For Naturopathic Physicians

Oregon Workers’ Compensation
MEDICAL BILLING & PAYMENT
Before treating workers’ compensation patients

As a naturopathic physician, you must certify that you have read and understand certain informational material provided by the Workers’ Compensation Division before treating patients with an Oregon workers’ compensation claims.

Insurers are not required to pay you for any medical services you provided before you certify.

You can find the materials online at www.oregonWCdoc.info, then select the Certification link.

Attending physician timeframes

As a naturopathic physician, you may, from the first visit on the initial claim:

• Provide treatment up to 60 consecutive days or 18 visits, whichever comes first, and
• Authorize time loss for up to 30 days.

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.

Attending physician timeframes

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

• Directing and managing treatment of patients,
• Authorizing time-loss,
• Determining the patient’s physical ability to stay-at-work and return-to-work, and
• Deciding when the patient becomes medically stationary.

Responsibilities as the attending physician

✓ If you are the attending physician and you refer the patient to an ancillary care provider (e.g. physical therapist), he or she must send you a treatment plan for signature within seven days. You are required to 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 you will continue to serve as the patient’s attending physician, i.e. you are responsible for authorizing any time-loss.

✓ 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.

First visit

Find out both private insurance company and workers’ compensation insurer: www4.cbs.state.or.us/ew/wcd/cov/

• Keep your search simple – less is more
• Call Employer Compliance for help: 503-947-7814

Is the worker enrolled in a managed care organization (MCO)?

• Contact the workers’ compensation insurer
• Clinic vs. provider credentialing

Obtain referral source and purpose
First visit

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

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

3. The patient seeks treatment after having been notified that the treatment is experimental, outmoded, unscientific, or unproven. (OAR 436-009-0010(12))

4. The patient seeks treatment for a service that has not been prescribed by the attending physician, authorized nurse practitioner, or specialist physician.

5. The patient seeks palliative care after it has been disapproved by the insurer or the director.

Form 827
“Worker’s and Physician’s Report for Workers’ Compensation Claim”

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

✓ You are the very first health care provider the patient sees for his or her injury. Send Form 827 to the insurer within three days.
✓ If you become the new attending physician and become primarily responsible for treating the patient. Send Form 827 to the insurer within five days.
✓ To help the worker request that the insurer accept a new or omitted medical condition. Attach chart notes that explain how this condition is causally related to the compensable injury. (If the worker checks this box it initiates a claim processing decision by the insurer that may negatively affect the worker’s benefits.) Send Form 827 to the insurer within five days.
Form 827
“Worker’s and Physician’s Report for Workers’ Compensation Claim”

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

✓ Progress report
✓ Closing report
✓ Palliative care request
   (Just checking the box does not meet the requirements for requesting palliative care.) (See OAR 436-010-0290(2))

Give the patient a copy of the completed Form 827.

Pre-authorization

Unless otherwise provided by an MCO, you may contact an insurer in writing for pre-authorization of diagnostic imaging studies other than plain film X-rays.

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.
Compensable medical services

- Care that is provided for the accepted condition
- Must be authorized by the attending physician
- After the accepted condition is medically stationary, medical services are subject to limitations (See ORS 656.245(1)(c))

Attending physician status

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

Matrix for healthcare provider types

<table>
<thead>
<tr>
<th>Type A: Medical Doctor</th>
<th>Type B: Naturopathic Physician</th>
<th>Type B: Chiropractic Physician</th>
<th>Type B: Physician Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be licensed by the state to practice medicine</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Must be authorized by the attending physician</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Compensable medical services</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Authorization status</td>
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<tr>
<td>Approval process</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Emergency care</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*This matrix does not apply to Managed Care Organizations. For more information, see ORS 656.240(2)(b) and ORS 656.245(2)(a).*
Medical billing

Tips for a smoother 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 the proper 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 (OSCs). If there is no CPT® or OSC, use the appropriate HCPCS code.

Medical billing

✓ 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 OSC R0001 or, if electronically, R0002.

✓ If you are asked to prepare a report or review records other than your own, use CPT® codes such as 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.

