is not physically capable of returning to any employment is entitled to benefits for temporary total disability (time loss). A worker who can return to modified work may be entitled to benefits for temporary partial disability if their wages or hours of modified work are reduced.

work capacity evaluation (WCE)

A physical capacity evaluation that focuses on the ability to perform work-related tasks.

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, regulates, and enforces Oregon's workers' compensation laws.

worsening

Actual worsening of underlying compensable condition. Increased symptoms may signify worsening. A worsening must be established by persuasive medical opinion and is supported by objective findings.



For more information about workers' compensation

Phone numbers

- Medical questions 503-947-7606
- MCO information 503-947-7650
- Workers' Compensation Information Line 800-452-0288 (toll-free)
- Injured Worker Help Line (Ombuds) 800-927-1271 (toll-free)

WCD website

wcd.oregon.gov

Continuing education units

After reading this guide, you may print the certificate on the last page of this publication.





CERTIFICATE of TRAINING



Presented to

for

Completion of the Workers' Compensation Division's
Claims Examiner Guide for Interaction with
Independent Medical Exam Providers

*The above recipient has fulfilled the requirements set forth by the
Oregon Administrative Rules 436-055-0070 by completing one hour of training related
to interaction with independent medical exam providers.*

Date: _____

