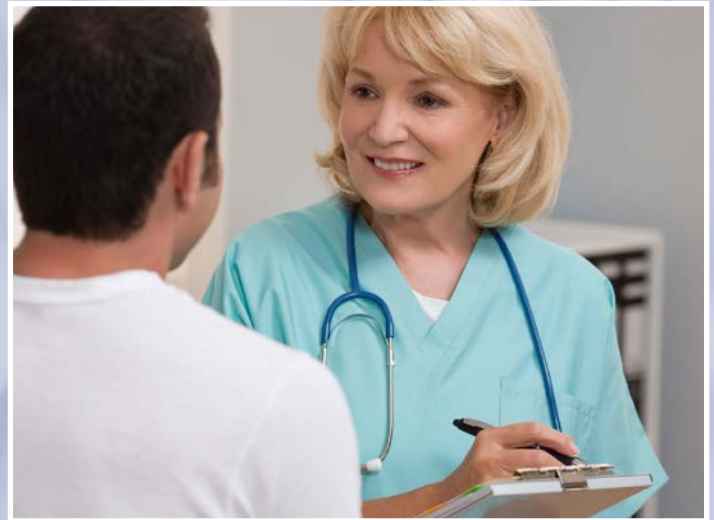


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# Guide to Providing Independent Medical Exams



community  
Workers' Compensation

# Guide to Providing Independent Medical Exams

The Workers' Compensation Division (WCD) developed this guide for health care providers who want to provide independent medical exams for Oregon workers' compensation.

Oregon's workers' compensation system is designed to:

- Prevent or reduce worker injuries and illnesses
- Provide appropriate medical treatment and benefits to help injured workers recover and return to work as soon as possible
- Resolve disputes quickly and fairly
- Be the exclusive liability for employers and the exclusive remedy for workers for injuries, diseases, symptom complexes, and similar conditions arising out of and in the course of employment, whether or not they are determined to be compensable under the workers' compensation law (ORS 656.018)



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## What is an independent medical examination (IME)?

An independent medical examination is an objective and impartial medical exam requested by a workers' compensation insurer or self-insured employer. The insurer chooses the health care provider and pays for the exam. A health care provider other than the worker's attending physician conducts the exam in an office or through an IME company. An exam performed by more than one health care provider, in one or more locations within a 72 hour period, is called a panel exam.

## What is your role as an IME provider?

Your role as an IME provider is to:

- Examine the injured worker, but not to provide treatment
- Remain unbiased and a neutral third party
- Write a report based on the findings from the exam and medical records
- Send a copy of the report to the workers' compensation insurer

## Who can perform an IME?

Health care providers can perform IMEs once they complete a director-approved training to conduct independent exams for workers' compensation claims and are placed on the director's list of authorized IME providers.

**Physical therapist (PT) and occupational therapist (OT):** A PT or OT may be asked to perform physical capacity evaluations (PCE) or work capacity evaluations (WCE), along with an IME. In this case, the insurer must use the director's list to select the PT or OT.

If the attending physician asks the insurer to arrange the PCE or WCE, or if an attending physician initiates the PCE or WCE, you or the insurer do not need to use the director's list when choosing the PT or OT.

## How do I become an IME provider?

To become an authorized IME provider, you must do all of the following:

- Hold a current license and be in good standing with the professional regulatory board that issued the license.
- Attend a director-approved training regarding IMEs or review IME training materials approved by the director (such as this guide).
- Complete the online certification form Independent Medical Exam Medical Service Provider Authorization at [www.oregonwcdoc.info](http://www.oregonwcdoc.info). On the application, you must provide your license number, which will be used to verify you are in good standing with the relevant licensing board. Also, if you attend a director-approved training, you must provide to the director the date of the approved IME training and name of the training vendor.
- Agree to abide by the standards of professional conduct that either the relevant medical licensing board has adopted or the “**IME Standards**” published in OAR 436-010 Appendix C and in this guide.
- Agree to abide by the Oregon workers' compensation laws and rules.

## IME standards

Below are the IME standards that you agree to abide by when you sign the IME provider application. Please review these standards before conducting an IME.

