Workers' Comp 101

(Part 1)

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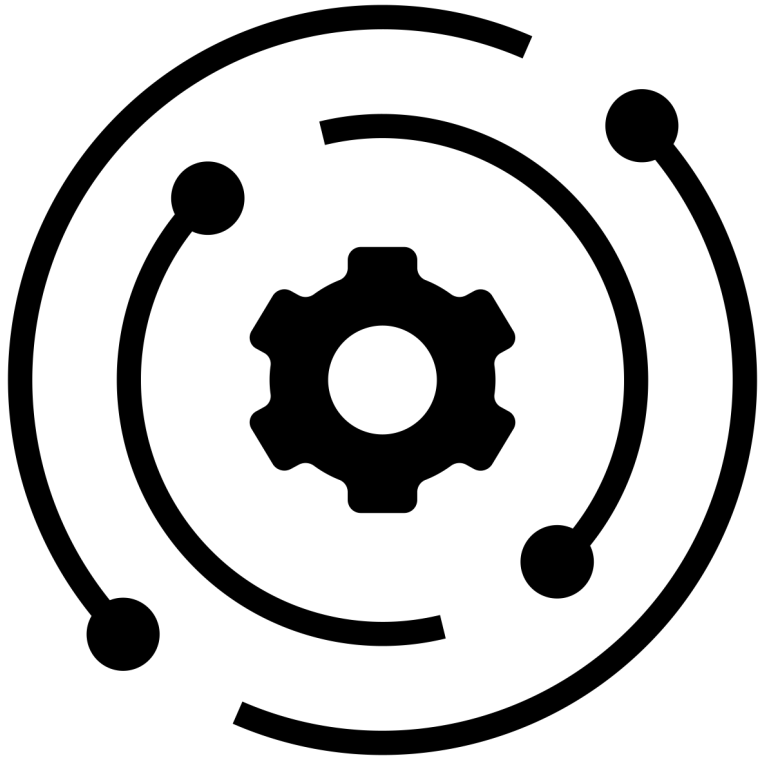
DCBS | Department of Consumer and Business Services

Today’s session

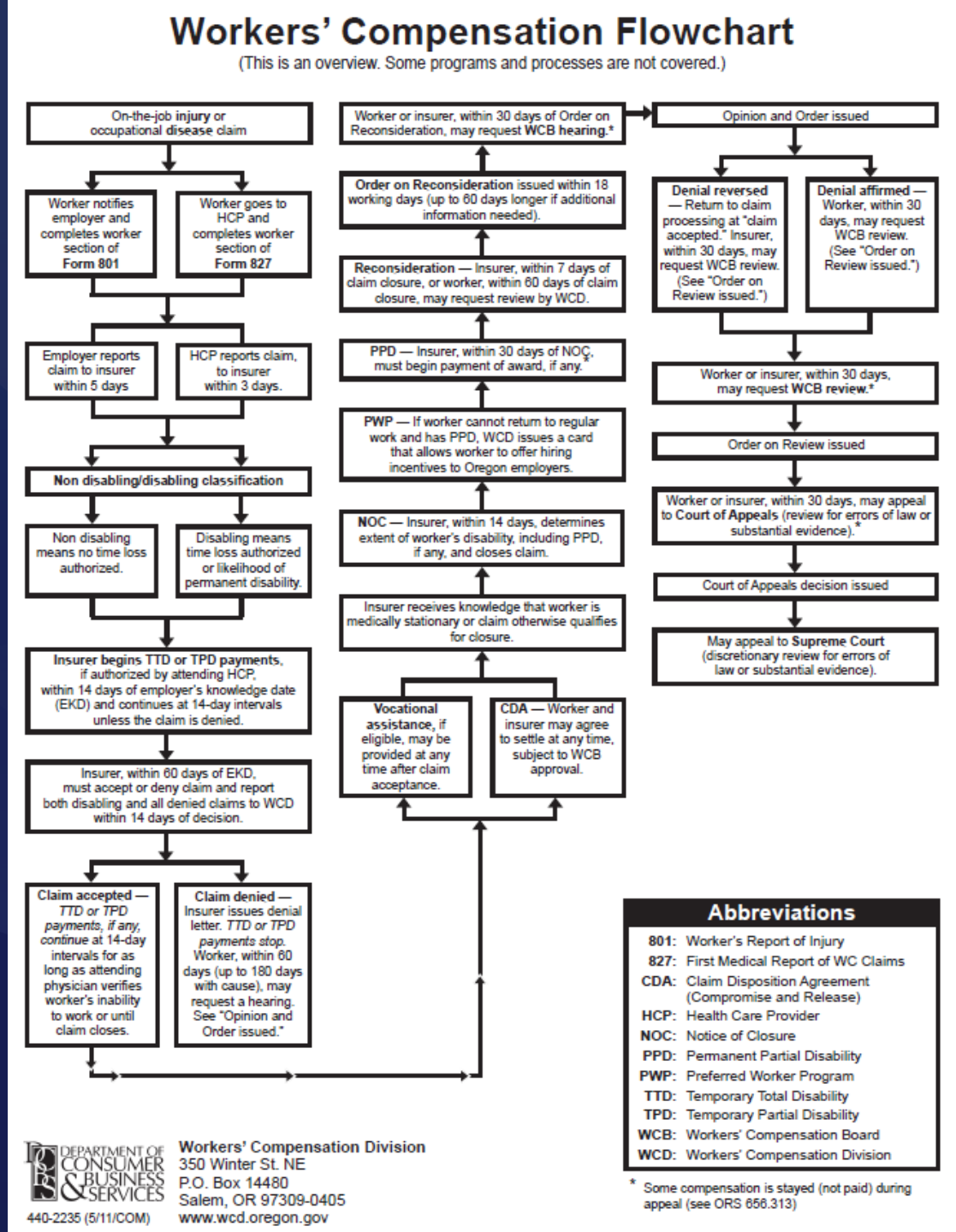
- The workers’ compensation system
  - Workers, employers, and others
- Life of a claim
- Digging into the details

The workers' compensation system

- Subject workers/subject employers
- Insurers and service companies
- Medical providers
- Workers' Compensation Division
- Workers' Compensation Board
- Attorneys
- Ombuds Office for Oregon Workers



Life of a claim



Workers' Compensation Flowchart

(This is an overview. Some programs and processes are not covered.)

On-the-job injury or occupational disease claim

Worker notifies employer and completes worker section of **Form 801**

Worker goes to HCP and completes worker section of **Form 827**

Employer reports claim to insurer within 5 days

HCP reports claim, to insurer within 3 days.

