Introduction to Workers’ Compensation for Health Care Providers
The purpose of this training is to:

- Introduce and explain workers’ compensation terms that affect providers.
- Provide insight to areas that are unique to treating workers’ compensation patients.
- Share the available resources and tools.
- Help providers get started.

Compensable medical services

In Oregon workers’ compensation, insurers accept specific conditions and only have to pay for treatment that is directed towards those conditions.

Appropriate treatment that is directed towards the accepted condition is considered **compensable medical services**.

Diagnostic services are not only covered when they are provided to evaluate a compensable condition, but also when used to determine the cause and extent of the injury or illness.

Claim acceptance or denial

When the insurer issues a claim denial or there is a de facto denial, you may bill the worker.

When the insurer issues a claim denial or there is a de facto denial, only the worker can appeal the denial.

If the denial has been appealed, you may not attempt to collect from the worker until a final decision has been made.
Types of providers

In workers' compensation there are three basic types of providers.

- Attending physician
- Specialist physician
- Ancillary care providers

Types of providers

Attending physician

An injured worker must choose an attending physician. The attending physician is primarily responsible for their treatment and determine time off from work or modified duties (time-loss authorization).

- Generally, a medical doctor, doctor of osteopathy, podiatric physician and surgeon, or oral or maxillofacial surgeon may assume the role as attending physician.
- A naturopathic physician, chiropractic physician, and physician assistant may also qualify as an attending physician for a limited period.
- Instead of treating with an attending physician, the patient may choose to treat with an authorized nurse practitioner for 180 consecutive days.

Types of providers

Specialist physician

A specialist physician is a licensed physician who qualifies as an attending physician and who provides a consultation to a patient at the request of the attending physician or authorized nurse practitioner.

A specialist physician may also provide specialized treatment upon referral from the attending physician.
Types of providers

An ancillary care provider is someone who is not the attending physician or no longer qualifies to be the attending physician. Examples include physical therapists, occupational therapists, acupuncturists, Oregon massage therapists, chiropractic physicians, and naturopathic physicians.

As an ancillary care provider, you can only provide treatment upon referral from the attending physician, authorized nurse practitioner, or specialist physician.

Types of providers

An attending physician, specialist physician, or authorized nurse practitioner must prescribe the services, and the ancillary care provider must prepare a treatment plan. The treatment plan must include objectives, modalities, frequency of treatment, and duration.

You must send the treatment plan to the insurer and referring physician or authorized nurse practitioner within seven days of beginning treatment.

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

Types of 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 of beginning treatment.
Medically stationary & 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 is medically stationary the patient’s attending physician should conduct a closing exam to measure impairment. If the attending physician does not want to perform a closing exam, they may contact the insurer to arrange one.

You can find the requirements for performing a closing exam and writing a closing report in Bulletin 239.

Treatment after medically stationary

When the patient becomes medically stationary, the insurer can close the claim based on the closing exam findings.

Even when the claim is closed, the patient can still receive medical care, such as:
- Diagnostic services
- Prescription medication and monitoring
- Prosthetics
- Aggravation
- Curative care
- Palliative care (requires insurer’s preauthorization)

Managed Care Organizations (MCOs)

A managed care organization (MCO) is a health care provider, or group of medical service providers, that contracts with insurers or self-insured employers to provide managed health care services to enrolled workers.

If you're interested in becoming an MCO panel provider, you may contact one of the four certified MCOs:
- CareMark Comp MCO (MHN)
- Kaiser On-the-job MCO
- Majoris Health Systems Oregon, Inc. MCO
- Providence MCO
Managed Care Organizations (MCOs)

The insurer decides whether to enroll a worker in an MCO. Once the worker is enrolled in an MCO, the worker must treat with the MCO’s panel providers.

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 or the referring provider are not on that MCO’s panel, the insurer will not have to pay you.

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

- Providers must have this form on hand.
- Providers may order free copies of Form 827 online or may directly download from the website.

www.oregonWCdoc.info

- If checked, ask the worker to sign.
- If checked, do not ask the worker to sign.
When the worker must sign Form 827

Check First report of injury or disease box if:

You are the very first health care provider the patient sees for his or her injury.

In this case, both you and the patient should sign and date the form.

Send Form 827 to the insurer within three days.

Give the patient a copy of the completed Form 827.

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When the worker must sign Form 827

When the patient checks the Request for acceptance of a new or omitted medical condition box:

You may assist the worker by identifying the new or omitted medical condition.

If the worker checks this box it initiates a claim processing decision by the insurer that may negatively affect the worker’s benefits.

In this case, both you and the patient should sign and date the form.

Send Form 827 to the insurer within five days.