1. Communicate honestly with the parties involved in the examination.
2. Conduct the examination with dignity and respect for the parties involved.
3. Identify yourself to the examinee as an independent examining physician.
4. Verify the examinee's identity.
5. Discuss the following with the examinee before beginning the examination:
  - a. Remind the examinee of the party who requested the examination.
  - b. Explain to the examinee that a physician-patient relationship will not be sought or established.
  - c. Tell the examinee the information provided during the examination will be documented in a report.
  - d. Review the procedures that will be used during the examination.
  - e. Advise the examinee a procedure may be terminated if the examinee feels the activity is beyond the examinee's physical capacities or when pain occurs.
  - f. Answer the examinee's questions about the examination process.
6. During the examination:
  - a. Ensure the examinee has privacy to disrobe.
  - b. Avoid personal opinions or disparaging comments about the parties involved in the examination.
  - c. Examine the conditions being evaluated sufficiently to answer the requesting party's questions.

- d. Let the examinee know when the examination has concluded, and ask if the examinee has questions or wants to provide more information.
7. Provide the requesting party a timely report that contains findings of fact and conclusions based on medical probabilities for which you are qualified to express an opinion.
8. Maintain the confidentiality of the parties involved in the examination subject to applicable laws.
9. At no time provide a favorable opinion based solely or in part upon an accepted fee for service.

## Types of exams and the differences between them

- **Independent medical exam (IME):** A medical examination of an injured worker by a health care provider other than the worker's attending physician at the request of the insurer. IME exams may be performed in order to determine the compensability or causation of the injury itself; whether the treatment the worker is receiving is appropriate; and whether the worker has a measurable impairment. This does not include a consultation arranged by a managed care organization (MCO) for an enrolled worker or a second surgical opinion. Insurers must choose from the [director's list of authorized IME providers](#) (ORS 656.325).

A physical examination by an attending physician is performed primarily for purposes of determining diagnosis and documenting the clinical course over time. The IME physical examination is an examination for the purpose of objective documentation of the worker's status. Specific measurements according to accepted protocols may be used to provide the basis for impairment ratings.

In an IME, there is usually only one opportunity for examination. Therefore, the IME needs to provide a complete, comprehensive, and objective description of the examinee's condition at that time, in the context of prior health, physical and vocational capabilities, and social functioning. In contrast, the attending physician's evaluations are based on multiple, shorter encounters over the course of time. Unlike the medical consultation that ends only with treatment recommendations, the IME is broader in scope. Often, the IME will answer specific questions posed by the referring source. Referring sources include insurers and Workers' Compensation Division.

- **Worker-requested medical exam (WRME):** An objective and impartial exam available to a worker whose claim has been denied based on an independent medical exam in which the injured worker's physician did not concur with the findings and the worker requests a hearing on the denial (ORS 656.325).

If the WRME is approved, the director chooses the physician from the authorized list of IME providers. The worker or the worker's attorney schedules the exam. The insurer is required to send the medical records. The examiner answers the questions asked during the original IME, as well as any additional questions from the worker or the worker's attorney.

- **Medical arbiter exams:** A health care provider selected by the director to perform an impartial examination regarding a disagreement over impairment findings at claim closure. This exam helps the division's appellate reviewer to resolve the disagreement. The reviewer asks specific questions related to the worker's impairment and may ask about the portion of the worker's impairment that is due to the accepted condition(s). Claim closure disputes do not review for compensability (ORS 656.268).

- **Physician review exam:** A health care provider is selected by the director to perform an exam or file review for a dispute regarding appropriateness of a treatment proposed or provided. This exam helps the division’s medical reviewer to resolve the dispute. The reviewer asks specific questions related to whether the treatment is appropriate given the worker’s accepted condition. Treatment disputes do not review for compensability (ORS 656.327).



**Note:** You do not need to be on the director’s list of IME providers to perform medical arbiter or physician review exams.

## How should I prepare for the exam?

Before you see the worker for an IME:

- Review the IME standards prior to performing the exam.
- Review the questions provided from the insurer.
- Review the medical records provided to you, including any testing and studies.



**Note:** If you do not receive all the medical records or diagnostic studies, contact the insurer.

This will provide the basis for your evaluation, highlighting the issues, and targeting your examination.

You must make Form 440-3923, “Important Information about Independent Medical Exams,” available to the worker before the exam, if asked.

