74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

(To Resolve Conflicts)

B-Engrossed
House Bill 2247

Ordered by the Senate May 15
Including House Amendments dated March 8 and Senate Amendments dated May 15 to resolve conflicts

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of Governor Theodore R. Kulongoski for Department of Consumer and Business Services)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Eliminates sunset of provisions related to services provided by nurse practitioners in workers' compensation claims. Modifies Workers' Compensation Law to specify compensable medical services provided by nurse practitioners.

1 **A BILL FOR AN ACT**

2 Relating to services provided by nurse practitioners in workers' compensation claims; creating new
3 provisions; amending ORS 656.005, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340,
4 656.726, 657.170, 659A.043, 659A.046, 659A.049 and 659A.063; and repealing section 33, chapter
5 811, Oregon Laws 2003.

6 **Be It Enacted by the People of the State of Oregon:**

7 **SECTION 1.** ORS 656.005, as amended by section 2, chapter 811, Oregon Laws 2003, is amended
8 to read:

9 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
10 ployment, as determined by the Employment Department, for the last quarter of the calendar year
11 preceding the fiscal year in which the injury occurred.

12 (2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a
13 worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

14 (a) A spouse of an injured worker living in a state of abandonment for more than one year at
15 the time of the injury or subsequently. A spouse who has lived separate and apart from the worker
16 for a period of two years and who has not during that time received or attempted by process of law
17 to collect funds for support or maintenance is considered living in a state of abandonment.

18 (b) A person who intentionally causes the compensable injury to or death of an injured worker.

19 (3) "Board" means the Workers' Compensation Board.

20 (4) "Carrier-insured employer" means an employer who provides workers' compensation cover-
21 age with a guaranty contract insurer.

22 (5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child to-
23 ward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such
24 stepchild was, at the time of the injury, a member of the worker's family and substantially dependent
25 upon the worker for support. An invalid dependent child is a child, for purposes of benefits, re-

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

gardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, an invalid dependent child is considered to be a child under 18 years of age.

(6) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

(b) "Compensable injury" does not include:

(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties;

(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

(C) Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption.

(c) A "disabling compensable injury" is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury.

(d) A "nondisabling compensable injury" is any injury which requires medical services only.

(8) "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

(11) "Director" means the Director of the Department of Consumer and Business Services.

(12)(a) "Doctor" or "physician" means a person duly licensed to practice one or more of the healing arts in any country or in any state, territory or possession of the United States within the limits of the license of the licentiate.

1 (b) Except as otherwise provided for workers subject to a managed care contract, "attending
2 physician" means a doctor or physician who is primarily responsible for the treatment of a worker's
3 compensable injury and who is:
4 (A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the
5 Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed
6 by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state,
7 territory or possession of the United States; or
8 (B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits,
9 whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners
10 for the State of Oregon or a similarly licensed doctor or physician in any country or in any state,
11 territory or possession of the United States.
12 (c) "Consulting physician" means a doctor or physician who examines a worker or the worker's
13 medical record to advise the attending physician **or nurse practitioner authorized to provide**
14 **compensable medical services under ORS 656.245** regarding treatment of a worker's compensable
15 injury.
16 (13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and
17 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
18 rations or political subdivisions, who contracts to pay a remuneration for and secures the right to
19 direct and control the services of any person.
20 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
21 a temporary service provider is not the employer of temporary workers provided by the temporary
22 service provider.
23 (c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning
24 for that term provided in ORS 656.850.
25 (14) "Guaranty contract insurer" and "insurer" mean the State Accident Insurance Fund Cor-
26 poration or an insurer authorized under ORS chapter 731 to transact workers' compensation insur-
27 ance in this state or an assigned claims agent selected by the director under ORS 656.054.
28 (15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.
29 (16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.
30 (17) "Medically stationary" means that no further material improvement would reasonably be
31 expected from medical treatment, or the passage of time.
32 (18) "Noncomplying employer" means a subject employer who has failed to comply with ORS
33 656.017.
34 (19) "Objective findings" in support of medical evidence are verifiable indications of injury or
35 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
36 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
37 sponses to physical examinations that are not reproducible, measurable or observable.
38 (20) "Palliative care" means medical service rendered to reduce or moderate temporarily the
39 intensity of an otherwise stable medical condition, but does not include those medical services ren-
40 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.
41 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
42 of injury and the insurer, if any, of such employer.
43 (22) "Payroll" means a record of wages payable to workers for their services and includes
44 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
45 similar advantage received from the employer. However, "payroll" does not include overtime pay,

vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments to reward workers for safe working practices. Bonus pay is limited to payments which are not anticipated under the contract of employment and which are paid at the sole discretion of the employer. The exclusion from payroll of bonus payments to reward workers for safe working practices is only for the purpose of calculations based on payroll to determine premium for workers′ compensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter.

(23) "Person" includes partnership, joint venture, association, limited liability company and corporation.

(24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment, provided that:

(A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the worker has been diagnosed with such condition, or has obtained medical services for the symptoms of the condition regardless of diagnosis; and

(B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes the initial injury;

(ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the new medical condition; or

(iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment precedes the onset of the worsened condition.

(b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim for worsening in such claims pursuant to ORS 656.273 or 656.278.

(c) For the purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury.

(25) "Self-insured employer" means an employer or group of employers certified under ORS 656.430 as meeting the qualifications set out by ORS 656.407.

(26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident Insurance Fund Corporation created under ORS 656.752.

(27) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

(28) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

(29) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

(30) "Worker" means any person, including a minor whether lawfully or unlawfully employed,

who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

(31) "Independent contractor" has the meaning for that term provided in ORS 670.600.

