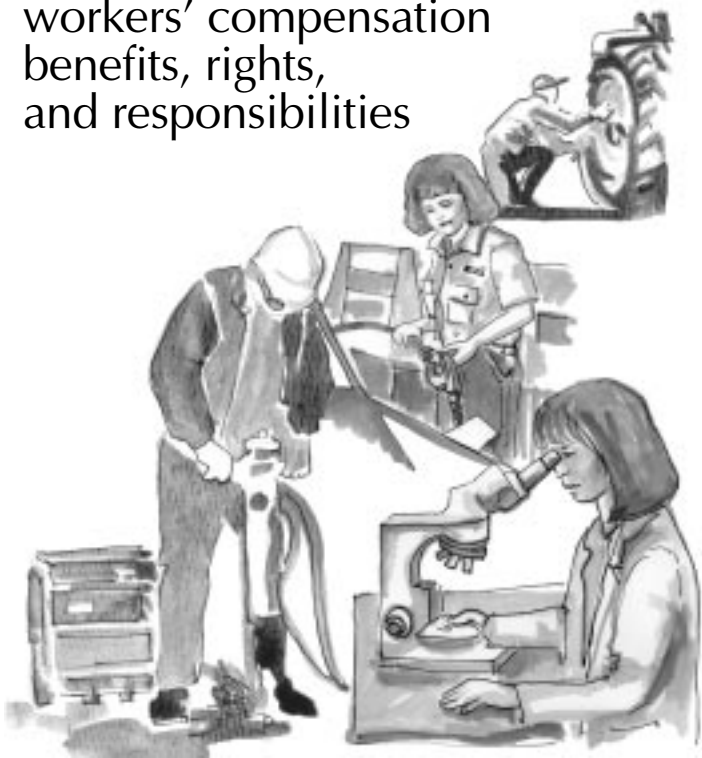


What happens if I'm hurt on the job?

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



Workers'
Compensation
Division



DEPARTMENT OF
CONSUMER
& BUSINESS
SERVICES

June 2004

Get answers to your questions.

Protect your rights —

Stay in touch with your **insurer**, who is your primary contact. Get the name and phone number of your workers' compensation insurer from your employer.

If you have other questions, call the State of Oregon:

The **Ombudsman for Injured Workers** is the state office that serves as an independent advocate for injured workers in their dealings with the workers' compensation system. The injured worker helpline is toll-free: (800) 927-1271 or TTY: (503) 947-7189.

The **Workers' Compensation Division (WCD)** can tell you what your workers' compensation rights and responsibilities are. WCD answers questions from injured workers, insurers, employers, attorneys, and medical providers. The workers' compensation helpline is toll-free in Oregon: (800) 452-0288 or TTY: (503) 947-7993.

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

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

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

Visit these Web sites —

Ombudsman for Injured Workers
www.cbs.state.or.us/wco

Workers Compensation Division
www.wcd.oregon.gov



In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternative formats. Call the Workers' Compensation Division, (503) 947-7810, or TTY (503) 947-7993.

The information in this brochure is in the public domain and may be reprinted without permission.

Table of contents

Get answers to your questions	1
If you are injured on the job	5
Rights and responsibilities	
Claim status	6
Classification as disabling or nondisabling	
Acceptance or denial of claim	
Medical treatment	9
Payment of medical bills	
Choosing and changing doctors	
Privacy rights at medical examinations	
Managed care organizations (MCOs)	
Elective surgery	
Insurer medical examinations	
Medical care after you are medically stationary	
New-medical-condition claims	
Aggravation claims	
Time-loss payments	14
Payment for lost wages	
Doctor's authorization	
Waiting period	
Returning to work	16
Reinstatement rights	
Modified work	
Vocational assistance	
Re-employment assistance	
Claim closure	19
Notice of closure	
Permanent disability	
Reconsideration (appeal) of closure	
Appeal rights and claim settlements	22
Appeals	
Insurer penalties	
Disputed claim settlement	
Claim disposition agreement	
Confidentiality of your claim records	
Glossary of workers' compensation terms	26
Services directory	30
Claim-process flow chart	32

Note: Information words that are in *bold italics* are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

If you are injured on the job:

- Tell your employer right away.
- If you want to file a workers' compensation claim, ask your employer for Oregon Form 801, "Worker's and Employer's Report of Occupational Injury or Disease/Illness."
- If you seek medical help, tell your doctor or nurse practitioner you were hurt on the job. You and your doctor or nurse practitioner should complete Oregon Form 827, "Worker's and Physician's Report for Worker's Compensation Claims."
- Read all letters and notices about your claim and keep copies of all letters you send and receive. Look for instructions about medical appointments, time limits in which to appeal claim decisions, and requests for information. If you fail to take action or you miss a deadline, you may lose your right to workers' compensation benefits.
- If you need the name of your employer's workers' compensation insurer, call the Workers' Compensation Division, (888) 877-5670.
- If you need information about the claim process, call the Workers' Compensation Division, (800) 452-0288.
- If you have questions about your claim or documents that you have received, call the insurer.
- Keep all medical appointments.
- Contact your employer immediately when your doctor releases you for work.
- Keep track of your claim on the *claim information record* located in the back of this brochure.

Claim status

Nondisabling claims

Your injury is **nondisabling** if you have a work injury or illness that requires medical services only, your doctor does not authorize time loss, or the injury will not result in permanent disability. Your rights to insurer-paid services will change when your doctor declares you to be medically stationary. Contact the insurer in writing within one year of your claim acceptance date if you believe your claim was mistakenly classified as nondisabling.

Disabling claims

If you receive temporary disability payments due to your injury or illness, or if permanent disability might reasonably be expected, your claim is classified as **disabling**.

Acceptance or denial of your claim

The insurer must accept or deny your claim within 60 days of the day you tell your employer about the injury. If your claim is denied, the insurer will tell you about your appeal rights in the denial letter. If your claim is accepted, the insurer will send you a “Notice of Acceptance” that lists the medical conditions accepted for benefits by the insurer. If you believe that a medical condition has been omitted from the notice, or the notice is otherwise incomplete or incorrect, you must notify the insurer of the error in writing.

The insurer will pay **time-loss** (temporary disability) benefits authorized by your doctor until your claim is denied or some other event causes time-loss benefits to stop. You won’t have to repay time-loss benefits if your claim is denied. However, if

Note: Information words that are in **bold italics** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

your claim is denied within two weeks of the date you reported the claim to your employer, you will not receive time-loss payments.

If your insurer denies your claim for compensability on the basis of an insurer medical examination (IME) report and if your doctor doesn't agree with the IME report and you are appealing that decision, you may request an examination by a doctor selected by the Workers' Compensation Division.



Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

Medical treatment

Payment of medical bills

If your claim is ***accepted***, the insurer should pay for injury-related medical treatment, medical services, and prescription drugs, within some limitations. The insurer also pays time-loss benefits if your physician or nurse practitioner authorizes it. You will be reimbursed within limits set by Oregon Administrative Rules for time loss, transportation, meals, and lodging necessary to visit medical offices for examinations and time lost from work. Your doctor should bill the insurer directly for medical services. Some insurers now make direct payments to pharmacies for prescriptions. Keep receipts for all out-of-pocket expenses. Send a written request for reimbursement with proof of expenses (copies of receipts) to the insurer within two years of the date of service.

If your claim is denied, the insurer will not pay medical bills associated with your claim, with the following exceptions:

- If you are required by the insurer to receive treatment from a ***managed care organization (MCO)***, the insurer will pay medical bills until your claim is denied.
- If you have personal health insurance, the workers' compensation insurer may pay charges not covered by your health insurer for necessary medical care unless your claim is denied within 14 days. Costs paid by a workers' compensation insurer may be recovered from future payments you may receive due to your injury or illness claims, if you have any.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Choosing doctors

Unless the insurer has enrolled you in a **managed care organization**, you may treat with any doctor who qualifies as an **attending physician** under Oregon law or with any nurse practitioner authorized by the director of the Department of Consumer and Business Services.

An **authorized nurse practitioner** is subject to limits on how long he or she may treat an injured worker and authorize time loss. To find out if your nurse practitioner is authorized to treat injured workers, contact the **Workers' Compensation Division**, (503) 947-7710, or use the division's Web site, www.wcd.oregon.gov, and click on "Medical Providers" to find a list of authorized nurse practitioners.