# Communication

## Worker and IME provider

Your role as an IME provider is as a consultant, thus no physician-patient privilege exists for IMEs. You should never discuss your findings or recommendations with the worker, family members, attending physicians, or worker’s attorney. However, if a health-threatening condition is discovered during the examination, you should bring this to the worker’s attention and tell the worker to seek appropriate medical care.

To review items that you can discuss with the worker, refer to the **IME Standards** section of this guide.

As noted in Form 3923, the worker may take a survey online about the IME at [www.wcdimesurvey.info](http://www.wcdimesurvey.info).

## Insurer and IME provider

All of your findings should be contained in your IME report, and you can discuss your report with the insurer.

A problem for insurers occurs when IME providers do not answer the questions. These providers either opine in areas they were not requested to address or do not answer questions. You should have a clear understanding of the questions the insurer wants answered. If you are unclear of the question the insurer is asking, clarify with the insurer. Make sure you answer only the questions asked in your report.

## What happens during the exam?

During the exam you should:

- Identify yourself to the worker as an independent examining physician.
- Verify the worker’s identity.
- Discuss the following with the worker before beginning the examination:
  - » Remind the worker of the party who requested the examination.
  - » Explain to the worker that a physician-patient relationship will not be sought or established.
  - » Tell the worker the information provided during the examination will be documented in a report.
  - » Review the procedures that will be used during the examination.
  - » Advise the worker a procedure may be terminated if the worker feels the activity is beyond his or her physical capacities or when pain occurs.



- » Answer the worker's questions about the examination process.
- Ensure the worker has privacy to disrobe.
- Avoid personal opinions or disparaging comments about the parties involved in the examination.
- Examine sufficiently the conditions being evaluated to answer the insurer's questions.
- Let the worker know when the examination has concluded, and ask if the worker has questions or wants to provide more information.
- Remind the worker they can go online and take a survey about the IME.

If the worker has a superimposed or unrelated condition, consider and describe both compensable and noncompensable conditions for overall impairment and identify impairment due to the compensable condition only.

### Observers in IME exams:

You must allow a worker to have an observer in the exam if the worker requests one, unless it is a psychological exam. The worker must give you an IME Observer Form, which is located in Form 3923, "Important Information about Independent Medical Exams for Injured Workers." By signing Form 3923, the worker is stating that he or she understands you may ask sensitive questions during the exam in front of

the observer.

You do not have to allow the observer to be present if Form 3923 is not completed and given to you. If the worker does not have the observer form and wants to have an observer present during the exam, give Form 440-3923, "Important Information about Independent Medical Exams," to the worker before the exam.

The observer cannot:

- Participate in or obstruct the exam.
- Be the worker's attorney or any representative of the worker's attorney.
- Receive compensation for attending the exam.

### Recording the exam

A worker may use a video camera or tape recorder to record the exam only if you approve.

### Invasive procedures

In an invasive procedure, the body is entered by a needle, tube, scope, or scalpel.

If you want to perform an invasive procedure during the IME you must:

- Explain the risks involved in the procedure.
- Explain to the worker his or her right to refuse the procedure.
- Give the worker the Form 3227, "Invasive Medical Procedure Authorization."
- Give the worker a copy of the completed form and send the original to the insurer.

The worker must:

- Check the applicable box on Form 3227, "Invasive Medical Procedure Authorization," either agreeing to the procedure or declining the procedure.
- Give permission by signing the form.

## Interpreters

A worker may choose a person to communicate with you when you and the worker speak different languages, including sign language. You may disapprove of the worker's choice at any time you feel the interpretation is not complete or accurate. A medical provider, medical provider's employee, or a family member or friend of the worker who provide interpreter services will not be paid by the insurer.

## What if the worker is a no show?

If the worker does not show for the exam, you should inform the insurer. If the worker fails to attend an IME without notifying the insurer before the date of the examination or without sufficient reason for not attending, the director may impose a monetary penalty against the worker or the insurer may request suspension of the worker's benefits.

## Worker objects to IME location

When the worker objects to the location of an IME, the worker may request review by the director within six business days of the mailing date of the appointment notice [OAR 436-010-0265(9)].