SECTION 2. ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and section 4, chapter 26, Oregon Laws 2005, is amended to read:

656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

(b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. A pharmacist or dispensing physician shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide such medical services continues for the life of the worker.

(c) Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:

(A) Services provided to a worker who has been determined to be permanently and totally disabled.

(B) Prescription medications.

(C) Services necessary to administer prescription medication or monitor the administration of prescription medication.

(D) Prosthetic devices, braces and supports.

(E) Services necessary to monitor the status, replacement or repair of prosthetic devices, braces and supports.

(F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.

(G) Services provided pursuant to an order issued under ORS 656.278.

(H) Services that are necessary to diagnose the worker's condition.

(I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.

(J) With the approval of the insurer or self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable the worker to continue current employment or a vocational training program. If the insurer or self-insured employer does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such treatment. The decision of the director is subject to review under ORS 656.704.

(K) With the approval of the director, curative care arising from a generally recognized, non-experimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. The decision of the director is subject to review under ORS 656.704.

(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

(d) When the medically stationary date in a disabling claim is established by the insurer or self-insured employer and is not based on the findings of the attending physician, the insurer or self-insured employer is responsible for reimbursement to affected medical service providers for otherwise compensable services rendered until the insurer or self-insured employer provides written notice to the attending physician of the worker's medically stationary status.

(e) Except for services provided under a managed care contract, out-of-pocket expense reimbursement to receive care from the attending physician **or nurse practitioner authorized to provide compensable medical services under this section** shall not exceed the amount required to seek care from an appropriate **nurse practitioner or** attending physician of the same specialty who is in a medical community geographically closer to the worker's home. For the purposes of this paragraph, all physicians **and nurse practitioners** within a metropolitan area are considered to be part of the same medical community.

(2)(a) The worker may choose an attending doctor**,** [*or*] physician **or nurse practitioner** within the State of Oregon. The worker may choose the initial attending physician **or nurse practitioner** and may subsequently change attending physician **or nurse practitioner** two times without approval from the director. If the worker thereafter selects another attending physician **or nurse practitioner**, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. The decision of the director is subject to review under ORS 656.704. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

(b) A medical service provider who is not a member of a managed care organization is subject to the following provisions:

(A) A medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of injury or occupational disease or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable.

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(C) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed under ORS 678.375 to 678.390 may:

(i) Provide compensable medical services for 90 days from the date of the first visit on the claim;

(ii) Authorize the payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim; and

(iii) When an injured worker treating with a nurse practitioner authorized to provide compensable services under this section becomes medically stationary within the 90-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse practitioner for the examination performed.

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to review under ORS 656.704.

(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provided to injured workers:

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians **or nurse practitioners,** or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician **or nurse practitioner authorized to provide compensable medical services under this section** under an expired or terminated managed care organization contract if the physician **or nurse practitioner** agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-

ployer may require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization.

(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician **or nurse practitioner authorized to provide compensable medical services under this section** who agrees to the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.

(C) If the insurer or self-insured employer does not give notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer is under no obligation to pay for services received by the worker unless the claim is later accepted.

(D) If the claim is denied, the worker may receive medical services after the date of denial from sources other than the managed care organization until the denial is reversed. Reasonable and necessary medical services received from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize [*nurse practitioners certified by the Oregon State Board of Nursing and*] physician assistants licensed by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disability compensation for injured workers for a period not to exceed 30 days from the date of the first visit on the claim. In addition, the director, by rule, may authorize such [*practitioners and*] assistants who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such payment.

(6) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the managed care organization, is authorized to provide the same level of services as a primary care physician as established by ORS 656.260 (4), if at the time the worker is enrolled in the managed care organization, the nurse practitioner maintains the worker's medical records and with whom the worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require and if that nurse practitioner agrees to comply with all the rules, terms and conditions regarding services performed by the managed care organization.

[*(6)*] **(7)** Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327.

SECTION 2a. If House Bill 2756 becomes law, section 2 of this 2007 Act (amending ORS 656.245) is repealed and ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, section 4, chapter 26, Oregon Laws 2005, and section 4, chapter ___, Oregon Laws 2007 (Enrolled House Bill 2756), is amended to read:

656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period

1 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
2 656.225, including such medical services as may be required after a determination of permanent
3 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
4 insurer or the self-insured employer shall cause to be provided only those medical services directed
5 to medical conditions caused in major part by the injury.
6 (b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances
7 and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and
8 supports and where necessary, physical restorative services. A pharmacist or dispensing physician
9 shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide
10 such medical services continues for the life of the worker.
11 (c) Notwithstanding any other provision of this chapter, medical services after the worker's
12 condition is medically stationary are not compensable except for the following:
13 (A) Services provided to a worker who has been determined to be permanently and totally dis-
14 abled.
15 (B) Prescription medications.
16 (C) Services necessary to administer prescription medication or monitor the administration of
17 prescription medication.
18 (D) Prosthetic devices, braces and supports.
19 (E) Services necessary to monitor the status, replacement or repair of prosthetic devices, braces
20 and supports.
21 (F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.
22 (G) Services provided pursuant to an order issued under ORS 656.278.
23 (H) Services that are necessary to diagnose the worker's condition.
24 (I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.
25 (J) With the approval of the insurer or self-insured employer, palliative care that the worker's
26 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
27 the worker to continue current employment or a vocational training program. If the insurer or
28 self-insured employer does not approve, the attending physician or the worker may request approval
29 from the Director of the Department of Consumer and Business Services for such treatment. The
30 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
31 (3) to aid in the review of such treatment. The decision of the director is subject to review under
32 ORS 656.704.
33 (K) With the approval of the director, curative care arising from a generally recognized, non-
34 experimental advance in medical science since the worker's claim was closed that is highly likely
35 to improve the worker's condition and that is otherwise justified by the circumstances of the claim.
36 The decision of the director is subject to review under ORS 656.704.
37 (L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
38 of symptoms of the worker's condition.
39 (d) When the medically stationary date in a disabling claim is established by the insurer or
40 self-insured employer and is not based on the findings of the attending physician, the insurer or
41 self-insured employer is responsible for reimbursement to affected medical service providers for
42 otherwise compensable services rendered until the insurer or self-insured employer provides written
43 notice to the attending physician of the worker's medically stationary status.
44 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
45 imbursement to receive care from the attending physician **or nurse practitioner authorized to**

