Claim Obligations

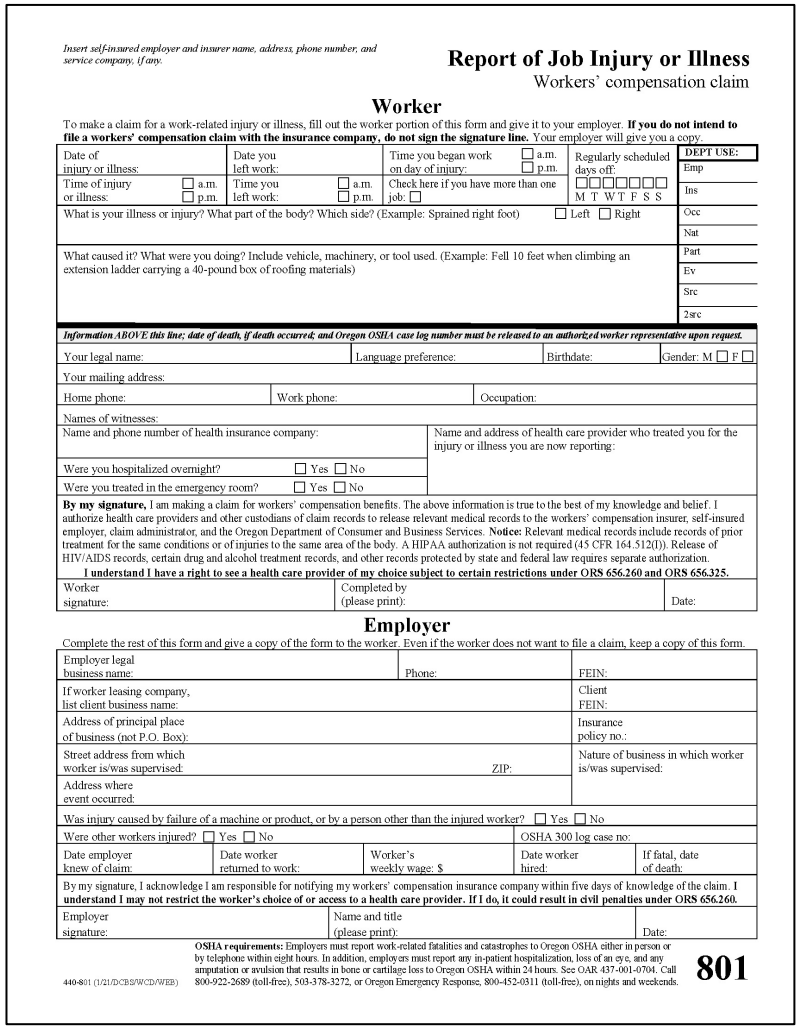
For Employers and Providers

Presenter: Mikaela Polk, field investigator

Department of Consumer
and Business Services

Incident or claim?

- Form 801 serves as both an incident report and a claim filing.
- Using separate forms is recommended, but not required.
- “If a worker signs a Form 801, the claim must be reported to the insurer.” OAR 436-060-0010(4).
- Worker's signature on Form 801 signifies notice of a claim.
  - Employer must report and insurer must process the claim.
- An unsigned Form 801 is used to document an incident, not a claim.
  - Employer needs knowledge of a claim or enough facts to reasonably infer workers' compensation liability before processing.



Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness
Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S	DEPT USE:
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part
				Ev
				Src
				2src

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:			
Home phone:	Work phone:	Occupation:	
Names of witnesses:			
Name and phone number of health insurance company:		Name and address of health care provider who treated you for the injury or illness you are now reporting:	
Were you hospitalized overnight? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised: ZIP:		Nature of business in which worker is/was supervised:
Address where event occurred:		

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

Were other workers injured? ☐ Yes ☐ No — OSHA 300 log case no:

Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I **understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

Employer signature:	Name and title (please print):	Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