Changing doctors

You may have only one doctor or authorized nurse practitioner at a time. After your initial choice, you may change doctors or nurse practitioners two more times without insurer or WCD approval. If you do change doctors or authorized nurse practitioners, fill out Form 827 at your new doctor's or authorized nurse practitioner's office.



Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

It is not considered a change of doctor or nurse practitioner when a physician treats you in an emergency or as an “on-call” physician or if your doctor or nurse practitioner sends you to a specialist but remains primarily responsible for your care. If you are enrolled in a managed care organization (MCO), your rights may differ. Contact the MCO if you have questions.

Privacy rights at medical examinations

Not without your written consent. You and the physician or authorized nurse practitioner have the right to refuse such attendance, and, if you do, your benefits cannot be reduced or stopped.

If your employer is covered by a managed care organization (MCO) contract

If your employer is covered by an MCO contract, the insurer may enroll you with the MCO at any time after your injury, and you may be required to select an MCO doctor. The insurer will give you a list of providers with the enrollment notice. Until you are enrolled, any doctor or nurse practitioner may treat you if he or she qualifies as an ***attending physician*** or ***authorized nurse practitioner***. After enrollment, if you have a regular doctor who is a family practitioner, general practitioner, or internal medicine specialist, he or she may continue to treat you if treatment is provided according to the MCO contract. This also applies to a nurse practitioner with whom you have established a relationship and who is authorized to treat injured workers.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Your doctor's responsibilities

Your doctor or authorized nurse practitioner is in charge of your medical treatment. When necessary, they will authorize time off work, authorize reduced work hours or duties, release you to go back to work, and decide when you are **medically stationary**. If a nurse practitioner has been treating you, he or she may refer you to a doctor for this purpose. Only a doctor qualified as an attending physician may determine whether or not you have permanent limitations.

Elective surgery

This is surgery other than emergency surgery. Before performing elective surgery, you or your doctor must notify the insurer, who may require a second opinion. (MCO procedures may differ.) If your doctor and the insurer don't agree about the need for surgery, the insurer may ask the Medical Review Unit of the **Workers' Compensation Division** to review the decision.

Insurer medical examinations (IME)

The insurer may require you to attend medical examinations with doctors it chooses, and workers' compensation benefits may be stopped if you fail to do so. Be aware that the IME doctor is much different than your attending physician. The exam may be short and impersonal. He or she may conduct a medical examination that includes a physical or work-capacity evaluation or consultation. Invasive procedures cannot be performed without your consent, and your benefits cannot be reduced or stopped if you decline them. If you can't afford to attend the examination, request help from the insurer as soon as you learn of the appointment. The insurer should pay all costs for the medical examination.

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

If the doctor approves, you may have a family member or friend accompany you during the examination, but the insurer will not pay that person's expenses. Consult your insurer if you believe your work-related condition requires you to have assistance to keep the appointment.

Medical care after you become medically stationary

You are medically stationary when you are not expected to get better with further treatment or the passage of time. After you are medically stationary, the insurer is responsible for future medical treatment and services, with some limitations. The insurer will continue to cover the costs of medical services such as prescription drugs, diagnostic care, life-preserving care, and some other services related to your accepted conditions. Some medical costs are not covered after you are medically stationary. Check with the insurer or the ***Workers' Compensation Division*** to find out what services are covered.

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

If you have new medical-condition claims

If you think the insurer omitted a condition from its acceptance notice or you develop a new medical condition due to your injury, write to the insurer and request written acceptance of your condition. The insurer has 60 days to accept or

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

deny your condition. If your date of injury is prior to January 1, 2002, your insurer may have up to 90 days to make a decision on a new condition.

If your condition gets worse

If your accepted condition gets worse after you become medically stationary, you may file a claim for “aggravation,” to have your claim reopened. Fill out Form 827 at your doctor’s office and check the box for “Report of aggravation of original injury.” Your doctor will send this form to the insurer, along with medical reports.

- Aggravation rights for a **disabling claim** expire five years after your claim is first closed.
- Aggravation rights for a **nondisabling claim** expire five years after your date of injury.

If your condition gets worse after your aggravation rights end

If you cannot work because your condition worsens, and you need hospitalization, surgery, or other curative treatment to allow you to return to work, contact the insurer. The insurer may reopen your claim (if disabling) and pay temporary disability compensation during your recovery as authorized by your doctor.