Interim medical benefits

✓ Interim medical benefits only apply 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. (See OAR 436-009-0035)

✓ 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 may submit a pre-authorization request to the health benefit plan before claim acceptance or denial.
Interim medical benefits

- The provider may not collect any health benefit plan co-pay, co-insurance, 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, co-pays, co-insurance, 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 form CMS-1500

- Fill out the CMS-1500 completely, legibly, and accurately.
- Include the patient’s complete name, date of injury, claim number if known, and employer name.
- Submit the CMS-1500 within 60 days of date of service.
- If billing personal insurance after denial, but claim is in litigation, continue to follow workers’ compensation statutes and rules.
- Must attach a copy of the corresponding chart note with every bill.
- E.g. Include x-ray report and lab report.
- List ICD-10 code; first code should be the primary reason for treatment.

Coding medical services

- Use valid codes (CPT®, OSC, HCPCS, NDC).
- Use codes that best describe the service provided.
- Avoid unlisted service code, if at all possible.
Click the ACCEPT button on the payment tables disclaimer page.

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**Appendix B for Administrative Order No. 16-050**

**Physician Fee Schedule**

*Note: All information shown here is for illustration only.*

**Effective April 1, 2016**

**Link to medical fee and payment rules**

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**Chart notes:**

It is crucial that your chart notes are clear and legible.

The insurer uses the information in your chart notes to determine what condition(s) to accept for the claim. Therefore, it is crucial that your assessment is comprehensive.

The patient is only entitled to medical services that are related to the accepted condition(s).
Chart notes:
How to document services
✓ Worker's description of what happened – mechanism of injury at initial visit
✓ Your chart notes need to be thorough and clear.
   “Time Spent Counseling Face-To-Face” = controlling factor; must be greater than 50%, must include time spent and specify content of counseling
✓ Must support services and level of services billed
   (Use appropriate ICD-10 codes)
✓ Must be legible – if using coded notes, must provide a legend
✓ SOAP or similar format
✓ Work restrictions (temporary and permanent)

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.

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.

Payment
Unless you have an MCO contract or a fee discount agreement, you should get paid either the amount you billed or the amount of the Oregon Workers’ Compensation fee schedule, whichever is lower.

Insurers do not have to pay you 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 completion of a Physical Capacity Exam form, when no tests are performed;
• A missed appointment ‘no show’; and
• Dietary supplements.
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 (with certain exceptions); and
• Cervical artificial disc replacement (with certain exceptions).

Special equipment needs justification

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

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

Referrals out

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.

Consultation exam:
• Document in the chart notes who you’re referring to, and
• What type of service (consult only or specialized care).

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.

If the worker is enrolled in a Managed Care Organization (MCO), you must refer to an MCO panel provider.
(This includes labs, Durable Medical Equipment, etc.).
Referrals out

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, i.e., you are responsible for authorizing any time-loss.

A specialist physician provides a consultation or specialized treatment without assuming the role of the attending physician.

When naturopathic 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.

Managed care organizations (MCOs)

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

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

In addition, if you refer an MCO enrolled patient, you must make sure the provider you are referring to is also on that MCO’s panel.
  • Off-panel referrals need pre-approval by the MCO.

Managed care organizations (MCOs)

Your rights and duties as an MCO panel provider may differ from those described in this training. Many MCOs require precertification 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.
Stay-at-work / Return-to-work

If you place, modify, or lift any work modifications, you must inform the patient immediately 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.

Ancillary providers

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 only provide treatment upon referral from the attending physician, authorized nurse practitioner, or specialist physician.

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

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

Ancillary providers

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:

1. Objectives (e.g., decreased pain, increased range of motion, etc.)
2. Modalities (e.g., homeopathy, ultrasound, etc.)
3. Frequency of treatment (e.g., once per week)
4. Duration (e.g., four weeks)
Ancillary providers

If you continue treatment beyond the duration outlined in the treatment plan, you will need a new prescription from the attending physician to continue treatment.

- You also must send a new treatment plan to the insurer and referring physician or authorized nurse practitioner within seven days.

If the treatment plan is not sent within seven days, the insurer is not required to pay for the services provided.

