

House Bill 2431

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Pre-session filed (at the request of former Representative Jeff Kropf)

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 **as introduced**.

Authorizes doctor or physician licensed by State Board of Chiropractic Examiners to serve as attending physician for workers' compensation claim on same basis as medical doctor or doctor of osteopathy licensed by Board of Medical Examiners.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to authority of licensed chiropractic doctor or physician to serve as attending physician for
3 workers' compensation claims; amending ORS 656.005, 656.245, 656.260, 656.262 and 656.268; and
4 declaring an emergency.

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

6 **SECTION 1.** ORS 656.005 is amended to read:

7 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
8 ployment, as determined by the Employment Department, for the last quarter of the calendar year
9 preceding the fiscal year in which the injury occurred.

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

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

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

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

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

20 (5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child to-
21 ward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such
22 stepchild was, at the time of the injury, a member of the worker's family and substantially dependent
23 upon the worker for support. An invalid dependent child is a child, for purposes of benefits, re-
24 gardless of age, so long as the child was an invalid at the time of the accident and thereafter re-
25 mains an invalid substantially dependent on the worker for support. For purposes of this chapter,
26 an invalid dependent child is considered to be a child under 18 years of age.

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

29 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
30 ances, arising out of and in the course of employment requiring medical services or resulting in

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.

1 disability or death; an injury is accidental if the result is an accident, whether or not due to acci-
 2 dental means, if it is established by medical evidence supported by objective findings, subject to the
 3 following limitations:

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

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

11 (b) "Compensable injury" does not include:

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

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

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

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

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

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

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

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

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

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

39 (b) Except as otherwise provided for workers subject to a managed care contract, "attending
 40 physician" means a doctor or physician who is primarily responsible for the treatment of a worker's
 41 compensable injury and who is:

42 (A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the
 43 Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed
 44 by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state,
 45 territory or possession of the United States; or

1 (B) *[For a period of 30 days from the date of first visit on the initial claim or for 12 visits,*
 2 *whichever first occurs,]* A doctor or physician licensed by the State Board of Chiropractic Examiners
 3 for the State of Oregon or a similarly licensed doctor or physician in any country or in any state,
 4 territory or possession of the United States.

5 (c) “Consulting physician” means a doctor or physician who examines a worker or the worker’s
 6 medical record to advise the attending physician or nurse practitioner authorized to provide
 7 compensable medical services under ORS 656.245 regarding treatment of a worker’s compensable
 8 injury.

9 (13)(a) “Employer” means any person, including receiver, administrator, executor or trustee, and
 10 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
 11 rations or political subdivisions, who contracts to pay a remuneration for and secures the right to
 12 direct and control the services of any person.

13 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
 14 a temporary service provider is not the employer of temporary workers provided by the temporary
 15 service provider.

16 (c) As used in paragraph (b) of this subsection, “temporary service provider” has the meaning
 17 for that term provided in ORS 656.850.

18 (14) “Guaranty contract insurer” and “insurer” mean the State Accident Insurance Fund Cor-
 19 poration or an insurer authorized under ORS chapter 731 to transact workers’ compensation insur-
 20 ance in this state or an assigned claims agent selected by the director under ORS 656.054.

21 (15) “Consumer and Business Services Fund” means the fund created by ORS 705.145.

22 (16) “Invalid” means one who is physically or mentally incapacitated from earning a livelihood.

23 (17) “Medically stationary” means that no further material improvement would reasonably be
 24 expected from medical treatment, or the passage of time.

25 (18) “Noncomplying employer” means a subject employer who has failed to comply with ORS
 26 656.017.

27 (19) “Objective findings” in support of medical evidence are verifiable indications of injury or
 28 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
 29 palpable muscle spasm. “Objective findings” does not include physical findings or subjective re-
 30 sponses to physical examinations that are not reproducible, measurable or observable.

31 (20) “Palliative care” means medical service rendered to reduce or moderate temporarily the
 32 intensity of an otherwise stable medical condition, but does not include those medical services ren-
 33 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

34 (21) “Party” means a claimant for compensation, the employer of the injured worker at the time
 35 of injury and the insurer, if any, of such employer.

36 (22) “Payroll” means a record of wages payable to workers for their services and includes
 37 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
 38 similar advantage received from the employer. However, “payroll” does not include overtime pay,
 39 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
 40 to reward workers for safe working practices. Bonus pay is limited to payments which are not an-
 41 ticipated under the contract of employment and which are paid at the sole discretion of the em-
 42 ployer. The exclusion from payroll of bonus payments to reward workers for safe working practices
 43 is only for the purpose of calculations based on payroll to determine premium for workers’ com-
 44 pensation insurance, and does not affect any other calculation or determination based on payroll for
 45 the purposes of this chapter.

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

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

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

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

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

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

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

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

21 (25) "Self-insured employer" means an employer or group of employers certified under ORS
 22 656.430 as meeting the qualifications set out by ORS 656.407.

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

25 (27) "Subject employer" means an employer who is subject to this chapter as provided by ORS
 26 656.023.

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

29 (29) "Wages" means the money rate at which the service rendered is recompensed under the
 30 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
 31 housing, lodging or similar advantage received from the employer, and includes the amount of tips
 32 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
 33 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
 34 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
 35 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
 36 which any worker shall be carried upon the payroll of the employer for the purpose of determining
 37 the premium of the employer.

38 (30) "Worker" means any person, including a minor whether lawfully or unlawfully employed,
 39 who engages to furnish services for a remuneration, subject to the direction and control of an em-
 40 ployer and includes salaried, elected and appointed officials of the state, state agencies, counties,
 41 cities, school districts and other public corporations, but does not include any person whose services
 42 are performed as an inmate or ward of a state institution or as part of the eligibility requirements
 43 for a general or public assistance grant. For the purpose of determining entitlement to temporary
 44 disability benefits or permanent total disability benefits under this chapter, "worker" does not in-
 45 clude a person who has withdrawn from the workforce during the period for which such benefits are

1 sought.