provide compensable medical services under this section shall not exceed the amount required to seek care from an appropriate **nurse practitioner or** attending physician of the same specialty who is in a medical community geographically closer to the worker's home. For the purposes of this paragraph, all physicians **and nurse practitioners** within a metropolitan area are considered to be part of the same medical community.

(2)(a) The worker may choose an attending doctor**,** [*or*] physician **or nurse practitioner** within the State of Oregon. The worker may choose the initial attending physician **or nurse practitioner** and may subsequently change attending physician **or nurse practitioner** two times without approval from the director. If the worker thereafter selects another attending physician **or nurse practitioner**, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. The decision of the director is subject to review under ORS 656.704. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

(b) A medical service provider who is not a member of a managed care organization is subject to the following provisions:

(A) A medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of injury or occupational disease or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable.

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. A medical service provider qualified to serve as an attending physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim.

(C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) who is serving as the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed under ORS 678.375 to 678.390:

(i) May provide compensable medical services for 90 days from the date of the first visit on the claim;

(ii) May authorize the payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim; and

(iii) When an injured worker treating with a nurse practitioner authorized to provide compensable services under this section becomes medically stationary within the 90-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse practitioner for the examination performed.

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to review under ORS 656.704.

(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provided to injured workers:

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians **or nurse practitioners,** or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician **or nurse practitioner authorized to provide compensable medical services under this section** under an expired or terminated managed care organization contract if the physician **or nurse practitioner** agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured employer may require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization.

(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician **or nurse practitioner authorized to provide compensable medical services under this section** who agrees to

the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.

(C) If the insurer or self-insured employer does not give notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer is under no obligation to pay for services received by the worker unless the claim is later accepted.

(D) If the claim is denied, the worker may receive medical services after the date of denial from sources other than the managed care organization until the denial is reversed. Reasonable and necessary medical services received from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

[*(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize nurse practitioners certified by the Oregon State Board of Nursing who practice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disability compensation for injured workers for a period not to exceed 30 days from the date of the first visit on the claim. In addition, the director, by rule, may authorize such practitioners who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such payment.*]

(5) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the managed care organization, is authorized to provide the same level of services as a primary care physician as established by ORS 656.260 (4), if at the time the worker is enrolled in the managed care organization, the nurse practitioner maintains the worker's medical records and with whom the worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require and if that nurse practitioner agrees to comply with all the rules, terms and conditions regarding services performed by the managed care organization.

(6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327.

SECTION 3. ORS 656.250, as amended by section 6, chapter 811, Oregon Laws 2003, is amended to read:

656.250. A physical therapist shall not provide compensable services to injured workers governed by this chapter except as allowed by a governing managed care organization contract or as authorized by the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**.

SECTION 4. ORS 656.252, as amended by section 8, chapter 811, Oregon Laws 2003, is amended to read:

656.252. (1) In order to ensure the prompt and correct reporting and payment of compensation in compensable injuries, the Director of the Department of Consumer and Business Services shall make rules governing audits of medical service bills and reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim to the injured worker's representative, the worker's employer, the employer's insurer and the Department of Consumer and Business Services. Such rules shall include, but not necessarily be limited to:

(a) Requiring attending physicians **and nurse practitioners authorized to provide compensable medical services under ORS 656.245** to make the insurer or self-insured employer a first report of injury within 72 hours after the first service rendered.

(b) Requiring attending physicians **and nurse practitioners authorized to provide compensable medical services under ORS 656.245** to submit follow-up reports within specified time limits or upon the request of an interested party.

(c) Requiring examining physicians **and nurse practitioners authorized to provide compensable medical services under ORS 656.245** to submit their reports, and to whom, within a specified time.

(d) Such other reporting requirements as the director may deem necessary to insure that payments of compensation be prompt and that all interested parties be given information necessary to the prompt determination of claims.

(e) Requiring insurers and self-insured employers to audit billings for all medical services, including hospital services.

(2) The attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** shall do the following:

(a) Cooperate with the insurer or self-insured employer to expedite diagnostic and treatment procedures and with efforts to return injured workers to appropriate work.

(b) Advise the insurer or self-insured employer of the anticipated date for release of the injured worker to return to employment, the anticipated date that the worker will be medically stationary, and the next appointment date. Except when the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** has previously indicated that temporary disability will not exceed 14 days, the insurer or self-insured employer may request a medical report every 15 days, and the attending physician **or nurse practitioner** shall forward such reports.

(c) Advise the insurer or self-insured employer within five days of the date the injured worker is released to return to work. Under no circumstances shall the physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

(d) After a claim has been closed, advise the insurer or self-insured employer within five days after the treatment is resumed or the reopening of a claim is recommended. The attending physician under this paragraph need not be the same attending physician who released the worker when the claim was closed.

(3) In promulgating the rules regarding medical reporting the director may consult and confer with physicians and members of medical associations and societies.

(4) No person who reports medical information to a person referred to in subsection (1) of this section, in accordance with department rules, shall incur any legal liability for the disclosure of such information.