Non disabling/disabling classification

Non disabling means no time loss authorized.

Disabling means time loss authorized or likelihood of permanent disability.

Insurer begins TTD or TPD payments, if authorized by attending HCP, within 14 days of employer's knowledge date (EKD) and continues at 14-day intervals unless the claim is denied.

Insurer, within 60 days of EKD, must accept or deny claim and report both disabling and all denied claims to WCD within 14 days of decision.

Claim accepted — *TTD or TPD payments, if any, continue* at 14-day intervals for as long as attending physician verifies worker's inability to work or until claim closes.

Claim denied — Insurer issues denial letter. *TTD or TPD payments stop.* Worker, within 60 days (up to 180 days with cause), may request a hearing. See "Opinion and Order issued."

Insurer receives knowledge that worker is medically stationary or claim otherwise qualifies for closure.

Vocational assistance, if eligible, may be provided at any time after claim acceptance.

CDA — Worker and insurer may agree to settle at any time, subject to WCB approval.

NOC — Insurer, within 14 days, determines extent of worker's disability, including PPD, if any, and closes claim.

PWP — If worker cannot return to regular work and has PPD, WCD issues a card that allows worker to offer hiring incentives to Oregon employers.

PPD — Insurer, within 30 days of NOC, must begin payment of award, if any.

Reconsideration — Insurer, within 7 days of claim closure, or worker, within 60 days of claim closure, may request review by WCD.

Order on Reconsideration issued within 18 working days (up to 60 days longer if additional information needed).

Worker or insurer, within 30 days of Order on Reconsideration, may request **WCB hearing.***

Opinion and Order issued

Denial reversed — Return to claim processing at "claim accepted." Insurer, within 30 days, may request WCB review. (See "Order on Review issued.")

Denial affirmed — Worker, within 30 days, may request WCB review. (See "Order on Review issued.")

Worker or insurer, within 30 days, may request **WCB review.***

Order on Review issued

Worker or insurer, within 30 days, may appeal to **Court of Appeals** (review for errors of law or substantial evidence).*

Court of Appeals decision issued

May appeal to **Supreme Court** (discretionary review for errors of law or substantial evidence).

Abbreviations

801:	Worker's Report of Injury
827:	First Medical Report of WC Claims
CDA:	Claim Disposition Agreement (Compromise and Release)
HCP:	Health Care Provider
NOC:	Notice of Closure
PPD:	Permanent Partial Disability
PWP:	Preferred Worker Program
TTD:	Temporary Total Disability
TPD:	Temporary Partial Disability
WCB:	Workers' Compensation Board
WCD:	Workers' Compensation Division

* Some compensation is stayed (not paid) during appeal (see ORS 656.313)

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

440-2235 (5/11/COM)

Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
www.wcd.oregon.gov

This flowchart is available online at:
https://wcd.oregon.gov/Publications/2235.pdf

Reporting requirements

Employers must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative.

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

Employers must report the claim to their insurer no later than five days after notice or knowledge of a claim or accident.

Form 827, written notice of claim when signed by **medical provider** and worker, must be sent to insurer within 72 hours of visit.

Employers must not persuade a worker to not file a claim.

Reporting requirements, continued

INJURY CLAIM:

- **Worker** must provide notice to employer within 90 days of date of injury
- **Worker** must provide notice to employer within one year of date of injury if:
  - The employer had knowledge of an incident
  - The worker “had good cause for failure to give notice” within 90 days
- What’s the difference between an incident and a claim?

OCCUPATIONAL DISEASE:

- **Workers** must file a claim within one year from the latest date of:
  - When they first discovered they were suffering from an occupational disease
  - When they should have discovered they had the disease
  - Date of disability
  - Date they were informed by a doctor that they have a disease

Choice of attending physician (AP)

- Worker has choice of provider
- Employer is not allowed to direct care

Who can provide treatment for an on-the-job injury?

Medical doctor (MD)

Doctor of osteopathy (DO)

Oral surgeon (DDS)

Podiatrist (DPM)

Authorized nurse practitioner (NP), physician assistant

- 180 days to treat and authorize time loss

Chiropractor, naturopath

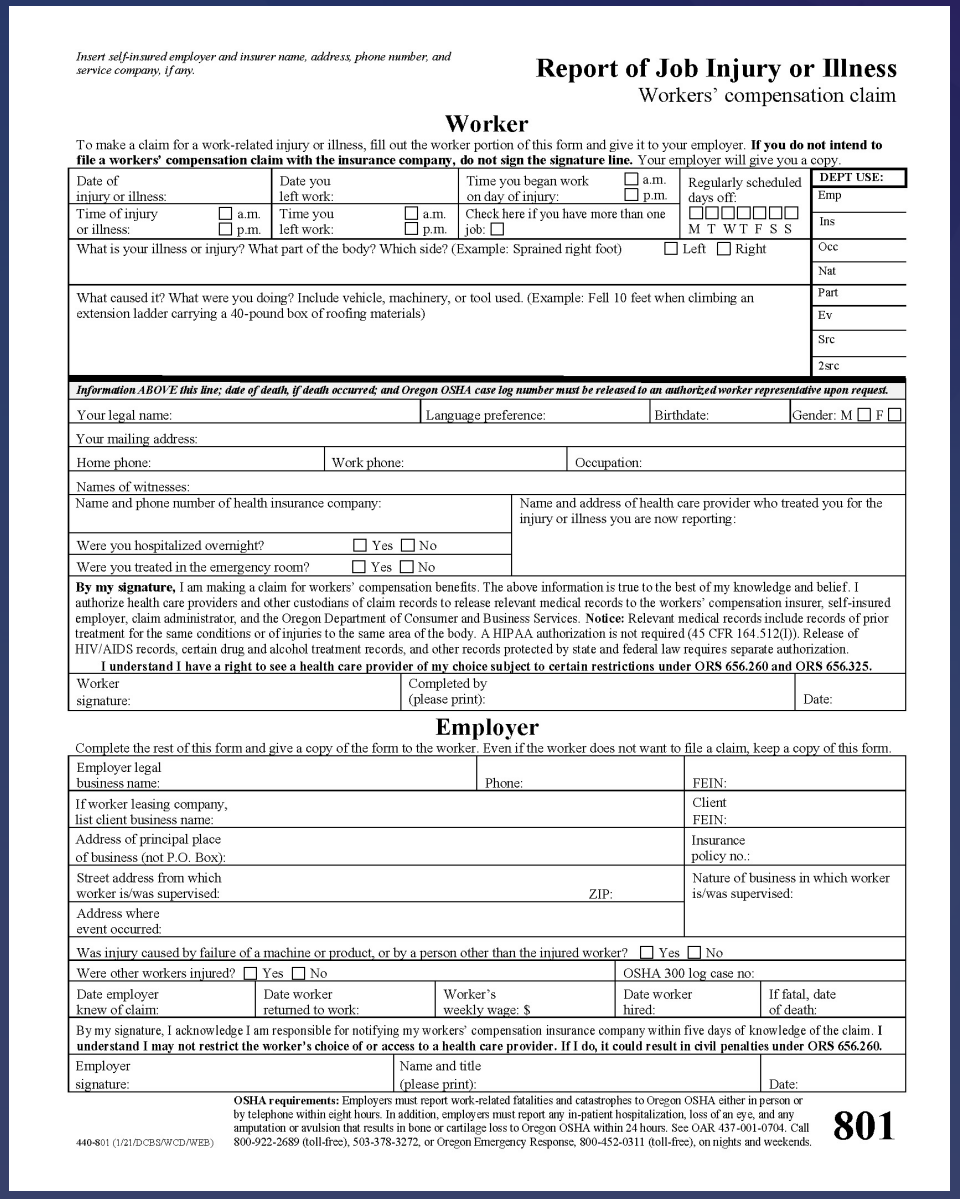
- 60 days or 18 visits to treat and 30 days to authorize time loss