You still have the right to make a claim if you develop a new medical condition related to the original injury or if you think a condition was omitted from an earlier acceptance notice. If the insurer accepts a new or omitted medical condition on a disabling claim, the insurer may pay you temporary disability compensation during your recovery as authorized by your doctor.

Questions?

Ombudsman for Injured Workers: (800) 927-1271
Workers’ Compensation Division: (800) 452-0288

When you are **medically stationary**, if you have permanent disability due to your accepted new or omitted condition, the insurer may grant you an award for your permanent disability.

Time-loss (temporary disability) payments

Payment for lost wages and doctor's authorization

You will get **time-loss payments** from the insurer if your doctor authorizes time off work or authorizes modified work (also called “light duty”) that causes you to lose wages. If the doctor provides written authorization to the insurer soon after you are injured, time-loss payments usually begin two weeks after you report the claim to your employer. Otherwise, your first check will be mailed within two weeks from the date the insurer receives authorization from your doctor.

Each time you see your doctor, ask for appropriate time-loss authorization to send to the insurer. If your time-loss authorization expires before your appointment, your doctor can approve time-loss payments only for the previous two weeks. You can help ensure timely payment by contacting the insurer as soon as you begin to miss work.

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

- Your doctor fails to provide time-loss authorization to the insurer.
- Your claim is denied.
- Your doctor gives you a written release to return to your regular job.

Note: Information words that are in **bold italics** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

- You return to work at full wages.
- A Notice of Closure closes your claim.
- You are incarcerated. Incarcerated means in pretrial detention or imprisonment following conviction for a crime.
- You remove yourself from the workforce.

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

- Your doctor approves a written offer of modified work that you are physically able to do, but you refuse to take it.
- Your doctor approves work with your employer and your employer fires you (with cause).
- You are in the United States in violation of federal immigration laws (can't legally work in the United States) and your doctor approves work with your employer.

Waiting period

You will not be paid for the first three calendar days you are off work unless you remain unable to perform any work for 14 consecutive days or are hospitalized as an inpatient during the first 14 days of total disability. If you lose time or wages on the day you are injured, that day will be the first day of the three-day waiting period. If you are released for modified duty at any time during the 14 days, the first three days are not paid.

Calculations used to determine time-loss payments

Time-loss benefits, sometimes called ***temporary total disability (TTD)*** or ***temporary partial disability (TPD)*** benefits, are based on your weekly wage at the time of your injury.

Questions?

Ombudsman for Injured Workers: (800) 927-1271
 Workers' Compensation Division: (800) 452-0288

Your weekly wage (or gross wage) may be calculated by averaging the wages you earned over the calendar year prior to your injury. If you had additional jobs at the time of injury, you may be eligible to receive additional disability payments. You must notify the insurer about your other jobs within 30 days of the insurer's receipt of your initial claim and provide check stubs or payroll records as proof of wages paid on the other jobs.

If you cannot work at all, time-loss payments will equal two-thirds of your gross wage, as long as that is not more than the maximum allowed under law. If your weekly wage was \$75 or less, your TTD rate will be 90 percent of your gross weekly wage or \$50, whichever is less. Each July 1 the worker's time-loss rate is adjusted. If your work hours are reduced or you are doing modified work that pays less than your regular wage, the insurer will send you time-loss payments (TPD) to replace part of your lost wages. If you have a ***disabling injury***, you will also receive TPD if you must leave work for four hours or more to receive medical treatment for your injury (unless your employer pays you wages for this absence).

Contact the insurer if you have questions about how your time-loss benefits were calculated.

Returning to work

Reinstatement rights

Most Oregon employers with more than 20 workers are required to return you to your job or another suitable job after your doctor releases you to work. The insurer will send you written notice when your doctor releases you to go back to work. When you receive this notice, you must ask your employer for

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

your job or another suitable job within seven calendar days (sooner if your union contract or employer's personnel policies require it) or you will lose your right to be reinstated with your employer.

If you have questions about your reinstatement rights or believe you have been unfairly treated by your employer because of your injury, call the Bureau of Labor and Industries, (503) 731-4075 in the Portland area, or (541) 686-7623 outside the Portland area.