(5) Whenever an injured worker changes attending physicians **or nurse practitioners authorized to provide compensable medical services under ORS 656.245**, the newly selected attending physician **or nurse practitioner** shall so notify the responsible insurer or self-insured employer not later than five days after the date of the change or the date of first treatment. Every attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** who refers a worker to a consulting physician promptly shall notify the responsible insurer or self-insured employer of the referral.

(6) A provider of medical services, including hospital services, that submits a billing to the insurer or self-insured employer shall also submit a copy of the billing to the worker for whom the service was performed after receipt from the injured worker of a written request for such a copy.

1 **SECTION 5.** ORS 656.262, as amended by section 10, chapter 811, Oregon Laws 2003, section
2 10, chapter 26, Oregon Laws 2005, section 2, chapter 511, Oregon Laws 2005, and section 3, chapter
3 588, Oregon Laws 2005, is amended to read:
4 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
5 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
6 claims as required in this chapter.
7 (2) The compensation due under this chapter shall be paid periodically, promptly and directly
8 to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except
9 where the right to compensation is denied by the insurer or self-insured employer.
10 (3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any
11 claims or accidents which may result in a compensable injury claim, report the same to their
12 insurer. The report shall include:
13 (A) The date, time, cause and nature of the accident and injuries.
14 (B) Whether the accident arose out of and in the course of employment.
15 (C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
16 therefor.
17 (D) The name and address of any health insurance provider for the injured worker.
18 (E) Any other details the insurer may require.
19 (b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
20 for any penalty the insurer is required to pay under subsection (11) of this section because of such
21 failure. As used in this subsection, "health insurance" has the meaning for that term provided in
22 ORS 731.162.
23 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
24 14th day after the subject employer has notice or knowledge of the claim, if the attending physician
25 **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**
26 authorizes the payment of temporary disability compensation. Thereafter, temporary disability com-
27 pensation shall be paid at least once each two weeks, except where the Director of the Department
28 of Consumer and Business Services determines that payment in installments should be made at some
29 other interval. The director may by rule convert monthly benefit schedules to weekly or other pe-
30 riodic schedules.
31 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an
32 injured worker who becomes disabled the same wage at the same pay interval that the worker re-
33 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability
34 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.
35 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
36 injured in the course and scope of that public office, full official salary paid to the holder of that
37 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
38 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public
39 office" has the meaning for that term provided in ORS 260.005.
40 (d) Temporary disability compensation is not due and payable for any period of time for which
41 the insurer or self-insured employer has requested from the worker's attending physician **or nurse**
42 **practitioner authorized to provide compensable medical services under ORS 656.245** verifica-
43 tion of the worker's inability to work resulting from the claimed injury or disease and the physician
44 **or nurse practitioner** cannot verify the worker's inability to work, unless the worker has been
45 unable to receive treatment for reasons beyond the worker's control.

(e) If a worker fails to appear at an appointment with the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment.

(f) If the insurer or self-insured employer has requested and failed to receive from the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician **or nurse practitioner** are not compensable until the attending physician **or nurse practitioner** submits such verification.

(g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** ceases to authorize temporary disability or for any period of time not authorized by the attending physician **or nurse practitioner**. No authorization of temporary disability compensation by the attending physician **or nurse practitioner** under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance.

(h) The worker's disability may be authorized only by a person described in ORS 656.005 (12)(b)(B) or 656.245 [*(5)*] for the period of time permitted by those sections. The insurer or self-insured employer may unilaterally suspend payment of temporary disability benefits to the worker at the expiration of the period until temporary disability is reauthorized by an attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**.

(i) The insurer or self-insured employer may unilaterally suspend payment of all compensation to a worker enrolled in a managed care organization if the worker continues to seek care from an attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** that is not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

(5) Payment of compensation under subsection (4) of this section or payment, in amounts not to exceed $1,500 per claim, for medical services for nondisabling claims, may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported. However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection.

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has

1 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
2 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
3 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
4 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
5 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
6 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
7 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
8 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
9 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
10 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
11 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
12 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
13 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
14 payable from the date any such benefits were terminated under the denial. Except as provided in
15 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
16 include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer
17 a copy of the notice of acceptance.
18 (b) The notice of acceptance shall:
19 (A) Specify what conditions are compensable.
20 (B) Advise the claimant whether the claim is considered disabling or nondisabling.
21 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
22 rights concerning nondisabling injuries, including the right to object to a decision that the injury
23 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.
24 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
25 chapter 659A.
26 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
27 ment Assistance Program under ORS 656.622.
28 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
29 information changes a previously issued notice of acceptance.
30 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
31 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
32 the insurer or self-insured employer from later denying the combined or consequential condition if
33 the otherwise compensable injury ceases to be the major contributing cause of the combined or
34 consequential condition.
35 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
36 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
37 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
38 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
39 revise the notice or to make other written clarification in response. A worker who fails to comply
40 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
41 hearing or other proceeding on the claim a de facto denial of a condition based on information in
42 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
43 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.
44 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
45 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be

furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer or self-insured employer receives written notice of such claims. A worker who fails to comply with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer.

(b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed.

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

(8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of acceptance or denial to the noncomplying employer.

(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319.

(10) Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted.

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be proportionate to the benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $2,000 absent a showing of extraordinary circumstances. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount and attorney fees described in this subsection, the provisions of this subsection shall apply in the other proceeding.

(12) The insurer may authorize an employer to pay compensation to injured workers and shall reimburse employers for compensation so paid.

(13) Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. However, if the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

(14) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim.

(15) In accordance with ORS 656.283 (4), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (13) of this section.

