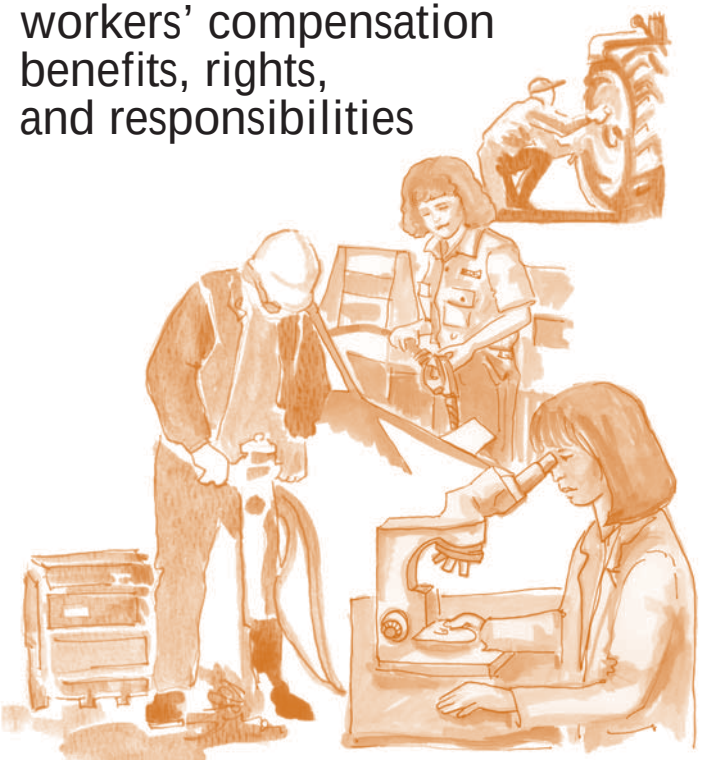
What happens if I'm hurt on the job?

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



Workers' Compensation Division

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

March 2006

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 by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. The injured worker help line is toll-free: (800) 927-1271 or TTY: (503) 947-7189.

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

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

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.

Чтобы приобрести копию публикации на русском языке, пожалуйста, позвоните в Отдел Компенсаций Рабочих (Workers' Compensation Division): (503) 947-7627.

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

Muon co ban pho bien nay bang tieng Viet, goi ñien thoai cho Sô Boi Thöông Lao Ñong tai so: (503) 947-7627.

Visit these Web sites —

Ombudsman for Injured Workers
egov.oregon.gov/DCBS/OIW/

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.

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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, "Report of Injury or Illness."
- If you seek medical help, tell your doctor or authorized nurse practitioner you were hurt on the job. You and your doctor or ***authorized nurse practitioner*** should complete Oregon Form 827, "Worker's and Physician's Report for Workers' 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 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 your insurer.
- Attend all medical appointments.
- Contact your employer immediately when your doctor releases you for work.
- Keep track of your claim on the *claim information record* in the back of this booklet.

Claim status

Nondisabling claims

You have a ***nondisabling injury*** if your work injury or illness requires only medical services, your doctor does not authorize time loss beyond the first three days after you leave work for the injury, and the injury will not result in permanent disability. Your rights to insurer-paid services will stop when your doctor declares you to be ***medically stationary***. Contact your insurer in writing within one year of your claim acceptance date if you believe your claim was classified as nondisabling in error.

Disabling claims

You have a ***disabling injury*** if you miss more than three days of work and your doctor authorizes time off from work. If you receive temporary disability payments because of your injury or illness, or if permanent disability could reasonably be expected, your claim is disabling.

Acceptance or denial of your claim

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

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Your 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 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 based on an independent medical examination (IME) report, your doctor doesn't agree with the IME report, and you appeal the claim denial, 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, your insurer should pay for injury-related medical treatment, transportation, meals, and lodging necessary to attend medical examinations, and prescription drugs, within some limitations. Your insurer also pays time-loss benefits if authorized by your physician or authorized nurse practitioner. You will be reimbursed, within limits set by Oregon Administrative Rules, for time loss. Your doctor should bill your insurer directly for medical services. Some insurers now make direct payments to pharmacies for prescriptions. Keep receipts for all your out-of-pocket expenses. Send a written request for reimbursement with proof of expenses (copies of receipts) to your insurer within two years of the date of service.