Any other medical practitioner not listed may ***treat*** for 30 days or 12 visits – no "attending" status

Appendix A - Matrix for health care provider types* See OAR 436-009-0005 and 436-010-0210

	Attending physician status (primarily responsible for treatment of a patient)	Provides compensable medical services for initial injury or illness	Authorizes payment of temporary disability and releases the patient to work	Establishes impairment findings (permanent disability)	Provides compensable medical services for aggravation of injury or illness
Type A attending physician Medical doctor Doctor of osteopathic medicine Oral and maxillofacial surgeon Podiatric physician and surgeon	Yes	Yes	Yes	Yes	Yes
Type B attending physician Chiropractic physician Naturopathic physician	Yes, for a total of 60 consecutive days or 18 visits, from the date of the first 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 first 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 a type A attending physician and under a written treatment plan.
Type C attending physician Physician Assistant	Yes, for a total of 180 consecutive days from the date of the first visit on the initial claim with any physician assistant.	Yes, for 180 consecutive days from the date of the first visit to any physician assistant on the initial claim. Or, if authorized by an attending physician.	Yes, for 180 days from the date of the first visit with any physician assistant on the initial claim.	No.	No, unless authorized by a type A attending physician.
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 with any authorized nurse practitioner on the initial claim.	No	No, unless authorized by a type A attending physician.
Emergency room physician	No, if the physician refers the patient to a primary care physician.	Yes	An ER physician who is not authorized to serve as attending physician under ORS 656.005(12)(c) may authorize temporary disability for up to 14 days, including retroactive authorization.	No, if patient referred to a primary care physician.	Yes
"Other Health Care Providers" (e.g. acupuncturist)	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 a type A attending physician and under a written treatment plan.

Forms used to report a claim



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
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Ins
				Occ
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)				Nat
				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:

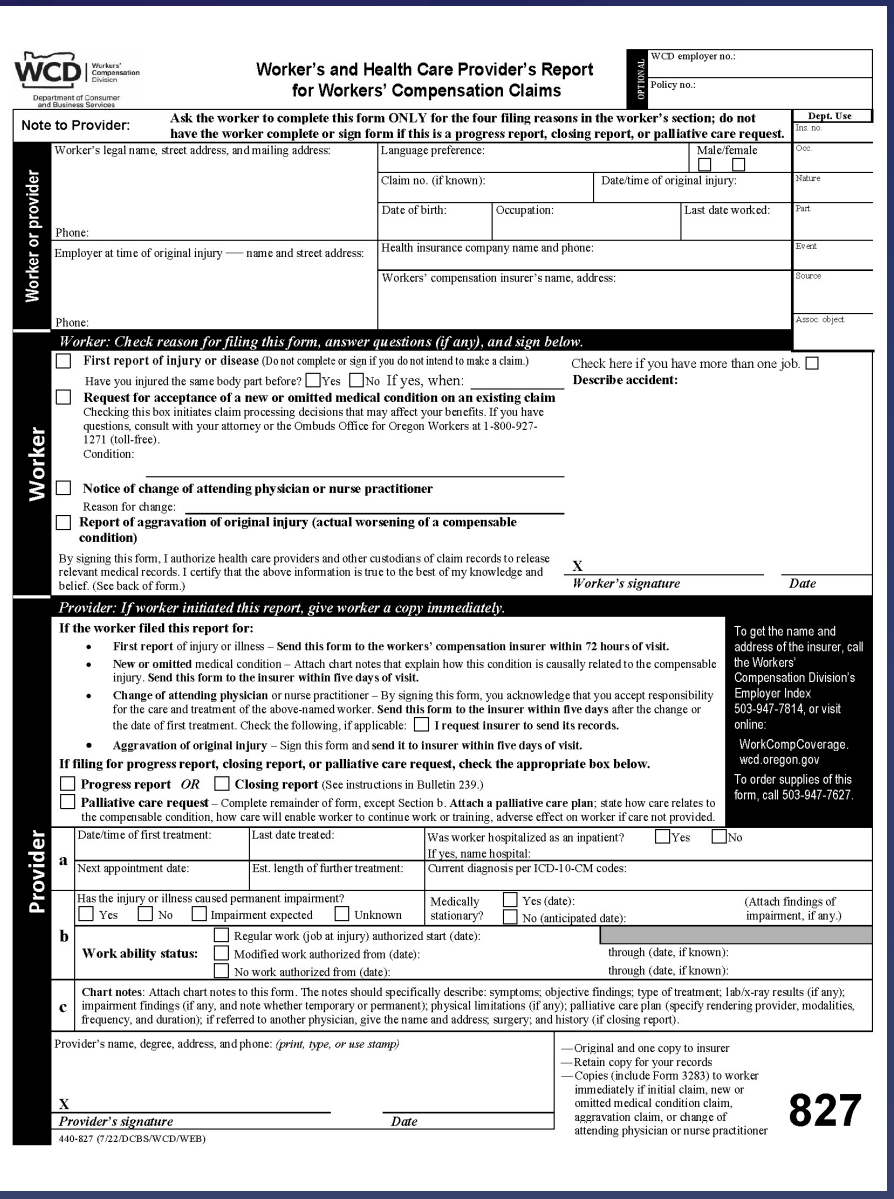
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

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



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

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: _____

☐ **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)**

Check here if you have more than one job. ☐
Describe accident:

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.**

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.