# What happens after the exam?

## IME reports

The IME, in some ways, is like many other medical examinations (e.g., obtaining a history, performing a physical examination, and making a diagnosis). However, IME reports *differ* from other medical consultations and reports in several important ways:

- **Content:** The medical report produced by the attending physician determines the course of treatment. An independent health care provider performs the IME at the request of the insurer. The IME answers specific questions. Because of

variability of the requirements in individual IME cases, it is impossible to define exactly what should be in every report.

- **Proofreading:** Providers often do not carefully proofread their IME report before it is finalized. Each mistake may reduce the validity of the report and call into question the correctness and the weight of your opinions. You should try to catch and correct all misspelled words, transcription errors, and grammatical mistakes before your IME report is finalized and sent to the parties.
- **Quality assurance statement:** Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false statements may result in sanctions by the director.
- **Time frames for completion:** Send the insurer a timely report that contains findings of fact and conclusions based on medical probabilities for which you are qualified to express an opinion.
- **Clear responses:** Providers often will refer generally to the medical records they reviewed. This opens up endless questions about what records they did and did not review. Providers should clearly list and accurately describe all of the medical records and other documents they reviewed before preparing their IME report.
- **History:** The history in an IME is often more comprehensive than history obtained in other medical examinations by an attending physician. Most medical examination history includes the usual subjective history of present illness. An IME history also includes a comprehensive review of prior medical records, and occupational and socioeconomic history. It is important that you provide an accurate history and document it. Providers should include a thorough, well-written, and accurate history as a part of their IME report. Often, providers perform a detailed

physical examination but fail to thoroughly document the exam. Providers should check their IME report to make sure that all of the tests performed and all of the findings made are clearly and accurately documented in the report.

- **Return to work:** It is important to respond to return-to-work questions and any questions about physical limitations (e.g., a back injury with no lifting more than 20 pounds or a knee injury where the worker cannot squat or stand for more than two hours on a permanent basis). There is often a job description or job analysis with IMEs that address return-to-work status. If there are job duties the worker can and cannot perform, either for a particular amount of time or permanently, you need to put that in your report. You should let the insurer know that vocational rehabilitation is necessary if the worker no longer has the physical capability to do his or her job.

In your report, answer all questions asked by the insurer. Send a copy of the report to the insurer. Include a Quality Assurance statement at the end of the IME report.

If, after the report is issued, you are asked to provide additional information, you should issue a supplemental report.

After the report is issued, if an error is found, you may correct your report.

The conventional medical report uses complex medical terminology. However, the reader of an IME may not have extensive medical background. Therefore, the independent medical examiner should write the report so that it is understandable to the lay reader.

## Who do I bill for the independent medical exam?

You bill the workers' compensation insurer or self-insured employer using Oregon-specific code D0003.

## Complaint process and what the IME provider should expect

After a worker has attended an IME, a complaint may be filed online at [www.wcd.oregon.gov](http://www.wcd.oregon.gov), or in writing to the director for investigation. The director will determine the appropriate action to take in a given case.

During the investigation the director may contact you regarding the allegation.

## Criteria for removal of health care providers from the list of approved IME providers

A provider may be sanctioned or excluded from the director's list of providers authorized to perform IMEs after a finding by the director that the provider did any of the following:

- Violated the standards of either the professional conduct for performing IMEs adopted by the provider's regulatory board or the independent medical examination standards published in Appendix C to the Division 010 rules
- Failed to comply with the requirements of OAR 436-010-0265, as determined by the director
- Has a current restriction on his or her license or is under a current disciplinary action from his or her professional regulatory board
- Entered into a voluntary agreement with his or her regulatory board that the director determines is detrimental to performing IMEs
- Violated workers' compensation laws or rules
- Failed to complete an approved training required by the director

Within 60 days of the director's decision to exclude a provider from the director's list, the provider may appeal the decision under ORS 656.704(2) and OAR 436-001-0019.



# Terms used in workers' compensation

## accepted condition

A medical condition for which an insurer accepts responsibility for the payment of benefits on a claim filed by an injured worker. The insurer provides written notice of accepted conditions (ORS 656.262). The insurer generally will accept specific conditions based on the diagnosis by the physician or nurse practitioner. It is important that the health care provider report a diagnosis rather than a symptom.