Modalities/therapeutic codes

- Constant attendance modalities/therapeutic codes are time-based; therefore, chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

- Constant attendance codes involves visual, verbal, or manual contact with the patient during provision of the service.

- Payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider. E/M codes and CMT codes do not count towards the three.

Medically stationary and closing exams

Once a patient reaches maximum recovery, the patient becomes medically stationary, meaning no further material improvement would reasonably be expected from medical treatment or the passage of time.

When the patient has reached maximum recovery you must refer the patient to a type A attending physician to determine whether the patient is medically stationary and to perform a closing exam.

Once the patient becomes medically stationary you are only allowed to treat the patient as directed by the attending physician.
Medical care after medically stationary

The patient is eligible for continued medical services after medically stationary, with limitations. (ORS 656.245(1)(c)

Diagnostic services
- Prescription medication and monitoring
- Prosthetics
- Aggravation
- Curative care
- Palliative care (requires insurer’s preauthorization)

Palliative care
- Ongoing, intermittent care to enable a worker to continue working or participate in a vocational rehab program
- Does not require claim reopening
- Requires preauthorization from the insurer
- Requires submission of a treatment plan by the attending physician
  - Any objective findings
  - ICD-10 code(s) for the condition being treated
  - Name of rendering provider
  - Specific treatment modalities
  - Frequency and duration of care
  - Not to exceed 180 days
  - How requested care is related to compensable condition
  - How will enable worker to continue employment/vocational training
  - Adverse effects if care not approved

Curative care
- To stabilize a temporary and acute waxing/waning of symptoms
- Does not require claim reopening
- Short duration to get back to medically stationary status

Aggravation
- Material worsening of condition supported by objective findings
- Longer duration of curative care to get back to medically stationary status
- Requires more comprehensive level of medical treatment, possibly surgery
- Requires claim reopening with additional benefits to the patient
- Less significant worsening of condition (sometimes referred to as waxing/waning of condition)
- Shorter duration of curative care to get back to medically stationary status
- Requires less comprehensive level of medical treatment
- Does not require claim reopening
- Not to be confused with palliative care, which is necessary to help the patient continue working, but is not curative
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.

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

Timeline summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>File Form 827 for first report of injury or disease</td>
<td>3 days</td>
</tr>
<tr>
<td>File Form 827 for change of attending physician or authorized nurse practitioner</td>
<td>5 days</td>
</tr>
<tr>
<td>When providing ancillary care send treatment plan to insurer and prescribing provider</td>
<td>7 days</td>
</tr>
<tr>
<td>Respond to records request from insurer or director</td>
<td>14 days</td>
</tr>
<tr>
<td>Sign copy of treatment plan when you are the attending physician and send to insurer</td>
<td>30 days</td>
</tr>
</tbody>
</table>

Dispute resolution

First, contact the insurer or insurer’s representative at number listed on the explanation of benefits (EOB) to attempt resolution.

If unsuccessful, request dispute resolution with WCD within 90 days of the mailing date of the most recent EOB or a similar notification.

Even if you are working with the insurer to resolve your issue during the 90 days, don’t let the 90 day timeframe pass before requesting dispute resolution with WCD.
How to request dispute resolution

Use Form 2842 to ensure the request is complete

- Be sure to provide a copy of the CMS 1500, chart notes, and EOB with request, call logs or other correspondence with insurer/service company, etc.
- Include any documentation of bill submission to the insurer/service company (laws)
- Send copies of all dispute documents to both the director and to the insurer

If you have an EOB, you can file a dispute by:

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

Administrative review

ADR Process: WCD medical resolution team (MRT) will attempt informal resolution of the dispute in most cases.

Formal review: MRT’s review may result in a Stipulated Letter of Agreement, General Letter, or an Administrative Order.

- Parties have 30 days to dispute an Administrative Order.
- Parties have 14 days after the Administrative Order is final to comply.