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.

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

What is a compensable injury claim?

- Injury to person or prosthetic device
- Arising out of and in the course of employment
- Requires medical treatment *or* results in disability or death
- Result is an accident, whether or not due to accidental means
- Requires medical evidence supported by objective findings

General course and scope rule

The statute: a compensable injury arises out of and occurs in the course of employment. ORS 656.007(7)(a)

Oregon applies a unitary approach in which “arising out of” and “in the course of” are two elements of a single inquiry into whether an injury is work related.

- “Arising out of” considers the causal connection between the injury and the employment.
- “In the course of employment” concerns the time, place, and circumstances of the injury.

Both elements must be satisfied to some extent

What is *not* a compensable claim?

Active participant in an assault/combat

Injury as result of recreational/social activities primarily for worker's personal pleasure

Major cause of injury is drug/alcohol use (unknown by employer)

- Burden of proof — employer/insurer
- Consumption of drugs/alcohol must be major cause

Deferred or “new” claim

Information is gathered and evaluated:

- Interim time loss paid as authorized
- Medical information
- Statement from worker, employer, and witnesses
- Mechanism of injury vs. claimed conditions
- Prior medical and work history
- A worker may be required to attend an independent medical examination (IME) for another medical opinion

Claim classification:

- *Nondisabling or medical only claims* have no expected time lost from work and/or no anticipated physical impairment
- *Disabling or time loss claims* have expected time lost from work and/or some anticipated physical impairment

Compensability decision

An insurer has **60 days** from the employer's knowledge to *timely* accept or deny the claim.

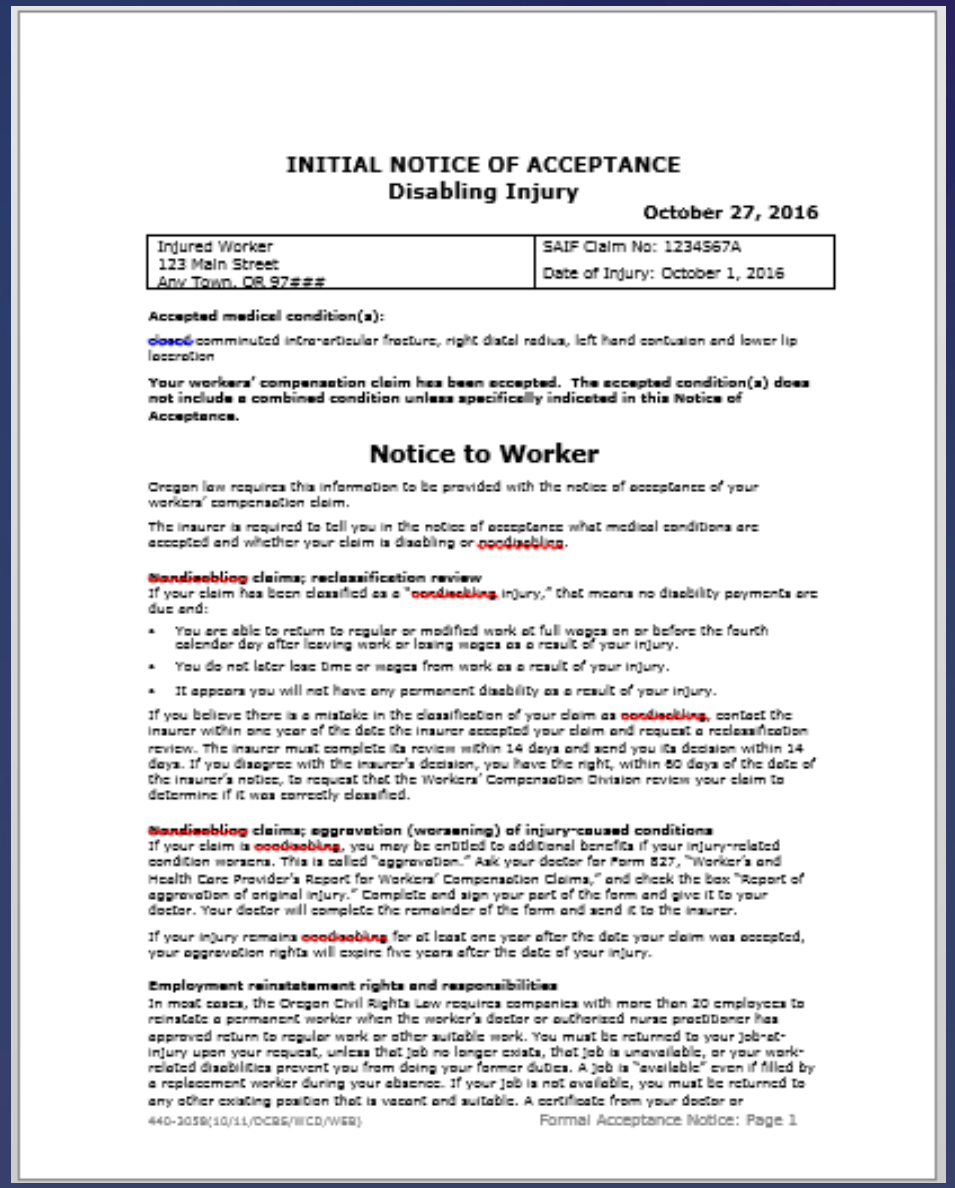
Notice of Acceptance

what conditions are compensable and whether the claim is disabling or nondisabling

Denial letter

must specify the factual and legal reasons for the denial and include the worker's appeal rights

Acceptance or Denial



INITIAL NOTICE OF ACCEPTANCE
Disabling Injury

October 27, 2016

Injured Worker 123 Main Street Any Town, OR 97###	SAIF Claim No: 1234567A Date of Injury: October 1, 2016

Accepted medical condition(a):

closed comminuted intra-articular fracture, right distal radius, left hand contusion and lower lip laceration

Your workers' compensation claim has been accepted. The accepted condition(a) does not include a combined condition unless specifically indicated in this Notice of Acceptance.

Notice to Worker

Oregon law requires this information to be provided with the notice of acceptance of your workers' compensation claim.