Give the patient a copy of the completed Form 827.

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When the worker must sign Form 827

The patient checks the Notice of change of attending physician or nurse practitioner box if:

The patient chooses you as the new attending physician or nurse practitioner and you become primarily responsible for treating the patient and authorizing time loss.

The patient may only choose to change their attending physician two times.

In this case, both you and the patient should sign and date the form.

Send Form 827 to the insurer within five days.

Give the patient a copy of the completed Form 827.
When the worker must sign Form 827

The patient checks the Request of aggravation of original injury box if:

The patient is medically stationary and an exam reveals an aggravation of the patient's accepted condition. You must write a report that includes objective findings that document whether the patient has suffered a worsened condition attributable to the compensable injury and whether the patient is unable to work as a result of the aggravation.

Send Form 827 to the insurer within five days.
Send the report to the insurer within 14 days.
Give the patient a copy of the completed Form 827.

Form 827

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

- Progress report
- Closing report
- Palliative care request

First visit

The first time you see a workers’ compensation patient, you are required to notify the patient that as the patient’s attending physician you are responsible for providing and directing treatment and authorizing any time-loss benefits.

When you know the patient’s injury is work related, you must mark the appropriate box on the CMS 1500 whether or not the patient chooses to file a workers’ compensation claim.
First visit

If the worker does not yet have an accepted workers’ compensation claim, find out both the workers’ compensation insurer and the private health insurer.

If the patient was injured at work, the patient’s employer is not allowed to pay you directly whether or not the patient chooses to file a workers’ compensation claim.

Billing

If the patient has a workers’ compensation claim, you are generally not allowed to bill the patient.

You must always bill your usual fees that you charge to the general public.

If the patient’s workers’ compensation claim has been accepted, only bill the workers’ compensation insurer.

If the patient’s workers’ compensation claim has not been accepted yet, bill both the workers’ compensation insurer and the patient’s private health insurer according to their billing requirements.

Billing

- Bill within 60 days of the date of service using the CMS 1500 form.
- With each bill you must send legible chart notes that accurately describe the service provided.
- CPT® codes are the primary billing codes.
- However, there are Oregon specific codes for services that are not otherwise described by CPT® codes.
- Use an appropriate HCPCS code if neither a CPT® nor an Oregon specific code describes the service accurately.
- Use appropriate ICD-10 codes to describe the patient’s diagnosis.
Chart notes

It is crucial that your chart notes are clear and legible. Capture the patient's description of what happened and include the mechanism of injury at the initial visit.

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

Payment

Once the claim is accepted, the insurer must issue payment within 45 days of receiving your bills and chart notes.

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.

You may not be paid for medical services:

- If you treat conditions that are not related to the accepted compensable injury or illness.
- If the patient has been enrolled in a managed care organization (MCO) and you are not a panel provider for that MCO.
- If you are not the attending physician or authorized nurse practitioner and you treat without a referral.
FEE SCHEDULE TABLES

Fee schedules and forms

Billing forms

Maximum allowable payment tables

Click the accept button on the payment tables disclaimer page.
Referrals

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.

Preauthorization

Generally, providers do not have to request preauthorization for any treatment/diagnostics, except for elective surgery, palliative care, ergonomic consultations, and more than three mechanical muscle tests. A provider may request preauthorization for diagnostic imaging studies.

If a patient is enrolled in a certified managed care organization (MCO), the MCO may require preauthorization of certain services. Please check with each MCO.
Data shows that Oregon workers with on-the-job injuries who are taken off work have a decreased long term earning potential. In other words, if your patients are able to continue regular work or perform modified duties while recovering from their injuries, there is a greater likelihood that your patients will keep their full earning potential in the future.

- When you determine a patient is unable to do their normal job duties, list what the patient can do rather than taking the patient off work. It is up to the employer to decide whether or not the employer can accommodate.
- When your patient tells you that their employer is ignoring what you said the patient can do, tell your patient to contact the Ombudsman (also known as the worker advocate) rather than getting involved in the patient/employer’s relationship.

**Return to work**

- **When you determine a patient is unable to do their normal job duties, list what the patient can do rather than taking the patient off work. It is up to the employer to decide whether or not the employer can accommodate.**
- **When your patient tells you that their employer is ignoring what you said the patient can do, tell your patient to contact the Ombudsman (also known as the worker advocate) rather than getting involved in the patient/employer’s relationship.**

**How WCD can help**

Find out both private insurance company and workers’ compensation insurer: [www4.cbs.state.or.us/ex/wcd/cov/](http://www4.cbs.state.or.us/ex/wcd/cov/)

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

**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/TPA, etc.
- Include any documentation of bill submission to the insurer/TPA (faxes)
- Send copies of all dispute documents to both the director and to the insurer

How to request dispute resolution

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.