## aggravation claim

A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. An aggravation is established by medical evidence supported by objective findings observed or measured by the physician. Aggravation rights expire five years after first closure on disabling claims or five years from date of injury on nondisabling claims (ORS 656.273). An attending physician who is an MD or DO must file Form 827 and a medical report with the insurer within five consecutive calendar days of the worker's visit to make a claim for aggravation. The insurer has 60 days to accept or deny a claim for an aggravation.

## ancillary care

Care such as physical or occupational therapy provided by a health care provider other than the attending physician, specialist physician, or authorized nurse practitioner.

## apportionment

A description of the current total overall findings of impairment and those findings that are due to the compensable condition when there is impairment due to the accepted condition and other unaccepted conditions. Describe specific findings that are partially attributable to the accepted condition, and any applicable superimposed or unrelated conditions.

*Example: Seventy-five percent of the decreased range of motion is due to the accepted condition and any direct medical sequela, and the remaining percentage is due to pre-existing degenerative joint disease.*

## attending physician (AP)

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

## bulletin

An official agency communication informing insurers or others regulated by DCBS of new information, processes, or requirements.

## claim

A written request by the worker or on the worker's behalf for compensation (ORS 656.005). The insurer has 60 consecutive calendar days from the employer's date of knowledge to accept or deny the claim. (See also disabling claim and nondisabling claim.)

## claim disposition agreement (CDA and C&R)

The written agreement as provided in ORS 656.236 in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim. The term "compromise and release" has the same meaning.

## closing examination

A medical examination to measure impairment, which occurs when the worker is



medically stationary.

### combined condition

A combined condition occurs when a pre-existing condition combines with a compensable condition. A combined condition may cause disability or prolong treatment. However, a combined condition is only compensable if the compensable injury is the major contributing cause of the disability or the need for prolonged treatment.

***Example:** A worker has arthritis of the knee and then sustains a job-related injury to the same knee. The acute condition is diagnosed as a sprain. Both conditions contribute to the worker's disability. The combined condition is compensable only if the compensable injury (the sprain) contributes more than 50 percent to the worker's disability or need for treatment.*

### compensable injury

An accidental injury to a person or prosthetic appliance, arising out of and in the course of employment that requires medical services or results in disability or death (ORS 656.005). A claim is compensable when the insurer accepts it.

### consequential condition or disease

A condition arising after a compensable injury of which the major contributing cause is the injury or treatment rendered that increases either disability or need for treatment (ORS 656.005). A consequential condition is only compensable if the compensable injury or disease contributes more than 50 percent of the worker's disability or need for treatment.

***Example:** Use of crutches due to a compensable knee condition may cause a consequential shoulder condition that requires treatment or leads to disability.*

### consulting physician

A physician who advises the attending physician or authorized nurse practitioner regarding the treatment of a worker's injury. A consulting physician is not considered an attending physician, and, therefore, the worker should not complete Form 827 for the consultation.

### curative care

In the workers' compensation system, treatment to stabilize a temporary waxing and waning of symptoms after a worker is medically stationary (ORS 656.245).

### denied claim (denial)

A written refusal by an insurer to accept compensability or responsibility for a worker's claim of injury (ORS 656.262). On accepted claims, the insurer may deny certain conditions only; this is known as a partial denial. Only a worker can appeal a denial of a claim.

### disabling claim

Any injury is classified as disabling if it causes the worker temporary disability (time-loss), permanent disability, or death. The worker will not receive time-loss benefits for the first three days unless he or she is off work and not released to return to any work for the first 14 consecutive days or is admitted to a hospital as an injured worker during the first 14 consecutive days. The claim is also classified as disabling if there is a reasonable expectation that permanent disability will result from the injury.

**Form 801 — First Report of Injury**

Official state form used by workers and employers to report occupational injury or disease.

**Form 827 — Worker’s and Physician’s Report for Workers’ Compensation Claims**

Form used by workers and physicians to report to insurers. Includes first report of injury, report of aggravation, notice of change of attending physician, progress report, closing report, and palliative care request.

**health care provider**

A person duly licensed to practice one or more of the healing arts.

**impairment findings**

A description of all impairment findings that are permanent and due to the accepted condition, and any direct medical sequela. A medical opinion addressing the validity of the impairment findings, with a full explanation based on sound medical principles, stating why the findings are valid or invalid.

**initial claim**

The first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared medically stationary by an attending physician or authorized nurse practitioner.