Contact medical resolution:

- Phone: 503-947-7606
- Fax: 503-947-7629
- Email: wcd.medicalquestions@oregon.gov
- Web: www.oregonWCdoc.info
# Matrix for health care provider types

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

*This matrix does not apply to Managed Care Organizations

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

Effective 4/1/15
Request for Dispute Resolution of Medical Issues and Medical Fees

Complete this form to request medical dispute resolution services from the Workers’ Compensation Division. You must notify all parties to the dispute about this request and provide the parties copies of any information submitted to the director. Copies must be provided free of charge to all other concerned parties. **Unrepresented workers may call the Medical Resolution Team for help in completing the form.** As an alternative to the administrative review process, a less formal dispute resolution process may resolve your issue. This process allows you to work with a trained facilitator on the Medical Resolution Team. The parties work with a facilitator collaboratively to reach agreement. A medical reviewer may contact you about this process, or you may contact the Medical Resolution Team at 503-947-7606.

**Dispute information**

What is the specific medical issue in dispute?  

Dates of services in dispute:  

Why is the medical issue in dispute?  

Accepted conditions (medical conditions the insurer accepted in writing or by litigation):

Dates of written acceptance, including Updated Notice of Acceptance:

**(Note: For medical fee disputes, complete both Form 2842 and Form 2842a)**

**Worker information**

Worker name:  

Phone:  

Address:  

City, State, ZIP:  

Date of injury:  

Claim no.:  

**Employer/insurer information**

Employer name:  

Employer’s workers’ compensation insurer:  

Insurer address:  

Insurer phone:  

**Provider information**

Medical provider name:  

Phone:  

Address:  

City, State, ZIP:  

Contact person:  

Are you the attending physician (AP)?  

Yes  

No  

Are you the nurse practitioner (NP)?  

Yes  

No  

If no, indicate name of AP or NP:  

Address:  

City, State, ZIP:  

(continued on back)
Managed care organization (MCO) information

☐ Yes  ☐ No  Is the worker covered by an MCO contract?
If yes, MCO name: ___________________________ Enrollment date: ________________

☐ Yes  ☐ No  Does MCO have a dispute resolution process?
If yes, date on which process was initiated: ___________________________
Date completed: ___________________________
If yes, all documents generated for the MCO review must be submitted with this form.

Review requested by
☐ Worker  ☐ Worker’s attorney
☐ Insurer  ☐ Insurer’s attorney
☐ Medical service provider  ☐ Managed care organization
☐ Other: ____________________________________________

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

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

By signing below, I certify that relevant medical and claim information has been provided with this request and that copies have been sent to all parties, required by OAR 436-010-0008.

Insurer’s signature: ___________________________ Date: ___________________________

Send the completed, signed original of this form and all accompanying documents to:
Workers’ Compensation Division
Resolution Section
Medical Resolution Team
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Or fax it to: 503-947-7629

For help or more information, please call the Medical Resolution Team, 503-947-7606.
Notice

When a dispute about fees exists between a medical provider and an insurer, the insurer, medical provider, or worker may request review by the director of the Department of Consumer and Business Services. The request for review must be submitted to the division within 90 days of the time the aggrieved party knew or should have known about the dispute. The insurer or medical provider should use both Forms 2842 and 2842a to request review of fee disputes. An injured worker may elect to use these forms, or may call the Medical Resolution Team at 503-947-7606 for assistance.

If you are aggrieved because of nonpayment or reduction of payment, you should do the following before submitting this form:

1. Contact the insurer to determine why payment has not been made or why payment has been reduced. Please provide the insurer’s explanation.

2. Wait at least 45 days from the date the insurer received your billing, unless you have received a denial of payment or reduced payment.

In all cases of an accepted compensable injury or illness under workers’ compensation law, the injured worker is not liable for payment for any services for the treatment of that injury or illness, except as provided in OAR 436-009-0010.

Worker information

Worker name: ____________________________ Phone: ____________________________
Provider name: ____________________________ Claim no.: ____________________________
Provider phone: ____________________________

Attention providers: List specific CPT codes and dates of services in dispute

<table>
<thead>
<tr>
<th>Service dates</th>
<th>CPT code</th>
<th>Amount billed</th>
<th>Amount paid</th>
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<tr>
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440-2842a (12/15/DCBS/WCD/WEB)  
Attach copies of this sheet if more lines are needed
Perform one-time exams with guaranteed payment

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

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

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

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

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