Modified work

If your employer offers you modified work, contact your doctor to find out if you are physically able to do the job. If you find after returning to work that you cannot do the job due to your injury, contact your doctor immediately. If your modified work pays less than your job at the time of injury, you will receive time-loss checks (TPD) to make up part of the lost wages. If your doctor says you can do modified work, you must accept the job or your **time-loss** benefits (TTD) may be reduced or stopped. You may refuse a modified job without ending your time-loss benefits if any of the following are true:

- The job is *not* with the employer at injury or at a job site of the employer at injury.
- Your doctor says you are physically unable to commute to the job site. Your commute is the distance from your residence to your job at injury, or the distance to the job you are offered as modified work.
- The job site is more than 50 miles from where you customarily worked before your injury.

Questions?

Ombudsman for Injured Workers: (800) 927-1271
Workers' Compensation Division: (800) 452-0288

However, greater distance may be appropriate if the employer has multiple or mobile job sites and prior to the injury you could have been assigned to any such site.

- The job's work schedule (shift) differs from the employer's written work-schedule-change policy or common practice of the employer or the collective bargaining agreement.

Vocational assistance

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

- You have permanent disability.
- You cannot return to your regular job or a job that pays at least 80 percent of the wage you were earning.
- You are authorized to work in the United States.

Within 35 days of your becoming ***medically stationary***, the insurer will determine if you are eligible for vocational assistance and notify you of its decision in writing. Contact the insurer if you need help getting back to work. If you have questions, you may call the Workers' Compensation Division in Salem, (800) 452-0288, or Medford, (800) 696-7161, toll-free.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Re-employment assistance from WCD

- The Employer-at-Injury Program helps workers stay on the job or get back to work with the employer at injury. Because of your injury, your employer may be eligible for benefits to assist in returning you to light-duty work while your claim is open.
- The Preferred Worker Program helps injured workers get back to work. If you have permanent disability due to your injury, and your doctor says you can't return to your regular job, you may qualify as a Preferred Worker. Preferred Workers can offer financial incentives for Oregon employers to hire them. To find out if you qualify, call (800) 445-3948 or, in the Medford region, (800) 696-7161.



Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

Claim closure

Notice of Closure

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

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

- A **Notice of Closure**, which is the legal document that closes your claim. It lists the periods for which time-loss benefits were authorized and tells you how much **permanent disability** you may have. This document also tells you what to do if you want to appeal the closure.
- An **Updated Notice of Acceptance at Closure** lists the medical conditions the insurer has accepted. If the updated notice is incomplete or incorrect, notify the insurer in writing.
- A brochure, “**Understanding Claim Closure and Your Rights**,” explains appeal rights and processes and the types of care paid for by the insurer after claim closure.

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

Note: Information words that are in **bold italics** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Permanent partial disability (PPD)

If your Notice of Closure shows you have ***permanent partial disability***, this means your injury resulted in a condition that has not returned to its normal or pre-injury condition. Disability is a combination of impairments in a body part, such as loss of movement or sensation in a hand or foot, and may include factors of age, education, work history, and current ability to work. Disability payments are based on a formula set by law.

You may be entitled to receive payment from the insurer for your disability — called an “award.” The amount will depend on the severity of the disability and whether overpayment of benefits occurred. If the insurer overpaid you for benefits while your claim was open, the insurer may recover the overpayment by reducing your permanent disability payment or by reducing future benefits.

If your award is \$6,000 or less, the insurer will pay you a lump sum — a single payment — within 30 days of the mailing date on the Notice of Closure.

If your PPD award is more than \$6,000, the insurer will make monthly payments to you until the award is paid. The first payment is due within 30 days of the mailing date on the Notice of Closure. Your monthly award payments are equal to your monthly temporary total disability rate. You may ask the insurer to pay you a lump sum. However, if you or the insurer appeal the amount of your permanent disability award, you cannot receive a lump-sum payment until the appeal process is finished. **If you apply for and accept lump-sum payment of any part of your permanent disability award, you give up your right to appeal the amount of the award.**

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

Permanent total disability (PTD)

If your Notice of Closure shows you have ***permanent total disability***, it means you are permanently unable to work. You will receive monthly disability payments for the rest of your life if you remain totally disabled. The insurer will reexamine your claim at least every two years to see if you remain unable to work.