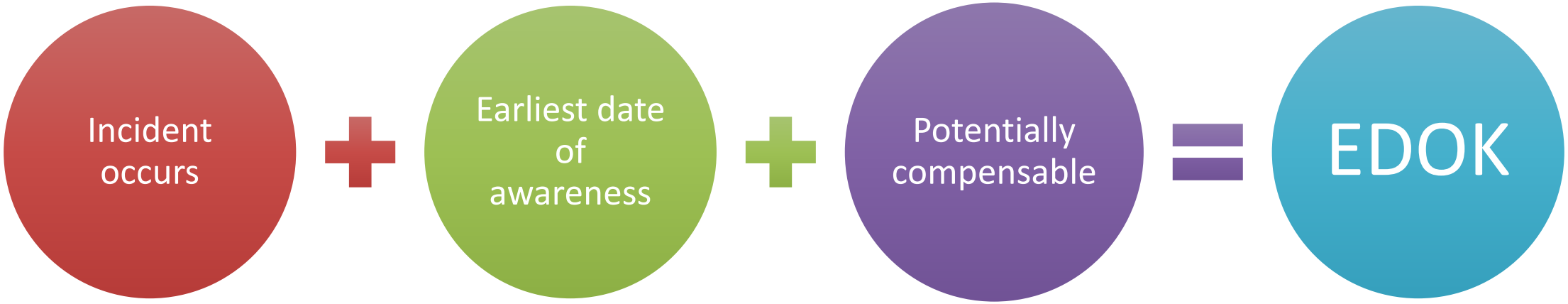
440-801 (1/21/DCBS/WCD/WEB)

801

When do we have knowledge of a claim?

Knowledge of a claim / employer date of knowledge

OAR 436-060-0010(2) *"The date an employer has knowledge of an accident that may result in a compensable injury is the earliest date any supervisor or manager of the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility."*



When do we have knowledge of a claim?

Small group discussion:

What can you conclude?
Is this an incident or a workers' compensation claim?

Paper cut at the office. Employee applied a Band-Aid and Neosporin.

Likely incident

Employee twisted her ankle in the conference room (limping, but not going to the doctor for treatment).

Possible claim, likely incident

On Thursday, an employee got a blistering burn on his hand from not using PPE. He said he might schedule a doctor's appointment, and left work early.

Claim

Filing a workers' compensation claim

90 days is timely filing (one year for occupational disease)

Insurer will determine timeliness – not employer

Form 801 with employer/insurer

Employer has **five days** to send Form 801 to insurer

Form 827 with medical provider

Medical provider has **three days** to send Form 827 to insurer

A worker always has a right to file a claim

Employer responsibility

Employers must:

Accept notice of a claim for workers' compensation benefits from an injured worker or worker's representative.

Provide the Form 801 and "A Guide for Workers Recently Hurt on the Job" to the worker, upon request.

Report the claim to the insurer no later than **five days** after notice or knowledge of a claim or accident.

Not discourage a worker from filing a claim.

Why do claims need to be filed so timely?

- Claim classification: disabling vs. nondisabling
- Insurer has **60 days** from EDOK to timely accept or deny the claim
- Interim time loss, if authorized – and claim is not denied within the first **14 days**
- Injured worker's medical treatment
- Any unreasonable delay in benefits to the worker may result in sanctions against the insurer of up to 25% of the amounts due.

I’ve filled out the Form 801, but …

I believe the claim to be suspicious …

- Attach a sheet to the 801, expressing concerns that the claim might be suspicious or fraudulent.
- Be specific about your concerns and provide documentation to back them up.

I’m worried about my insurance experience rating …

- You can reimburse the insurer up to the amount published annually in Bulletin 345.
- Reimbursed costs cannot be used for experience-rating calculations.
- Only for accepted, nondisabling claims

Oregon employment laws

- Administered by the Oregon Bureau of Labor and Industries.
- “At will" employment: Oregon employers may discharge an employee at any time and for any reason, or no reason at all.
- Employers may not fire or let employees go for discriminatory reasons.
- “Protected class” is a shared characteristic that employers cannot use as a basis for an employment decision under the law.
- Injured workers (no longer only for companies with six-plus employees) are a protected class.