SECTION 6. ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12, chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461, Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when:

(a) The worker has become medically stationary and there is sufficient information to determine

permanent impairment;

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent impairment, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated;

(c) Without the approval of the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or

(d) An insurer or self-insured employer finds that a worker who has been receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the worker, if requested by the worker.

(4) Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

(b) The attending physician **or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245** advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician **or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245** advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician **or the nurse practitioner who may authorize temporary disability under ORS 656.245**;

(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement; or

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld

or terminated under ORS 656.262 (4) or other provisions of this chapter.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the worker's attorney if the worker is represented, and to the director. The notice must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice;

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within 60 days of the date of the notice of claim closure; of the right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(b) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of the decision not to close; of the right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close the claim; of the right to be represented by an attorney; and of such other information as the director may require.

(c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(d) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the

penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional compensation awarded to the worker.

(d) The reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (7) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's request for reconsideration pursuant to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker, the date of receipt of a waiver from the worker of the right to request reconsideration or the date of expiration of the right of the worker to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully par-

ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If neither party requests a medical arbiter and the director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.

(c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

(d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the director in consultation with the Board of Medical Examiners for the State of Oregon and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, there shall be no further opportunity for the worker to attend a medical arbiter examination for this claim closure. The reconsideration record shall be closed, and the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended pursuant to this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, shall not be due and payable to the worker.

(f) The costs of examination and review by the medical arbiter or panel of medical arbiters shall be paid by the insurer or self-insured employer.

(g) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter prior

to the completion of the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(8) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for unscheduled disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(10) If the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(11) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(12) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by a guaranty contract insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(13)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the

beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

(14) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied.

SECTION 7. ORS 656.325, as amended by section 12, chapter 657, Oregon Laws 2003, section 14, chapter 811, Oregon Laws 2003, and section 2, chapter 675, Oregon Laws 2005, is amended to read:

656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. No more than three independent medical examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

(b) When a worker is requested by the director, the insurer or self-insured employer to attend an independent medical examination, the examination must be conducted by a physician selected from a list of qualified physicians established by the director under ORS 656.328.

(c) The director shall adopt rules applicable to independent medical examinations conducted pursuant to paragraph (a) of this subsection that:

(A) Provide a worker the opportunity to request review by the director of the reasonableness of the location selected for an independent **medical** examination. Upon receipt of the request for review, the director shall conduct an expedited review of the location selected for the independent medical examination and issue an order on the reasonableness of the location of the examination. The director shall determine if there is substantial evidence for the objection to the location for the independent medical examination based on a conclusion that the required travel is medically contraindicated or other good cause establishing that the required travel is unreasonable. The determinations of the director about the location of independent medical examinations are not subject to review.

(B) Impose a monetary penalty against a worker who fails to attend an independent medical examination without prior notification or without justification for not attending the examination. A penalty imposed under this subparagraph may be imposed only on a worker who is not receiving temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may offset any future compensation payable to the worker to recover any penalty imposed under this subparagraph from a claim with the same insurer or self-insured employer. When a penalty is recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment may not exceed 25 percent of the benefit payment without prior authorization from the worker.

(C) Impose a sanction against a medical service provider that unreasonably fails to provide in a timely manner diagnostic records required for an independent medical examination.

(d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for an independent medical examination is unreasonable, the insurer or self-insured employer shall accept or deny the claim within 90 days after the employer has notice or knowledge of the claim.

(e) If the worker has made a timely request for a hearing on a denial of compensability as required by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pursuant to paragraph (a) of this subsection and the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** does not concur with the report or reports, the worker may request an examination to be conducted by a physician selected by the director from the list described in ORS 656.328. The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.

(f) The insurer or self-insured employer shall pay the costs of the medical examination and related services which are reasonably necessary to allow the worker to submit to any examination requested under this section. As used in this paragraph, "related services" includes, but is not limited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages for the period during which the worker is absent if the worker does not receive benefits pursuant to ORS 656.210 (4) during the period of absence. A claim for "related services" described in this paragraph shall be made in the manner prescribed by the director.

(g) A worker who objects to the location of an independent medical examination must request review by the director under paragraph (c)(A) of this subsection within six business days of the date the notice of the independent medical examination was mailed.

(2) For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal.

(3) A worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268.

(4) When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to this chapter, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate.

(5)(a) Except as provided by ORS 656.268 (4)(c) and (10), an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered.

(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician **or nurse practitioner authorized**

to provide compensable medical services under ORS 656.245 approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers.

(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** approves employment in a modified job whether or not such a job is available.

(6) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

SECTION 8. ORS 656.340, as amended by section 16, chapter 811, Oregon Laws 2003, is amended to read:

656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be provided to an injured worker who is eligible for assistance in returning to work.

(b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for vocational assistance within five days of:

(A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical or investigation report, notification from the worker, or otherwise; or

(B) The time the worker is medically stationary, if the worker has not returned to the worker's regular employment or other suitable employment with the employer at the time of injury or aggravation and the worker is not receiving vocational assistance.

(c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new information that would change the eligibility determination.

(2) Contact under subsection (1) of this section shall include informing the worker about reemployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job site modification assistance and the provisions of the preferred worker program pursuant to rules adopted by the Director of the Department of Consumer and Business Services.

(3) Within five days after notification that the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** has released a worker to return to work, the insurer or self-insured employer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the employer of the worker's reemployment rights, wage subsidy and the job site modification assistance and the provisions of the preferred worker program.