**major contributing cause (MCC)**

A cause deemed to have contributed more than 50 percent to an injured worker’s disability or need for treatment.

**managed care organization (MCO)**

An organization that may contract with an insurer to provide medical services to injured workers (OAR 436-015, ORS 656.260).

**material cause**

Substantial cause, up to 50 percent, compared to all other causes combined.

**medical sequela**

Also known as direct medical sequela, it is a condition that is clearly established medically and originates or stems from an accepted condition.

*Example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to the accepted condition. The weakness is considered a direct medical sequela.*

**medical service**

Medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulance, drug, prosthetic, or other physical restorative services (ORS 656.245).

**medically stationary**

The point at which no further significant improvement can reasonably be expected from medical treatment or the passage of time (ORS 656.005).

**new medical condition claim**

A worker’s written request that the insurer accept a new medical condition related to the original occupational injury or disease. Medical services for new conditions are not compensable unless conditions are accepted.

*Example: An initial diagnosis of low back sprain/strain results in the acceptance of that condition. After further diagnostic studies, a herniated disk is diagnosed and the injured worker makes a new condition claim in writing for that herniated disk.*

**nondisabling claim**

An injury is classified as nondisabling if it does not cause the worker to lose more work time than the three-day waiting period or it requires medical services only, and the worker has no permanent impairment (ORS 656.005).



### **objective findings**

Indications of an injury or disease that are measurable, observable, and reproducible; used to establish compensability and determine permanent impairment (ORS 656.005).

*Examples: Range of motion, atrophy, muscle strength, palpable muscle spasm, etc.*

### **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 to other than during employment and requires medical services or results in disability or death. A mental disorder, or physical disorder caused or worsened by job-related mental stress, also may be an occupational disease.

If an occupational disease claim is based on a worsening of a pre-existing disease or condition, the employment conditions must be the major contributing cause of the combined condition and pathological worsening of the disease.

### **omitted medical condition**

A worker's written request that the insurer accept a medical condition the worker believes was incorrectly omitted from the Notice of Acceptance. Medical services for omitted conditions are not compensable unless conditions are accepted.

### **palliative care**

Medical services rendered to reduce or temporarily moderate the intensity of an otherwise stable condition to enable the worker to continue employment or training (ORS 656.005, 656.245). (See also the back of the Form 827.)

### **partial denial**

Denial by the insurer of one or more conditions of a worker's claim, leaving some conditions of the claim accepted as compensable.

### **permanent partial disability (PPD)**

The permanent loss of use or function of any portion of the body as defined by ORS 656.214 and OAR 436-035.

### **physical capacity evaluation (PCE)**

The measurements of a worker's ability to perform a variety of physical tasks.

### **precipitating cause**

Immediate temporal relationship between work activities and onset of symptoms; not always the major cause.

### **pre-existing condition**

A condition that existed before the compensable injury or disease.

### **prosthetic appliance**

The artificial substitution for a missing body part, such as a limb or eye, or any device that augments or aids the performance of a natural function, such as a hearing aid or glasses (ORS 656.005, 656.245).

### **regular work**

The job the worker held at the time of injury or a substantially similar job.

### release of medical records

Filing a workers' compensation claim authorizes health care providers to release relevant medical records to the insurer, self-insured employers, or the Department of Consumer and Business Services. The privacy rule of HIPAA allows health care providers to disclose protected health information to regulatory agencies, insurers, and employers as authorized and necessary to comply with the laws relating to workers' compensation. However, this authorization does not authorize the release of information regarding the following:

- Federally funded alcohol and drug abuse treatment programs.
- HIV-related information.
  - » HIV-related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition.



**Note:** Any disclosures to employers are limited to specific purposes, such as return to work or modified work.

### specialist physician

A specialist physician is a physician who qualifies as an attending physician but does not assume the role of attending physician.

A specialist physician examines the worker or provides specialized treatment, such as surgery or pain management, at the request of the attending physician or authorized nurse practitioner. During the time a physician provides specialized treatment, the attending physician continues to monitor the worker and authorizes any time-loss.

### temporary partial disability benefits (TPD)

Payment for wages lost based on the worker's ability to perform temporary modified or part-time work due to a compensable injury. (See also time-loss benefits.)