The insurer is required to tell you in the notice of acceptance what medical conditions are accepted and whether your claim is disabling or nondisabling.

Nondisabling claims; reclassification review
If your claim has been classified as a "nondisabling injury," that means no disability payments are due and:

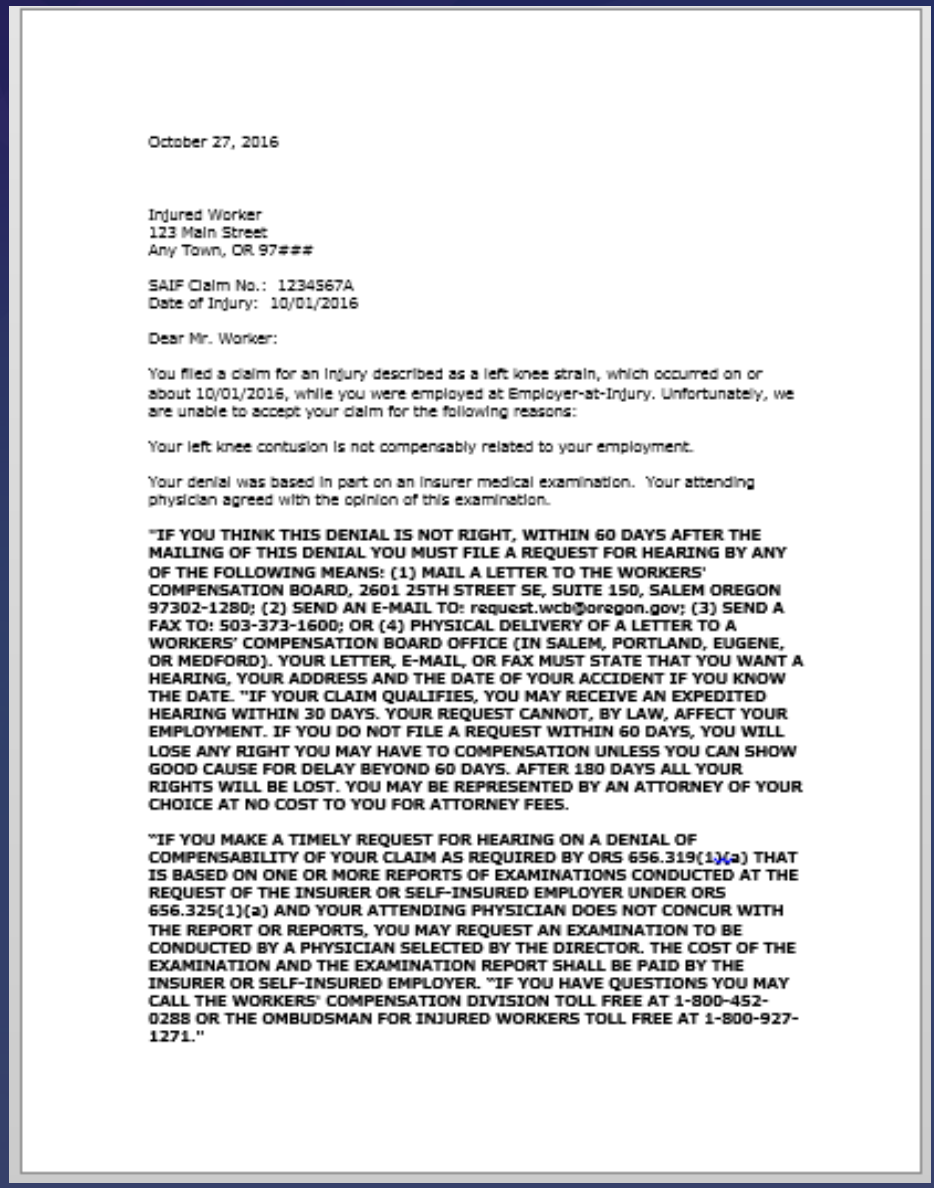
- You are able to return to regular or modified work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.
- You do not lose time or wages from work as a result of your injury.
- It appears you will not have any permanent disability as a result of your injury.

If you believe there is a mistake in the classification of your claim as nondisabling, contact the insurer within one year of the date the insurer accepted your claim and request a reclassification review. The insurer must complete its review within 14 days and send you its decision within 14 days. If you disagree with the insurer's decision, you have the right, within 60 days of the date of the insurer's notice, to request that the Workers' Compensation Division review your claim to determine if it was correctly classified.

Nondisabling claims; aggravation (worsening) of injury-caused conditions
If your claim is nondisabling, you may be entitled to additional benefits if your injury-related condition worsens. This is called "aggravation." Ask your doctor for Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," and check the box "Report of aggravation of original injury." Complete and sign your part of the form and give it to your doctor. Your doctor will complete the remainder of the form and send it to the insurer.

If your injury remains nondisabling for at least one year after the date your claim was accepted, your aggravation rights will expire five years after the date of your injury.

Employment reinstatement rights and responsibilities
In most cases, the Oregon Civil Rights Law requires employers with more than 20 employees to reinstate a permanent worker when the worker's doctor or authorized nurse practitioner has approved return to regular work or other suitable work. You must be returned to your job-at-injury upon your request, unless that job no longer exists, that job is unavailable, or your work-related disabilities prevent you from doing your former duties. A job is "available" even if filled by a replacement worker during your absence. If your job is not available, you must be returned to any other existing position that is vacant and suitable. A certificate from your doctor or



October 27, 2016

Injured Worker
123 Main Street
Any Town, OR 97###

SAIF Claim No.: 1234567A
Date of Injury: 10/01/2016

Dear Mr. Worker:

You filed a claim for an injury described as a left knee strain, which occurred on or about 10/01/2016, while you were employed at Employer-at-Injury. Unfortunately, we are unable to accept your claim for the following reasons:

Your left knee contusion is not compensably related to your employment.

Your denial was based in part on an insurer medical examination. Your attending physician agreed with the opinion of this examination.