Retaliation

Retaliation may include:

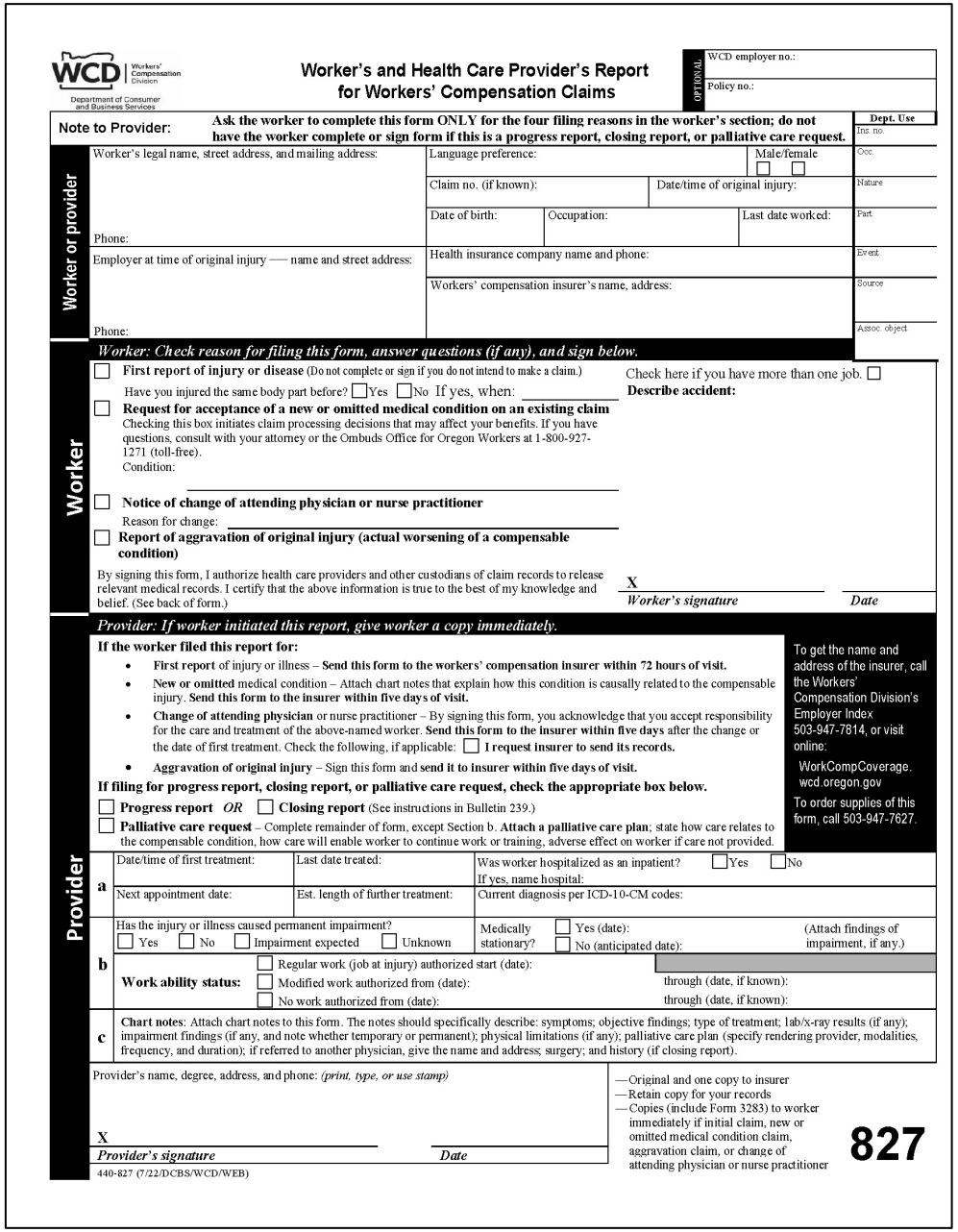
- Downgrading or denial of an upgrade
- Denial of earned benefits, such as sick leave or vacation
- Assignment to an unwanted job or shift
- Harassment
- Loss of seniority
- Blacklists
- Reduction of pay or hours

Workers may file a retaliation complaint with the Bureau of Labor and Industries (BOLI) within **one year.**

BOLI will investigate the allegation, which may result in a hefty penalty from that agency.

Medical provider responsibility

- A provider has 72 hours to send Form 827 to insurer
  - What if I don't think it's work related?
  - What is I can't find the employers workers' compensation coverage?