Fatality

When a worker dies due to an on-the-job injury or occupational disease or illness, Oregon law requires insurers to make monthly payments to the worker's spouse and children.

Reconsideration of closure

If you disagree with the Notice of Closure, you must write to the Workers' Compensation Division within 60 days of the mailing date printed on the Notice of Closure. Your appeal rights and the address to which to send your appeal are printed on the back of the Notice of Closure. You may also go to our Web site (www.cbs.state.or.us/external/wcd/policy/rdrs/aru/ccrp_1.html) and print a copy of the form, "Worker's Request for Reconsideration."

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Appeal rights and claim settlements

Appeals

An “appeal” is a request by an injured worker, an insurer, or another party to the claim for a review of a decision made about a claim. If you receive a notice that your claim or benefits are denied or ended, the document you receive will have instructions on how to appeal if you disagree with the decision. **There are time limits for most appeals. You’ll lose your appeal rights if you don’t appeal within the limits as printed in the letter you received.** Benefits that are the subject of the appeal are usually not paid until the appeal process is completed. If you want legal advice, check the yellow pages of your phone directory under “Attorneys” or call the Oregon State Bar, (800) 452-7636, to find a lawyer who handles workers’ compensation cases in your area.

Insurer penalties

If you believe that the insurer acted unreasonably by delaying acceptance or denial of your claim or by delaying payment of benefits, you may write to the Workers’ Compensation Division and request that a penalty be levied on the insurer. If the WCD finds that a penalty is appropriate, the penalty will be paid to you by the insurer.

Disputed-claim settlement

When you disagree with the insurer about whether you have a valid workers’ compensation claim or condition, you and the insurer may agree on a settlement. **If you agree, your claim will remain denied, and you give up all rights to future**

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers’ Compensation Division: (800) 452-0288

benefits for the denied medical conditions of the claim. Medical providers may bill you for services not paid by the insurer, so find out what your obligations will be before you agree to a settlement.

Claim disposition agreement

On an accepted claim, in return for an agreed-upon amount of money in a claim disposition agreement, you may give up your right to the following:

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

However, you cannot release your right to medical benefits or your eligibility for the Preferred Worker Program.

The agreement you and the insurer sign is the claim disposition agreement. All claim disposition agreements are reviewed by the ***Workers' Compensation Board***, which approves or disapproves the agreement. If you have questions about claim disposition agreements, contact the ***Ombudsman for Injured Workers***.

Note: Information words that are in ***bold italics*** are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Confidentiality of your claim records

Legal orders issued by state agencies and courts are public information. However, claim documents and medical reports that the insurer sends to the **Workers' Compensation Division** are not open to the public and your records will be released only in limited circumstances:

- When requested by you or your attorney
- When you are involved in litigation and relevant records are subpoenaed
- When a court orders release of the records
- When needed by governmental agencies of this state or the United States
- When the insurer requests information about your past claims, including relevant medical information, in order to make decisions about your current claim

Release of your information for any other reason requires your written permission. Employers may not legally consider individuals' workers' compensation histories in hiring decisions.

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

Glossary of workers' compensation terms

aggravation claim A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. Aggravation is established by medical evidence supported by objective findings of the physician. Aggravation rights expire five years after first closure or five years from date of injury on non-disabling claims. ORS 656.273

attending physician (AP) A physician primarily responsible for the treatment of an injured worker. ORS 656.005

authorized nurse practitioner A nurse practitioner authorized to provide compensable medical services to an injured worker for a period of 90 days from the date of the first visit to a nurse practitioner on the initial claim. The authorized nurse practitioner also may authorize temporary disability benefits for a period of up to 60 days from the first visit to a nurse practitioner on the initial claim. Nurse practitioners authorized to treat by managed care organizations may treat longer than 90 days. ORS 656.245

disabling compensable injury An on-the-job injury that entitles the worker to temporary or permanent, partial or total disability compensation or death benefits. ORS 656.005

injury An on-the-job injury (a sudden and discrete event) or occupational disease.