(4) As soon as possible, and not more than 30 days after the contact required by subsection (1) of this section, the insurer or self-insured employer shall cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance. The insurer or self-insured employer shall notify the worker of the decision regarding the worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the worker is not eligible, the worker may apply to the director for review of the decision as provided in ORS 656.283 (2). A worker determined ineligible upon evaluation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under standards prescribed by the director, may not be found eligible thereafter unless that eligibility determination is rejected by the director under ORS 656.283 (2) or the worker's condition worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for such benefits arises from a worsening of the worker's condition that occurs

after the expiration of the worker's aggravation rights under ORS 656.273.

(5) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the weekly wage currently being paid for employment which was the worker's regular employment even though the wage available following employment may be less than the wage prescribed by subsection (6) of this section. As used in this subsection and subsection (6) of this section, "regular employment" means the employment the worker held at the time of the injury or the claim for aggravation under ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of the aggravation, the employment the worker held on the last day of work prior to the aggravation.

(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A "substantial handicap to employment" exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) "Suitable employment" means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and

(iii) Employment that produces a weekly wage within 20 percent of that currently being paid for employment that was the worker's regular employment as defined in subsection (5) of this section. The director shall adopt rules providing methods of calculating the weekly wage currently being paid for the worker's regular employment for use in determining eligibility and for providing assistance to eligible workers. If the worker's regular employment was seasonal or temporary, the worker's wage shall be averaged based on a combination of the worker's earned income and any unemployment insurance payments. Only earned income evidenced by verifiable documentation such as federal or state tax returns shall be used in the calculation. Earned income does not include fringe benefits or reimbursement of the worker's employment expenses.

(7) Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training.

(8) An insurer or self-insured employer may utilize its own staff or may engage any other individual certified by the director to perform the vocational evaluation required by subsection (4) of this section.

(9) The director shall adopt rules providing:

(a) Standards for and methods of certifying individuals and authorizing vocational assistance providers qualified by education, training, experience and plan of operation to provide vocational assistance to injured workers;

(b) Conditions and procedures under which the certification of an individual or the authorization

of a vocational assistance provider to provide vocational assistance services may be suspended or revoked for failure to maintain compliance with the certification or authorization standards;

(c) Standards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work; and

(d) Procedures, schedules and conditions relating to the payment for services performed by a vocational assistance provider, which shall be based on payment for specific services performed and not fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for direct worker purchases and for all vocational assistance providers and shall be the same within suitable geographic areas.

(10) Insurers and self-insured employers shall maintain records and make reports to the director of vocational assistance actions at such times and in such manner as the director may prescribe. Such requirements shall be for the purpose of assisting the Department of Consumer and Business Services in monitoring compliance with this section to insure that workers receive timely and appropriate vocational assistance. The director shall minimize to the greatest extent possible the number, extent and kinds of reports required. The director shall compile a list of the organizations or agencies authorized to provide vocational assistance. A current list shall be distributed by the director to all insurers and self-insured employers. The insurer shall send the list to each worker with the notice of eligibility.

(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer shall notify the director and the director shall select a provider. Any change in the choice of vocational assistance provider is subject to the approval of the director.

(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months, subject to extension to 21 months by order of the director for good cause shown. The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months.

(13) As used in this section, "vocational assistance provider" means a public or private organization or agency which provides vocational assistance to injured workers.

(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the same type or extent of assistance.

(b) Training shall not be provided to an eligible worker solely because the worker cannot obtain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage significantly closer to that prescribed in subsection (6) of this section.

(c) Nothing in this section shall be interpreted to expand the availability of training under this section.

(15) A physical capacities evaluation shall be performed in conjunction with vocational assistance or determination of eligibility for such assistance at the request of the insurer or self-insured employer or worker. Such request shall be made to the attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245**. The attending physician **or nurse practitioner**, within 20 days of the request, shall perform a physical capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer

1 and the worker in writing that the injured worker is incapable of participating in a physical ca-
2 pacities evaluation.
3 **SECTION 9.** ORS 656.726, as amended by section 4, chapter 657, Oregon Laws 2003, section 18,
4 chapter 811, Oregon Laws 2003, section 17, chapter 26, Oregon Laws 2005, and section 2a, chapter
5 653, Oregon Laws 2005, is amended to read:
6 656.726. (1) The Workers' Compensation Board in its name and the Director of the Department
7 of Consumer and Business Services in the director's name as director may sue and be sued, and each
8 shall have a seal.
9 (2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges
10 in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction
11 under this chapter and providing such policy advice as the director may request, and providing such
12 other review functions as may be prescribed by law. To that end any of its members or assistants
13 authorized thereto by the members shall have power to:
14 (a) Hold sessions at any place within the state.
15 (b) Administer oaths.
16 (c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attend-
17 ance of witnesses and the production of papers, contracts, books, accounts, documents and testimony
18 before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.
19 (d) Generally provide for the taking of testimony and for the recording of proceedings.
20 (3) The board chairperson is hereby charged with the administration of and responsibility for the
21 Hearings Division.
22 (4) The director hereby is charged with duties of administration, regulation and enforcement of
23 ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:
24 (a) Make and declare all rules and issue orders which are reasonably required in the perform-
25 ance of the director's duties. Unless otherwise specified by law, all reports, claims or other docu-
26 ments shall be deemed timely provided to the director or board if mailed by regular mail or
27 delivered within the time required by law. Notwithstanding any other provision of this chapter, the
28 director may adopt rules to allow for the electronic transmission and filing of reports, claims or
29 other documents required to be filed under this chapter. Notwithstanding ORS 183.310 to 183.410,
30 if a matter comes before the director that is not addressed by rule and the director finds that
31 adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily
32 burdensome to the public, the director may resolve the matter by issuing an order, subject to review
33 under ORS 656.704. Such order shall not have precedential effect as to any other situation.
34 (b) Hold sessions at any place within the state.
35 (c) Administer oaths.
36 (d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
37 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
38 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director
39 or the director's representatives. The director may require the attendance and testimony of em-
40 ployers, their officers and representatives in any inquiry under this chapter, and the production by
41 employers of books, records, papers and documents without the payment or tender of witness fees
42 on account of such attendance.
43 (e) Generally provide for the taking of testimony and for the recording of such proceedings.
44 (f) Provide standards for the evaluation of disabilities. The following provisions apply to the
45 standards:

(A) The criteria for evaluation of disabilities under ORS 656.214 (5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214 (5) if:

(i) The worker returns to regular work at the job held at the time of injury;

(ii) The attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

(iii) The attending physician **or nurse practitioner authorized to provide compensable medical services under ORS 656.245** releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295 and 654.750 to 654.780 and this chapter.