WCD Workers' Compensation Division
Department of Consumer and Business Services

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

WCD employer no.:
Policy no.:

Note to Provider: **Ask the worker to complete this form ONLY for the four filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report, closing report, or palliative care request.**

Dept. Use
Ins. no.
Occ.
Nature
Part.
Event
Source
Assoc. object

Worker or provider

Worker's legal name, street address, and mailing address:
Phone:
Language preference:
Male/female
Claim no. (if known):
Date/time of original injury:
Date of birth:
Occupation:
Last date worked:
Employer at time of original injury — name and street address:
Phone:
Health insurance company name and phone:
Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Have you injured the same body part before? ☐Yes ☐No If yes, when: _____
Check here if you have more than one job. ☐
Describe accident:

☐ **Request for acceptance of a new or omitted medical condition on an existing claim**
Checking this box initiates claim processing decisions that may affect your benefits. If you have questions, consult with your attorney or the Ombuds Office for Oregon Workers at 1-800-927-1271 (toll-free).
Condition: _____

☐ **Notice of change of attending physician or nurse practitioner**
Reason for change: _____

☐ **Report of aggravation of original injury (actual worsening of a compensable condition)**

By signing this form, I authorize health care providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See back of form.)

X _____ *Worker's signature* *Date*

Provider

Provider: If worker initiated this report, give worker a copy immediately.

If the worker filed this report for:

- **First report** of injury or illness – **Send this form to the workers' compensation insurer within 72 hours of visit.**
- **New or omitted** medical condition – Attach chart notes that explain how this condition is causally related to the compensable injury. **Send this form to the insurer within five days of visit.**
- **Change of attending physician** or nurse practitioner – By signing this form, you acknowledge that you accept responsibility for the care and treatment of the above-named worker. **Send this form to the insurer within five days** after the change or the date of first treatment. Check the following, if applicable: ☐ **I request insurer to send its records.**
- **Aggravation of original injury** – Sign this form and **send it to insurer within five days of visit.**

To get the name and address of the insurer, call the Workers' Compensation Division's Employer Index 503-947-7814, or visit online: WorkCompCoverage.wcd.oregon.gov
To order supplies of this form, call 503-947-7627.

If filing for progress report, closing report, or palliative care request, check the appropriate box below.

☐ **Progress report** *OR* ☐ **Closing report** (See instructions in Bulletin 239.)
☐ **Palliative care request** – Complete remainder of form, except Section b. **Attach a palliative care plan**; state how care relates to the compensable condition, how care will enable worker to continue work or training, adverse effect on worker if care not provided.

a
Date/time of first treatment:
Last date treated:
Was worker hospitalized as an inpatient? ☐Yes ☐No
If yes, name hospital:
Next appointment date:
Est. length of further treatment:
Current diagnosis per ICD-10-CM codes:

Has the injury or illness caused permanent impairment? ☐ Yes ☐ No ☐ Impairment expected ☐ Unknown
Medically stationary? ☐ Yes (date): ☐ No (anticipated date):
(Attach findings of impairment, if any.)

b
Work ability status:
☐ Regular work (job at injury) authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c
Chart notes: Attach chart notes to this form. The notes should specifically describe: symptoms; objective findings; type of treatment; lab/x-ray results (if any); impairment findings (if any, and note whether temporary or permanent); physical limitations (if any); palliative care plan (specify rendering provider, modalities, frequency, and duration); if referred to another physician, give the name and address; surgery; and history (if closing report).

Provider's name, degree, address, and phone: *(print, type, or use stamp)*

X _____ *Provider's signature* *Date*

—Original and one copy to insurer
—Retain copy for your records
—Copies (include Form 3283) to worker immediately if initial claim, new or omitted medical condition claim, aggravation claim, or change of attending physician or nurse practitioner

440-827 (7/22/DCBS/WCD/WEB)

827

Claim suppression

Employer cannot force or coerce a worker to not file a claim.

Employer cannot force or coerce a worker to say the injury did not happen while working.

Claim suppression may result in an investigation conducted by the division, as well as potential imposed sanctions.

Question and answer time!

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