### temporary total disability benefits (TTD)

Payment for wages lost based on the worker's temporary inability to work due to a compensable injury. (See also time-loss benefits.)

### time-loss authorization

When an attending physician authorizes time-loss, the insurer may request periodic progress reports. Form 827 is not required if the chart notes provide the information requested.

### time-loss benefits

Compensation paid to an injured worker who loses time or wages because of a compensable injury. A worker who is not physically capable of returning to any employment is entitled to benefits for temporary total disability (time-loss). A worker who can return to modified work may be entitled to benefits for temporary partial disability if his or her wages or hours of modified work are reduced.

### work capacity evaluation (WCE)

See physical capacity evaluation.

### 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 Oregon's workers' compensation laws.

### Worsening

Actual worsening of underlying compensable condition. Increased symptoms may signify worsening. A worsening must be established by persuasive medical opinion and is supported by objective findings.

# History of IME authorization

The Workers' Compensation Division (WCD) conducted a study of independent medical examinations (IMEs) in Oregon, at the request of the Management-Labor Advisory Committee (MLAC). The study included surveys of injured workers, attending and IME health care providers, worker and defense attorneys, and IME facilities. Focus groups were held to get insurer and third-party administrator input. WCD made recommendations to MLAC and as a result, Senate Bill 311 was created. The 2005 Legislature unanimously passed Senate Bill 311. The bill:

- Requires health care providers to be authorized by the director of the Department of Consumer and Business Services (DCBS) to conduct IMEs for workers' compensation claims in Oregon.
- Requires WRME providers to be selected from an IME list of authorized providers.
- Requires a Quality Assurance statement at the end of the IME report.
- Provides the worker an opportunity to request review by the director of the reasonableness of the location selected for the IME.
- Imposes a monetary penalty against a worker who fails to attend an IME without prior notification or without justification for not attending.
- Imposes a sanction against a health care provider who unreasonably fails to provide diagnostic records required for an IME in a timely manner.
- Provides the director of DCBS authority to investigate complaints and exclude a health care provider if they violate standards of professional conduct.

## How do I apply to become an IME provider?

Once you have read this guide, go to [www.oregonwcdoc.info](http://www.oregonwcdoc.info) to complete the application.

# For your information about Workers' Compensation

# How to Find Workers' Compensation Coverage Information

## Resources

### Phone numbers

Medical service/fee info ..... 503-947-7606  
 MCO information .....503-947-7697  
 Workers' Compensation  
 Information Line .....800-452-0288 \*  
 Injured Worker Help Line  
 (Ombudsman).....800-927-1271 \*  
 Employer Index.....503-947-7814  
 Investigations – Fraud Hotline.....800-452-0288  
 WCD Publications .....503-947-7627  
 \*Spanish-speaking help lines are available.

### WCD website

Oregon Workers' Compensation Division  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov) or [www.oregonwcdoc.info](http://www.oregonwcdoc.info)

These topics can be visited (and bookmarked)  
 from our main page:

- Health Care Providers
- Managed Care Organizations
- Laws & Rules
- Bulletins (includes forms)
- Información en Español

Time frames for filing Form 827

File	→	Within
New injury or disease	→	3 days of treatment
New attending physician	→	5 days of treatment
Aggravation of existing injury	→	5 days of treatment
Send closing report to insurer	→	14 days of date declared medically stationary

- **First** — Call the employer for information about insurance coverage.
- **If you need more help** — Contact the Employer Compliance Unit of the Workers' Compensation Division (WCD) by phone, fax, e-mail, or Internet.
  - » Phone: 503-947-7815
  - » Fax: 503-947-7718
  - » E-mail: [wcd.employerinfo@state.or.us](mailto:wcd.employerinfo@state.or.us)
  - » Internet: [www.wcd.oregon.gov](http://www.wcd.oregon.gov), under "Business Tools," click on "Employer Coverage."
- **Provide this information to WCD:**
  - » Employer's legal business name, street address, city, and phone number.
  - » Coverage inquiry date.
  - » Worker's name.
- **If necessary, the Employer Compliance Unit will conduct further research.**
- Please send a copy of Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," or Form 801, "Report of Injury or Illness" to:
  - » Workers' Compensation Division
  - » Employer Compliance Unit
  - » P.O. Box 14480
  - » Salem, OR 97309-0405