"IF YOU THINK THIS DENIAL IS NOT RIGHT, WITHIN 60 DAYS AFTER THE MAILING OF THIS DENIAL YOU MUST FILE A REQUEST FOR HEARING BY ANY OF THE FOLLOWING MEANS: (1) MAIL A LETTER TO THE WORKERS' COMPENSATION BOARD, 2601 25TH STREET SE, SUITE 150, SALEM OREGON 97302-1280; (2) SEND AN E-MAIL TO: request.wcb@oregon.gov; (3) SEND A FAX TO: 503-373-1600; OR (4) PHYSICAL DELIVERY OF A LETTER TO A WORKERS' COMPENSATION BOARD OFFICE (IN SALEM, PORTLAND, EUGENE, OR MEDFORD). YOUR LETTER, E-MAIL, OR FAX MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE. "IF YOUR CLAIM QUALIFIES, YOU MAY RECEIVE AN EXPEDITED HEARING WITHIN 30 DAYS. YOUR REQUEST CANNOT, BY LAW, AFFECT YOUR EMPLOYMENT. IF YOU DO NOT FILE A REQUEST WITHIN 60 DAYS, YOU WILL LOSE ANY RIGHT YOU MAY HAVE TO COMPENSATION UNLESS YOU CAN SHOW GOOD CAUSE FOR DELAY BEYOND 60 DAYS. AFTER 180 DAYS ALL YOUR RIGHTS WILL BE LOST. YOU MAY BE REPRESENTED BY AN ATTORNEY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES.

"IF YOU MAKE A TIMELY REQUEST FOR HEARING ON A DENIAL OF COMPENSABILITY OF YOUR CLAIM AS REQUIRED BY ORS 656.319(1)(a) THAT IS BASED ON ONE OR MORE REPORTS OF EXAMINATIONS CONDUCTED AT THE REQUEST OF THE INSURER OR SELF-INSURED EMPLOYER UNDER ORS 656.325(1)(a) AND YOUR ATTENDING PHYSICIAN DOES NOT CONCUR WITH THE REPORT OR REPORTS, YOU MAY REQUEST AN EXAMINATION TO BE CONDUCTED BY A PHYSICIAN SELECTED BY THE DIRECTOR. THE COST OF THE EXAMINATION AND THE EXAMINATION REPORT SHALL BE PAID BY THE INSURER OR SELF-INSURED EMPLOYER. "IF YOU HAVE QUESTIONS YOU MAY CALL THE WORKERS' COMPENSATION DIVISION TOLL FREE AT 1-800-452-0288 OR THE OMBUDSMAN FOR INJURED WORKERS TOLL FREE AT 1-800-927-1271."

For more information:

Dan Schmelling
SAIF Corporation
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503-315-3606

Jaylee Hlad-Mosgrove
Ombuds Office for Oregon Workers
oow.questions@dcbs.oregon.gov
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Julie Stratton
Benefit Consultation Unit
workcomp.questions@dcbs.oregon.gov
800-452-0288

Workers' Comp 101

(Part 2)

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DCBS | Department of Consumer and Business Services

Digging into the details

- Attending physician and medical services
- Time-loss benefits and modified work
- Compensability decision process
  - IMEs and WRMEs
- Medically stationary and claim closure
- Litigation and settlements
  - Disputed claim settlements
  - Claim disposition agreements

Claim management

Ongoing time-loss benefits

Ongoing medical services

Responsibilities of:

Worker

- Communication and attending medical appointments
- New or omitted conditions

Employer

- Communicating with the worker and insurer
- Modified/light-duty work

Insurer/service company

- Providing timely and accurate benefits and notices
- Communication, answering questions, etc.

Attending physician and ongoing medical services

If the claim is accepted, the insurer should pay for the following:

- Medical treatment related to the on-the-job injury
- Prescription drugs related to the on-the-job injury
- Transportation (mileage), meals, and lodging as necessary to attend medical appointments, with limitations

The attending physician is responsible for the following:

- Authoring time loss
- Determining work restrictions
- Directing the worker's medical services
- Deciding whether the worker is medically stationary, etc.

Note:

- After the worker's initial choice of an attending physician, they may choose to change attending physicians **two more times**.
- The insurer may schedule **up to three** IMEs during each "opening" of a claim.

Time loss and modified work

Initial time-loss payment due within 14 days of employer knowledge of claim and disability

Must be authorized by attending physician

66 2/3 percent of worker's weekly wage (current max: $1,723.49)

- Weekly wage calculation varies (52-week average) salary, etc.)

Supplemental disability (other concurrent subject jobs)

Modified work and Employer-at-Injury Program

Additional time-loss benefits are paid every 14-days, if authorized by the worker's AP and due and payable.

“Wages” used in average weekly wage (AWW) calculation

All wages from the job at injury must be considered when calculating a worker’s AWW:

- Regular earnings
- Overtime earnings
- Holiday
- PTO (e.g., vacation/sick)
- Special pay (e.g., shift differentials)
- Bonuses
- Tips
- Commissions
- In-kind considerations (“reasonable value” only included when the consideration will not continue during period of disability)

ORS 656.005(27)

“Wages” means the money rate at which the services rendered is recompensed under the contract of hiring in force at the time of the accident.

AWW calculation

AWW is based on:

Up to 52 weeks of wages prior to Date of Injury (DOI) or Date of Disability (DOD)

Less than 52 weeks if:

- Employed less than 52 weeks since date of hire or re-hire/start date (break in employment)
- Change in wage earning agreement
- Intent of hire (less than four weeks)

Rate of pay

- Regular wages: a constant and uniform pay rate (e.g., paid weekly or monthly)
- Irregular wages: a variable rate of pay or hours worked (e.g., paid hourly, piece rate, commission, tips, etc.)
- Assumed wage: employees with no wages (e.g., sole proprietors, partners, volunteers, etc.)

AWW calculation, continued

Change in wage earning agreement

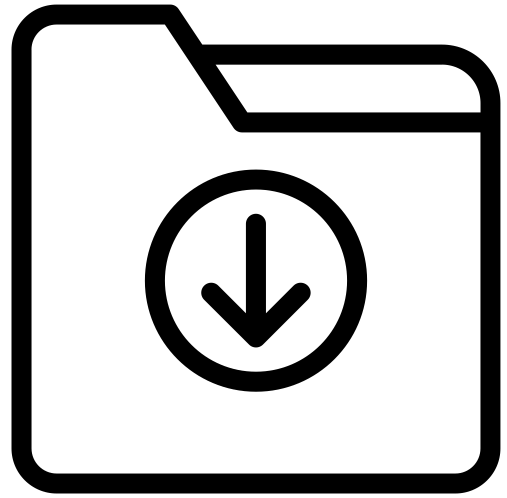
- Change in job duties (e.g., promotion or demotion)
- Change in hours worked (e.g., full time or part time)