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

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

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Choosing doctors

Unless your 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 times. For additional changes you need approval from your insurer or the Workers' Compensation Division. If you do change doctors or authorized nurse practitioners, fill out Form 827 at your new doctor's or authorized nurse practitioner's office.

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.

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

Privacy rights at medical examinations

You have the right to privacy at medical examinations. Your employer or your insurer cannot send a representative to your medical examinations unless you have given written consent. You have the right to refuse such attendance. If you refuse such attendance, your benefits cannot be stopped or reduced.

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

If your employer is covered by an MCO contract, your insurer may enroll you with the MCO at any time after your injury, and you may be required to select an MCO doctor. Your 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 he or she agrees to treat you 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.

Your doctor's responsibilities

Your doctor or authorized nurse practitioner is in charge of your medical treatment. When necessary, he or she 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 a closing examination if your disability appears to be permanent.

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Elective surgery

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

Independent medical examinations (IMEs)

Your insurer may require you to attend medical examinations with doctors it chooses, and your workers' compensation benefits may be stopped if you fail to do so. The IME doctor(s) will not be providing treatment; the doctor(s) will try to answer questions asked by your insurance company about your injury or occupational disease and may perform a physical- or work-capacity evaluation. Invasive procedures require your consent, and your benefits cannot be reduced or stopped if you decline an invasive procedure. Your insurer should pay all costs for the medical examination. Your insurer will reimburse your expenses necessary to attend the exam. If you need advance payment in order to attend, contact your insurer. You may have a family member or friend accompany you to the examination, but your insurer is not required to pay that person's expenses. Consult your insurer if you believe your work-related condition requires you to have assistance to attend the appointment.

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

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, your insurer is responsible for future medical treatment related to your accepted condition(s). Your 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 condition(s). Some medical costs are not covered after you are medically stationary. Check with your 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 your insurer or the Workers' Compensation Division.

If you have new medical condition claims

If you think your insurer omitted a condition from its acceptance notice or you develop a new medical condition due to your injury, write to your insurer and request written acceptance of your condition. Your insurer has 60 days to accept or deny your new medical condition claim. If your date of injury is prior to Jan. 1, 2002, your insurer may have up to 90 days to make a decision on a new condition.

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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 your 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 your insurer. Your insurer may reopen your claim and pay you time-loss benefits 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 your insurer accepts a new or omitted medical condition, your insurer may pay you time-loss benefits during your recovery as authorized by your doctor.

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

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

Time-loss (temporary disability) payments

Payment for lost wages and doctor's authorization

You will get time-loss payments from your insurer if your doctor authorizes time off work or modified work (also called "light duty") that causes you to lose wages. If the doctor provides written authorization to your 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 your insurer receives authorization from your doctor.

Each time you see your doctor, ask for appropriate time-loss authorization to send to your 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 your 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 your insurer.
- Your claim is denied.
- Your doctor gives you a written release to return to regular work.
- You return to regular work at full wages.
- A Notice of Closure closes your claim.

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- You are incarcerated. Incarcerated means in pretrial detention or in prison 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).
- Your doctor or authorized nurse practitioner releases you to work, but you are unable to work because you are in the United States in violation of federal immigration laws.

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 your insurer about your other jobs within 30 days of your 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 workers' time-loss rate is adjusted. If your work hours are reduced or you are doing modified work that pays less than your regular wage, your 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).

For dates of injury on or after Jan. 1, 2005, your time-loss rate is an important factor in calculating any permanent disability benefits you may receive. It is very important to verify the proper wage is being used in these calculations. Contact your insurer if you have questions about how your time-loss benefits were calculated.

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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. Your 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 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. In addition, you should take any releases for work to your employer as soon as possible, as work may be available that is physically appropriate for you.