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

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

medically stationary The point at which the attending physician states no further significant improvement for your condition resulting from the injury or illness can reasonably be expected from medical treatment or the passage of time. ORS 656.005

non-disabling injury Any injury that requires medical services only and does not result in an inability to work or permanent disability. ORS 656.005

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 to which an employee is not ordinarily subjected or exposed other than during employment and requires medical services or results in disability or death. ORS 656.802

Ombudsman for Injured Workers The state office that serves as an independent advocate for injured workers in their dealings with the workers' compensation system.

permanent partial disability (PPD) The permanent loss of use or function of any portion of the body as defined by ORS 656.214.

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

temporary partial disability benefits (TPD) Payment for wages lost based on a worker's ability to perform temporary modified or part-time work due to a compensable injury.

temporary total disability benefits (TTD)

Payment for wages lost based on a worker's temporary inability to work due to a compensable injury.

time-loss payments Compensation paid to an injured worker who loses time or wages as a result of compensable injury.

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 Department of Consumer and Business Services, a state agency, that administers Oregon's workers' compensation laws.

Note: Information words that are in *bold italics* are defined in the Glossary, Page 26. Agency phone numbers are listed in the Services Directory, Page 30.

Questions?

Ombudsman for Injured Workers: (800) 927-1271

Workers' Compensation Division: (800) 452-0288

Services Directory

Visit one of the following State of Oregon Web pages for more information:

Workers' Compensation Division

www.wcd.oregon.gov

Ombudsman for Injured Workers

www.cbs.state.or.us/wco

Workers' Compensation Board

www.cbs.state.or.us/wcb

Workers' Compensation Division

350 Winter Street NE

P.O. Box 14480

Salem, OR 97309-0405

General information (503) 947-7810

Workers' Compensation Infoline

(toll-free in Oregon) (800) 452-0288

or send email to: workcomp.questions@state.or.us

TTY* (503) 947-7993

Benefits information (503) 947-7585

(toll-free in Oregon) (800) 452-0288

WCD Employer Index (to verify
employer's insurance)

(toll-free in Oregon) (888) 877-5670

Investigations — Fraud Hotline

(toll-free in Oregon) (800) 452-0288

Managed care organization

(MCO) questions (503) 947-7821

Medical fee, medical treatment, curative care,
palliative care disputes, and interim

medical benefits (503) 947-7816

Reconsideration of claim closures ... (503) 947-7816

Re-employment assistance (503) 947-7588

or (toll-free in Oregon) (800) 445-3948

Medford region (541) 776-6032 (V/TTY)*

or (toll-free in Oregon) (800) 696-7161

■ Employer-at-Injury Program

■ Preferred Worker Program

Vocational eligibility/assistance, return-to-work plans, and vocational disputes (503) 947-7816
 Medford region (541) 776-6032 (V/TTY)*
 or (toll-free in Oregon) (800) 696-7161

Workers' Compensation Board (WCB) (and Hearings Division)

2601 25th Street SE, Suite 150
 Salem, Oregon 97302-1282
 (503) 378-3308 For TTY* use ext. 307

Ombudsman for Injured Workers (Ombudsman)

(503) 378-3351 or TTY* (503) 947-7189
 or call the Injured Worker Helpline
 (Toll-free) (800) 927-1271