(5) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent

1 the Director of the Department of Revenue requires such information to determine that a person
2 complies with the revenue and tax laws of this state and to the Director of the Employment De-
3 partment to the extent the Director of the Employment Department requires such information to
4 determine that a person complies with ORS chapter 657.
5 (10) The director shall collect hours-worked data information in addition to total payroll for
6 workers engaged in various jobs in the construction industry classifications described in the job
7 classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon
8 Special Rules Section published by the National Council on Compensation Insurance. The informa-
9 tion shall be collected in the form and format necessary for the National Council on Compensation
10 Insurance to analyze premium equity.
11 **SECTION 9a. If House Bill 2244 becomes law, section 9 of this 2007 Act (amending ORS**
12 **656.726) is repealed.**
13 **SECTION 10.** ORS 657.170, as amended by section 20, chapter 811, Oregon Laws 2003, and
14 section 6, chapter 218, Oregon Laws 2005, is amended to read:
15 657.170. (1) If the Director of the Employment Department finds that during the base year of the
16 individual any individual has been incapable of work during the greater part of any calendar quar-
17 ter, such base year shall be extended a calendar quarter. Except as provided in subsection (2) of
18 this section, no such extension of an individual's base year shall exceed four calendar quarters.
19 (2) If the director finds that during and prior to the individual's base year the individual has
20 had a period of temporary total disability caused by illness or injury and has received compensation
21 under ORS chapter 656 for a period of temporary total disability during the greater part of any
22 calendar quarter, the individual's base year shall be extended as many calendar quarters as neces-
23 sary to establish a valid claim, up to a maximum of four calendar quarters prior to the quarter in
24 which the illness or injury occurred, if the individual:
25 (a) Files a claim for benefits not later than the fourth calendar week of unemployment following
26 whichever is the latest of the following dates:
27 (A) The date the individual is released to return to work by the attending physician, as defined
28 in ORS chapter 656**, or a nurse practitioner authorized to provide compensable medical ser-**
29 **vices under ORS 656.245**; or
30 (B) The date of mailing of a notice of claim closure pursuant to ORS chapter 656; and
31 (b) Files such a claim within the three-year period immediately following the commencement of
32 such period of illness or injury.
33 (3) Notwithstanding the provisions of this section, benefits payable as a result of the use of
34 wages paid in a calendar quarter prior to the individual's current base year shall not exceed one-
35 third of such wages less benefits paid previously as a result of the use of such wages in computing
36 a previous benefit determination.
37 **SECTION 11.** ORS 659A.043, as amended by section 22, chapter 811, Oregon Laws 2003, and
38 section 470, chapter 22, Oregon Laws 2005, is amended to read:
39 659A.043. (1) A worker who has sustained a compensable injury shall be reinstated by the
40 worker's employer to the worker's former position of employment upon demand for such rein-
41 statement, if the position exists and is available and the worker is not disabled from performing the
42 duties of such position. A worker's former position is available even if that position has been filled
43 by a replacement while the injured worker was absent. If the former position is not available, the
44 worker shall be reinstated in any other existing position that is vacant and suitable. A certificate
45 by the attending physician **or a nurse practitioner authorized to provide compensable medical**

1 **services under ORS 656.245** that the physician **or nurse practitioner** approves the worker's re-
2 turn to the worker's regular employment or other suitable employment shall be prima facie evidence
3 that the worker is able to perform such duties.
4 (2) Such right of reemployment shall be subject to the provisions for seniority rights and other
5 employment restrictions contained in a valid collective bargaining agreement between the employer
6 and a representative of the employer's employees.
7 (3) Notwithstanding subsection (1) of this section:
8 (a) The right to reinstatement to the worker's former position under this section terminates
9 when whichever of the following events first occurs:
10 (A) A medical determination by the attending physician or, after an appeal of such determi-
11 nation to a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656, has been made
12 that the worker cannot return to the former position of employment.
13 (B) The worker is eligible and participates in vocational assistance under ORS 656.340.
14 (C) The worker accepts suitable employment with another employer after becoming medically
15 stationary.
16 (D) The worker refuses a bona fide offer from the employer of light duty or modified employment
17 that is suitable prior to becoming medically stationary.
18 (E) Seven days elapse from the date that the worker is notified by the insurer or self-insured
19 employer by certified mail that the worker's attending physician **or a nurse practitioner author-**
20 **ized to provide compensable medical services under ORS 656.245** has released the worker for
21 employment unless the worker requests reinstatement within that time period.
22 (F) Three years elapse from the date of injury.
23 (b) The right to reinstatement under this section does not apply to:
24 (A) A worker hired on a temporary basis as a replacement for an injured worker.
25 (B) A seasonal worker employed to perform less than six months' work in a calendar year.
26 (C) A worker whose employment at the time of injury resulted from referral from a hiring hall
27 operating pursuant to a collective bargaining agreement.
28 (D) A worker whose employer employs 20 or fewer workers at the time of the worker's injury
29 and at the time of the worker's demand for reinstatement.
30 (4) Any violation of this section is an unlawful employment practice.
31 **SECTION 12.** ORS 659A.046, as amended by section 24, chapter 811, Oregon Laws 2003, is
32 amended to read:
33 659A.046. (1) A worker who has sustained a compensable injury and is disabled from performing
34 the duties of the worker's former regular employment shall, upon demand, be reemployed by the
35 worker's employer at employment which is available and suitable.
36 (2) A certificate of the worker's attending physician **or a nurse practitioner authorized to**
37 **provide compensable medical services under ORS 656.245** that the worker is able to perform
38 described types of work shall be prima facie evidence of such ability.
39 (3) Notwithstanding subsection (1) of this section, the right to reemployment under this section
40 terminates when whichever of the following events first occurs:
41 (a) The worker cannot return to reemployment at any position with the employer either by de-
42 termination of the attending physician **or a nurse practitioner authorized to provide**
43 **compensable medical services under ORS 656.245** or upon appeal of that determination, by de-
44 termination of a medical arbiter or panel of medical arbiters pursuant to ORS chapter 656.
45 (b) The worker is eligible and participates in vocational assistance under ORS 656.340.