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 (TPD) may be reduced or stopped. You may refuse a modified job without ending your time-loss benefits if any of the following are true:

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Workers' Compensation Division: (800) 452-0288

- 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, unless that job site is less than 50 miles from your home. 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 policy for changing work schedules, the common practice of the employer, or 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, your insurer will determine if you are eligible for vocational assistance and notify you of its decision in writing. Contact your 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.

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Reemployment 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 to Oregon employers that hire them. To find out if you qualify, call (800) 445-3948 or, in the Medford region, (800) 696-7161, toll-free.

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 attend medical appointments. Your insurer will send you the following important documents when your claim is closed:

- A Notice of Closure 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 your insurer has accepted. If the updated notice is incomplete or incorrect, notify your insurer in writing.
- A brochure, "Understanding Claim Closure and Your Rights," explains appeal rights and processes, and the types of care paid for by your 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.

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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 your insurer for your disability; this is called an "award." The amount will depend on the severity of the disability and whether overpayment of benefits occurred. If your insurer overpaid you for benefits while your claim was open, your insurer may recover the overpayment by reducing your permanent disability payment or by reducing future benefits.

If your award is $6,000 or less, your 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, your 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 your insurer to pay you a lump sum. However, if you or your 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 perform gainful and suitable employment. You will receive monthly disability payments for the rest of your life if you remain totally disabled. Your insurer will re-examine 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, children, and other eligible beneficiaries, and to pay burial expenses.

Reconsideration of closure

If you disagree with the Notice of Closure, you must write to the Workers' Compensation Division (WCD) within 60 days of the mailing date printed on the Notice of Closure. Your appeal rights and the address to send your appeal are printed on the back of the Notice of Closure. You may also fill out and send to WCD the form "Worker's Request for Reconsideration." You can obtain the form by contacting WCD and asking for a copy of the form to be mailed to you, or going to the WCD Web site, www.wcd.oregon.gov. Click on "Forms," then click "Forms by category." Select "Requests to WCD for review of a decision or resolution of a dispute." The Worker's Request for Reconsideration is available in several formats for you to download, print, and fill out.

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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.

Disputed-claim settlement

If you and your insurer disagree about whether you have a valid workers' compensation claim or condition, you and your insurer may resolve the disagreement by a disputed-claim settlement. **If you agree to such a settlement, your claim will remain denied, and you will give up all rights to future benefits for the denied medical conditions of the claim.** Medical providers may bill you for services not paid by your insurer, so know what your obligations will be under the agreement before you agree to a settlement.

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

Claim disposition agreement

If you have an accepted claim, you may exchange for money your rights to the claim through a claim disposition agreement. In such an agreement you may give up your rights to one or more of the following claim benefits:

- 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
- Survivor benefits

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

The agreement you and your insurer sign is the claim disposition agreement. All claim disposition agreements are reviewed for approval by the ***Workers' Compensation Board***. If you have a question about the claim disposition agreement, you may contact the Ombudsman for Injured Workers.

Insurer penalties

If you believe that your 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 your insurer be penalized. If the Workers' Compensation Division finds that a penalty is appropriate, your insurer will pay the penalty to you.

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Confidentiality of your claim records

Legal orders issued by state agencies and courts are public information. However, claim documents and medical reports on file with your insurer or 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 a workers' compensation 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 rights expire five years after first closure or five years from date of injury on nondisabling 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 by the Workers' Compensation Division 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 injury An on-the-job injury that entitles the worker to 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 coordinate medical services to injured workers. ORS 656.260

medically stationary The point at which the attending physician or authorized nurse practitioner 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

nondisabling injury Any injury that requires medical services only and does not result in an inability to work beyond the first three days or result in any measurable 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 A state office that serves as an independent advocate for injured workers by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. ORS 656.709

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 pre-existing disability that permanently prevents the worker from regularly performing gainful and suitable work. ORS 656.206

temporary partial disability benefits (TPD) Payment for partial loss of wages if a worker can work only part time or light duty after an injury. ORS 656.212

temporary total disability benefits (TTD) Payment for total loss of wages after an injury. ORS 656.210

time-loss payments Payments to an injured worker who loses time or wages as a result of an injury. ORS 656.210