Other resources

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

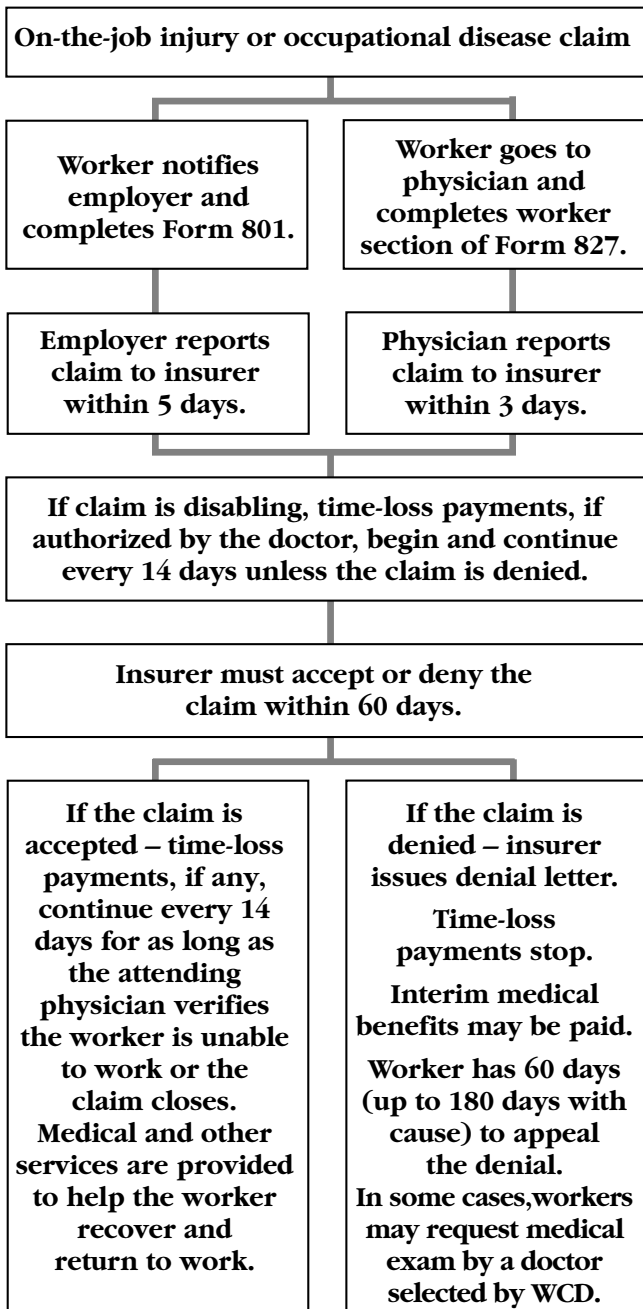
- Contact the Oregon Employment Department to find out if you are eligible for unemployment benefits.
- Contact the Social Security Administration to find out if you are eligible for disability benefits.
- Contact the Oregon Vocational Rehabilitation Division to find out if you are eligible for rehabilitation services.

If you have any other questions about your benefits, contact the Ombudsman for Injured Workers, (800) 927-1271, or the Workers' Compensation Division, (800) 452-0288.

*TTY: Text-display telephone

Workers' Compensation Claim Process

From injury through acceptance or denial:



From acceptance through closure and beyond:

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

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

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

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

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

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

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

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



Oregon Department of
Consumer & Business Services
Workers' Compensation Division
350 Winter Street NE,
P.O. Box 14480
Salem, OR 97309-0405
(800) 452-0288



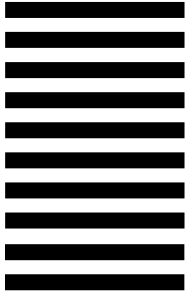
NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

Name & Address (optional)

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 1266 SALEM OR

POSTAGE WILL BE PAID BY ADDRESSEE



WORKERS' COMPENSATION DIVISION - COMMUNICATIONS
DEPARTMENT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE RM 2
SALEM OR 97301-3878



Please complete this card and keep it with you
so you have access to claim information at all times.

Claim Information Record

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

Keep this card with you so you have access to claim information at all times.

Dear reader,

This booklet is provided by the State of Oregon Workers' Compensation Division. Please let us know if this booklet is useful and if you have suggestions for improvements. Write your comments about this booklet in the space below and drop this card in the mail — no postage necessary. Thank you.

Comments: _____

If you would like to be contacted by the Workers' Compensation Division, please print your name and address on reverse side and provide your phone number: (____) _____

440-3138 (6/04/COM)

Service Directory

Workers' Compensation Division

- General information (503) 947-7810
- TTY (text-display telephone) (503) 947-7993
- Workers' Compensation Infoline (toll-free in Oregon) (800) 452-0288
- Benefits information (see also Ombudsman) (503) 947-7585
- Employer index (to verify employer's insurance) (888) 877-5670
- Investigations - fraud hotline (toll-free in Oregon) (800) 452-0288
- Re-employment assistance (toll-free in Oregon) (800) 445-3948
- Medford region (toll-free in Oregon) (800) 696-7161

Medical and vocational disputes:

- Reconsideration of claim closure (503) 947-7816

Workers' Compensation Board (503) 378-3308

Ombudsman for Injured Workers (503) 378-3351

- Injured Worker Helpline (toll-free) (800) 927-1271

Web address: oregonwcd.org