Where to go from here

The health care provider webpage offers several resources, tools, and help to successfully treat workers' compensation patients.

[www.oregonWCdoc.info](http://www.oregonWCdoc.info)
www.oregonWCdoc.info

- Look up the fee schedule amounts

www.oregonWCdoc.info

- Determine treatment restrictions and responsibilities by provider type

www.oregonWCdoc.info

- Request dispute resolution
Where to go from here

Instructions on who must certify and how
www.oregonWCdoc.info

The types of exams we have and how they differ
www.oregonWCdoc.info

Use online training resources – review handbooks, attend webinars, watch videos
www.oregonWCdoc.info
www.oregonWCdoc.info

- Read the Oregon Administrative Rules
  - Division 436-009, Oregon Medical Fee and Payment
  - Division 436-010, Medical Services
  - Division 436-015, Managed Care Organizations
  - Division 436-008, Electronic Medical Billing

Stay informed

To stay informed on workers' compensation changes that may affect you, sign-up to receive email notification from our provider web page.

Where to send the worker for help

The Ombudsman for Injured Workers is here to help the worker navigate and understand the workers' compensation system. They offer help and serve as a worker advocate.

For example, if the worker doesn’t want to file a workers’ compensation claim for when they’ve been injured at work, the Ombudsman can explain the possible consequences for not filing.

Ombudsman (Worker Advocate): 503-378-3351
Contact WCD

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. | Yes, unless the total of 60 consecutive days or 18 visits from the date of the initial visit on the initial claim with any Type B attending physician has passed. Or if authorized by an attending physician and under a treatment plan. | Yes, 30 days from the date of the first visit with any Type B attending physician on the initial claim, if within the specified 18-visit period. | No, unless the Type B attending physician is a chiropractic physician. | No, unless authorized by attending physician and under a written treatment plan. (Note: Physician assistants are not required to have a written treatment plan.) |
| **Emergency room physicians** | No, if the physician refers the patient to a primary care physician. | Yes | ER physicians may authorize time loss for up to 14 days only, including retroactive authorization. | No, if patient referred to a primary care physician. | Yes |
| **Authorized nurse practitioner** | No | Yes, for 180 consecutive days from the date of the first visit to any authorized nurse practitioner on the initial claim. Or if authorized by attending physician. | Yes, for 180 days from the date of the first visit on the initial claim. | No | No, unless authorized by the attending physician. |
| **“Other Health Care Providers”**
  - e.g. acupuncturists | No | Yes for 30 consecutive days or 12 visits from the date of the first visit on the initial claim with any “Other Health Care Providers.” Thereafter, services must be provided under a treatment plan and authorized by the attending physician. | No | No | No, unless referred by the attending physician and under a written treatment plan. |

*This matrix does not apply to Managed Care Organizations

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

Effective 4/1/15
Complete this form to request medical dispute resolution services from the Workers’ Compensation Division. You must notify all parties to the dispute about this request and provide the parties copies of any information submitted to the director. Copies must be provided free of charge to all other concerned parties. **Unrepresented workers may call the Medical Resolution Team for help in completing the form.** As an alternative to the administrative review process, a less formal dispute resolution process may resolve your issue. This process allows you to work with a trained facilitator on the Medical Resolution Team. The parties work with a facilitator collaboratively to reach agreement. A medical reviewer may contact you about this process, or you may contact the Medical Resolution Team at 503-947-7606.

**Dispute information**

What is the specific medical issue in dispute?

Dates of services in dispute:

Why is the medical issue in dispute?

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

Dates of written acceptance, including Updated Notice of Acceptance:

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

**Worker information**

Worker name: ____________________________ Phone: ____________________________

Address: ____________________________ City, State, ZIP: ____________________________

Date of injury: ____________________________ Claim no.: ____________________________

**Employer/insurer information**

Employer name: ____________________________

Employer’s workers’ compensation insurer: ____________________________

Insurer address: ____________________________

Insurer phone: ____________________________

**Provider information**

Medical provider name: ____________________________ Phone: ____________________________

Address: ____________________________ City, State, ZIP: ____________________________

Contact person: ____________________________

Are you the attending physician (AP)?  □ Yes  □ No  
Are you the nurse practitioner (NP)?  □ Yes  □ No

If no, indicate name of AP or NP: ____________________________ Phone: ____________________________

Address: ____________________________ City, State, ZIP: ____________________________

*(continued on back)*
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

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<thead>
<tr>
<th>Service dates</th>
<th>CPT code</th>
<th>Amount billed</th>
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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.