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

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
egov.oregon.gov/DCBS/OIW/

Workers' Compensation Board
www.wcb.oregon.gov

Workers' Compensation Division

350 Winter St. 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 e-mail 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) 947-7710

Medical fee, medical treatment, curative care, palliative care disputes, and interim medical benefits..... (503) 947-7816

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

Reemployment 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

Vocational eligibility/assistance, return-to-work plans, and vocational disputes..... (503) 947-7816

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

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

Ombudsman for Injured Workers

(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.

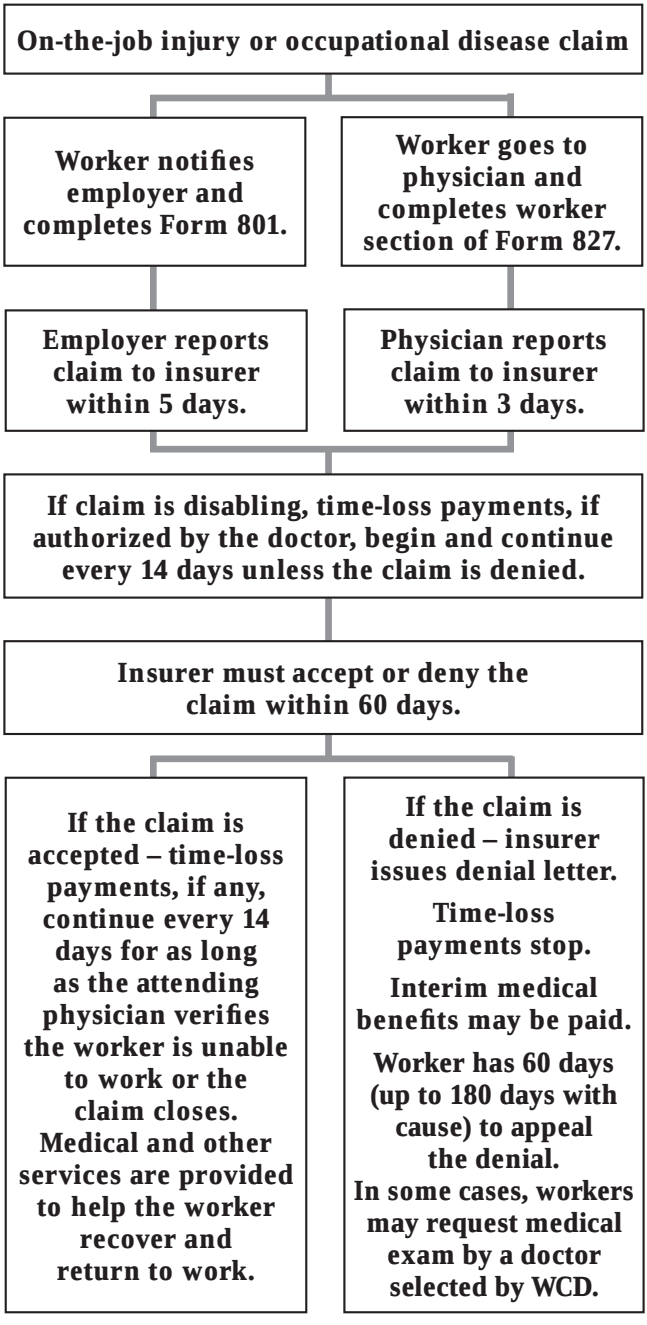
If you have any other questions about your benefits, contact the Ombudsman for Injured Workers, (800) 927-1271, or the Workers' Compensation Division, (800) 452-0288.

If you have questions about an injured workers' employments rights, contact the Civil Rights Division, Bureau of Labor and Industries (workers' compensation discrimination issues):
(503) 731-4874 in Portland, (541) 686-7623 in Eugene, or (503) 378-3292 in Salem.

*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 your 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 of the notice of closure) 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
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440-1138 (3/06/COM)