Gaps or breaks in employment

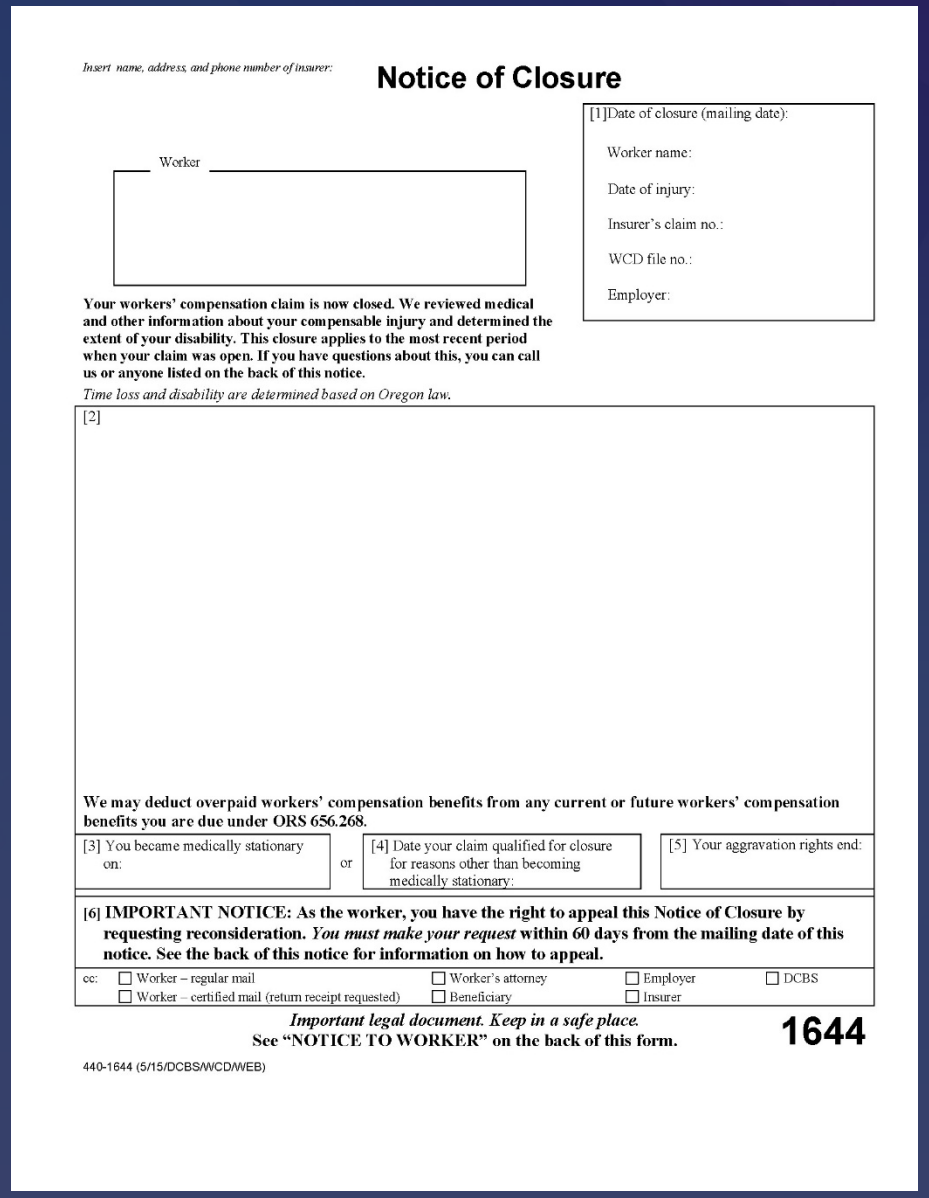
- Gap less than 14 days – included in AWW calculation
- Gap greater than 14 days – likely excluded from AWW calculation
- Break in employment – likely viewed as a “re-hire”

Medically stationary and claim closure

- Medically stationary
- Sufficient information to rate PPD and work disability
- Impact on benefits (time loss and medical)
- Vocational eligibility
- Preferred Worker Program
- Aggravation rights
- Reinstatement/re-employment rights



Notice of Closure



Insert name, address, and phone number of insurer:

Notice of Closure

[1]Date of closure (mailing date):

Worker name:

Date of injury:

Insurer's claim no.:

WCD file no.:

Employer:

Worker _____

Your workers' compensation claim is now closed. We reviewed medical and other information about your compensable injury and determined the extent of your disability. This closure applies to the most recent period when your claim was open. If you have questions about this, you can call us or anyone listed on the back of this notice.

Time loss and disability are determined based on Oregon law.

[2]

We may deduct overpaid workers' compensation benefits from any current or future workers' compensation benefits you are due under ORS 656.268.

[3] You became medically stationary on:

or

[4] Date your claim qualified for closure for reasons other than becoming medically stationary:

[5] Your aggravation rights end:

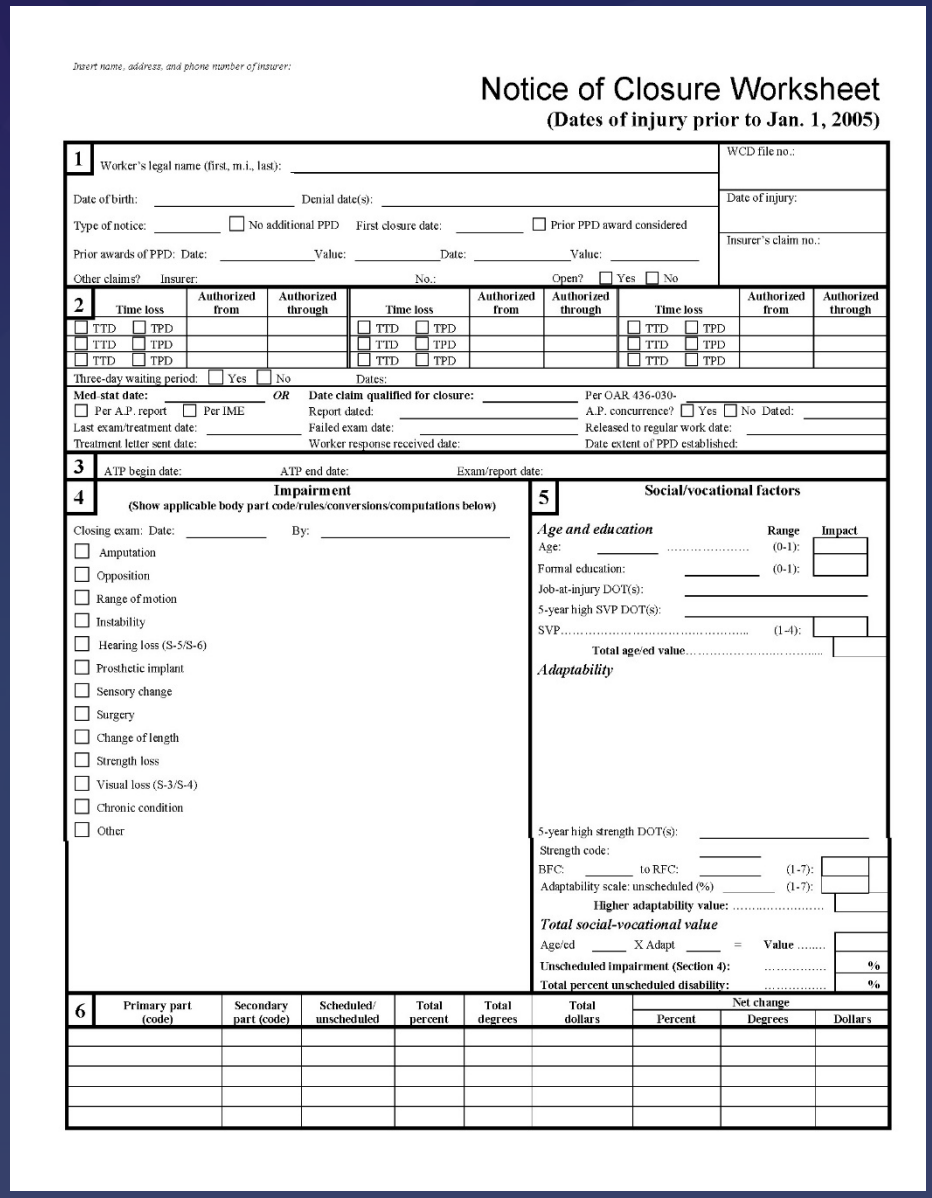
[6] IMPORTANT NOTICE: As the worker, you have the right to appeal this Notice of Closure by requesting reconsideration. *You must make your request* within 60 days from the mailing date of this notice. See the back of this notice for information on how to appeal.

cc: ☐ Worker – regular mail ☐ Worker – certified mail (return receipt requested) ☐ Worker's attorney ☐ Beneficiary ☐ Employer ☐ Insurer ☐ DCBS

Important legal document. Keep in a safe place.
See "NOTICE TO WORKER" on the back of this form.

1644

440-1644 (5/15/DCBS/WCD/WEB)



Insert name, address, and phone number of insurer:

Notice of Closure Worksheet
(Dates of injury prior to Jan. 1, 2005)

1 Worker's legal name (first, m.i., last): _____ WCD file no.:

Date of birth: _____ Denial date(s): _____ Date of injury:

Type of notice: _____ ☐ No additional PPD First closure date: _____ ☐ Prior PPD award considered Insurer's claim no.:

Prior awards of PPD: Date: _____ Value: _____ Date: _____ Value: _____

Other claims? Insurer: _____ No.: _____ Open? ☐ Yes ☐ No

2

Time loss	Authorized from	Authorized through	Time loss	Authorized from	Authorized through	Time loss	Authorized from	Authorized through
☐ TTD ☐ TPD			☐ TTD ☐ TPD			☐ TTD ☐ TPD		
☐ TTD ☐ TPD			☐ TTD ☐ TPD			☐ TTD ☐ TPD		
☐ TTD ☐ TPD			☐ TTD ☐ TPD			☐ TTD ☐ TPD		

Three-day waiting period: ☐ Yes ☐ No Dates:

Med-stat date: _____ ***OR*** **Date claim qualified for closure:** _____ Per OAR 436-030-

☐ Per A.P. report ☐ Per IME Report dated: _____ A.P. concurrence? ☐ Yes ☐ No Dated: _____

Last exam/treatment date: _____ Failed exam date: _____ Released to regular work date: _____

Treatment letter sent date: _____ Worker response received date: _____ Date extent of PPD established: _____

3 ATP begin date: _____ ATP end date: _____ Exam/report date: _____

4 **Impairment**
(Show applicable body part code/rules/conversions/computations below)

Closing exam: Date: _____ By: _____

- ☐ Amputation
- ☐ Opposition
- ☐ Range of motion
- ☐ Instability
- ☐ Hearing loss (S-5/S-6)
- ☐ Prosthetic implant
- ☐ Sensory change
- ☐ Surgery
- ☐ Change of length
- ☐ Strength loss
- ☐ Visual loss (S-3/S-4)
- ☐ Chronic condition
- ☐ Other

5 **Social/vocational factors**

Age and education	Range	Impact
Age: _____	(0-1):	
Formal education: _____	(0-1):	
Job-at-injury DOT(s): _____		
5-year high SVP DOT(s): _____		
SVP	(1-4):	
Total age/ed value		

Adaptability

5-year high strength DOT(s): _____

Strength code: _____

BFC: _____ to RFC: _____ (1-7):

Adaptability scale: unscheduled (%) _____ (1-7):

Higher adaptability value: _____

Total social-vocational value

Age/ed _____ X Adapt _____ = **Value** _____

Unscheduled impairment (Section 4): _____ %

Total percent unscheduled disability: _____ %

6

Primary part (code)	Secondary part (code)	Scheduled/ unscheduled	Total percent	Total degrees	Total dollars	Net change Percent	Net change Degrees	Net change Dollars

Appeal rights and notices

- Read all notices carefully
- Many have time frames to act or respond to requests for information
- Failure to respond may affect benefits
- For questions, contact the insurer, Ombuds Office for Oregon Workers, or WCD to determine next steps

Litigation and settlements

Reconsideration of a Notice of Closure

Appeal level of review

- WCD/Hearings/Board
  - Court of Appeals/Supreme Court

Claim disposition agreements (CDA)

- Unrepresented workers

Disputed claim settlements (DCS)

Helpful tips

- Report injury right away
- Inform medical provider injury has been filed as workers' compensation claim
- Read all letters, notices carefully
- Attend all appointments
- Follow medical providers' instructions – work within your restrictions
- Keep insurer informed of medical status, return-to-work releases
- Failure to respond may affect benefits

Don't be afraid to ask questions!

For more information:

Dan Schmelling
SAIF Corporation
dansch@SAIF.com
503-315-3606

Jaylee Hlad-Mosgrove
Ombuds Office for Oregon Workers
oow.questions@dcbs.oregon.gov
503-378-3351

Molly Van Houten
Benefit Consultation Unit
workcomp.questions@dcbs.oregon.gov
800-452-0288