(c) The worker accepts suitable employment with another employer after becoming medically stationary.

(d) The worker refuses a bona fide offer from the employer of light duty or modified employment that is suitable prior to becoming medically stationary.

(e) Seven days elapse from the date that the worker is notified by the insurer or self-insured employer by certified mail that the worker's attending physician **or a nurse practitioner authorized to provide compensable medical services under ORS 656.245** has released the worker for reemployment unless the worker requests reemployment within that time period.

(f) Three years elapse from the date of injury.

(4) Such right of reemployment shall be subject to the provisions for seniority rights and other employment restrictions contained in a valid collective bargaining agreement between the employer and a representative of the employer's employees.

(5) Any violation of this section is an unlawful employment practice.

(6) This section applies only to employers who employ six or more persons.

SECTION 13. ORS 659A.049, as amended by section 26, chapter 811, Oregon Laws 2003, is amended to read:

659A.049. The rights of reinstatement afforded by ORS 659A.043 and 659A.046 shall not be forfeited if the worker refuses to return to the worker's regular or other offered employment without release to such employment by the worker's attending physician **or a nurse practitioner authorized to provide compensable medical services under ORS 656.245**.

SECTION 14. ORS 659A.063, as amended by section 28, chapter 811, Oregon Laws 2003, is amended to read:

659A.063. (1) The State of Oregon shall cause group health benefits to continue in effect with respect to that worker and any covered dependents or family members by timely payment of the premium that includes the contribution due from the state under the applicable benefit plan, subject to any premium contribution due from the worker that the worker paid before the occurrence of the injury or illness. If the premium increases or decreases, the State of Oregon and worker contributions shall be adjusted to remain consistent with similarly situated active employees. The State of Oregon shall continue the worker's health benefits in effect until whichever of the following events occurs first:

(a) The worker's attending physician **or a nurse practitioner authorized to provide compensable medical services under ORS 656.245** has determined the worker to be medically stationary and a notice of closure has been entered;

(b) The worker returns to work for the State of Oregon, after a period of continued coverage under this section, and satisfies any probationary or minimum work requirement to be eligible for group health benefits;

(c) The worker takes full or part-time employment with another employer that is comparable in terms of the number of hours per week the worker was employed with the State of Oregon or the worker retires;

(d) Twelve months have elapsed since the date the State of Oregon received notice that the worker filed a workers' compensation claim pursuant to ORS chapter 656;

(e) The claim is denied and the claimant fails to appeal within the time provided by ORS 656.319 or the Workers' Compensation Board or a workers' compensation hearings referee or a court issues an order finding the claim is not compensable;

(f) The worker does not pay the required premium or portion thereof in a timely manner in ac-

cordance with the terms and conditions under this section;

(g) The worker elects to discontinue coverage under this section and notifies the State of Oregon in writing of this election;

(h) The worker's attending physician **or a nurse practitioner authorized to provide compensable medical services under ORS 656.245** has released the worker to modified or regular work, the work has been offered to the worker and the worker refuses to return to work; or

(i) The worker has been terminated from employment for reasons unrelated to the workers' compensation claim.

(2) If the workers' compensation claim of a worker for whom health benefits are provided pursuant to subsection (1) of this section is denied and the worker does not appeal or the worker appeals and does not prevail, the State of Oregon may recover from the worker the amount of the premiums plus interest at the rate authorized by ORS 82.010. The State of Oregon may recover the payments through a payroll deduction not to exceed 10 percent of gross pay for each pay period.

(3) The State of Oregon shall notify the worker of the provisions of ORS 659A.060 to 659A.069, and of the remedies available for breaches of ORS 659A.060 to 659A.069, within a reasonable time after the State of Oregon receives notice that the worker will be absent from work as a result of an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter 656. The notice from the State of Oregon shall include the terms and conditions of the continuation of health benefits and what events will terminate the coverage.

(4) If the worker fails to make timely payment of any premium contribution owing, the State of Oregon shall notify the worker of impending cancellation of the health benefits and provide the worker with 30 days to pay the required premium prior to canceling the policy.

(5) It is an unlawful employment practice for the State of Oregon to discriminate against a worker, as defined in ORS 659A.060, by terminating the worker's group health benefits while that worker is absent from the place of employment as a result of an injury or illness for which a workers' compensation claim has been filed pursuant to ORS chapter 656, except as provided for in this section.

SECTION 15. Section 33, chapter 811, Oregon Laws 2003, is repealed.