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

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

5 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
6 ployment, as determined by the Employment Department, for the last quarter of the calendar year
7 preceding the fiscal year in which the injury occurred.

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

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

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

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

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

18 (5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child to-
19 ward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such
20 stepchild was, at the time of the injury, a member of the worker's family and substantially dependent
21 upon the worker for support. An invalid dependent child is a child, for purposes of benefits, re-
22 gardless of age, so long as the child was an invalid at the time of the accident and thereafter re-
23 mains an invalid substantially dependent on the worker for support. For purposes of this chapter,
24 an invalid dependent child is considered to be a child under 18 years of age.

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

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

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

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

39 (b) "Compensable injury" does not include:

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

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

44 (C) Injury the major contributing cause of which is demonstrated to be by a preponderance of
45 the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption

1 of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of
 2 such consumption.

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

6 (d) A “nondisabling compensable injury” is any injury which requires medical services only.

7 (8) “Compensation” includes all benefits, including medical services, provided for a compensable
 8 injury to a subject worker or the worker’s beneficiaries by an insurer or self-insured employer pur-
 9 suant to this chapter.

10 (9) “Department” means the Department of Consumer and Business Services.

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

18 (11) “Director” means the Director of the Department of Consumer and Business Services.

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

22 (b) Except as otherwise provided for workers subject to a managed care contract, “attending
 23 physician” means a doctor or physician who is primarily responsible for the treatment of a worker’s
 24 compensable injury and who is:

25 (A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the
 26 Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed
 27 by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state,
 28 territory or possession of the United States; or

29 (B) *[For a period of 30 days from the date of first visit on the initial claim or for 12 visits,*
 30 *whichever first occurs,]* A doctor or physician licensed by the State Board of Chiropractic Examiners
 31 for the State of Oregon or a similarly licensed doctor or physician in any country or in any state,
 32 territory or possession of the United States.

33 (c) “Consulting physician” means a doctor or physician who examines a worker or the worker’s
 34 medical record to advise the attending physician regarding treatment of a worker’s compensable
 35 injury.

36 (13)(a) “Employer” means any person, including receiver, administrator, executor or trustee, and
 37 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
 38 rations or political subdivisions, who contracts to pay a remuneration for and secures the right to
 39 direct and control the services of any person.

40 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
 41 a temporary service provider is not the employer of temporary workers provided by the temporary
 42 service provider.

43 (c) As used in paragraph (b) of this subsection, “temporary service provider” has the meaning
 44 for that term provided in ORS 656.850.

45 (14) “Guaranty contract insurer” and “insurer” mean the State Accident Insurance Fund Cor-

1 poration or an insurer authorized under ORS chapter 731 to transact workers' compensation insur-
2 ance in this state or an assigned claims agent selected by the director under ORS 656.054.

3 (15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.

4 (16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

5 (17) "Medically stationary" means that no further material improvement would reasonably be
6 expected from medical treatment, or the passage of time.

7 (18) "Noncomplying employer" means a subject employer who has failed to comply with ORS
8 656.017.

9 (19) "Objective findings" in support of medical evidence are verifiable indications of injury or
10 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
11 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
12 sponses to physical examinations that are not reproducible, measurable or observable.

13 (20) "Palliative care" means medical service rendered to reduce or moderate temporarily the
14 intensity of an otherwise stable medical condition, but does not include those medical services ren-
15 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.

16 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
17 of injury and the insurer, if any, of such employer.

18 (22) "Payroll" means a record of wages payable to workers for their services and includes
19 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
20 similar advantage received from the employer. However, "payroll" does not include overtime pay,
21 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
22 to reward workers for safe working practices. Bonus pay is limited to payments which are not an-
23 ticipated under the contract of employment and which are paid at the sole discretion of the em-
24 ployer. The exclusion from payroll of bonus payments to reward workers for safe working practices
25 is only for the purpose of calculations based on payroll to determine premium for workers' com-
26 pensation insurance, and does not affect any other calculation or determination based on payroll for
27 the purposes of this chapter.

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

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

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

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

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

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

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

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

3 (25) “Self-insured employer” means an employer or group of employers certified under ORS
 4 656.430 as meeting the qualifications set out by ORS 656.407.

5 (26) “State Accident Insurance Fund Corporation” and “corporation” mean the State Accident
 6 Insurance Fund Corporation created under ORS 656.752.

7 (27) “Subject employer” means an employer who is subject to this chapter as provided by ORS
 8 656.023.

9 (28) “Subject worker” means a worker who is subject to this chapter as provided by ORS
 10 656.027.

11 (29) “Wages” means the money rate at which the service rendered is recompensed under the
 12 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
 13 housing, lodging or similar advantage received from the employer, and includes the amount of tips
 14 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
 15 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
 16 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
 17 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
 18 which any worker shall be carried upon the payroll of the employer for the purpose of determining
 19 the premium of the employer.

20 (30) “Worker” means any person, including a minor whether lawfully or unlawfully employed,
 21 who engages to furnish services for a remuneration, subject to the direction and control of an em-
 22 ployer and includes salaried, elected and appointed officials of the state, state agencies, counties,
 23 cities, school districts and other public corporations, but does not include any person whose services
 24 are performed as an inmate or ward of a state institution or as part of the eligibility requirements
 25 for a general or public assistance grant. For the purpose of determining entitlement to temporary
 26 disability benefits or permanent total disability benefits under this chapter, “worker” does not in-
 27 clude a person who has withdrawn from the workforce during the period for which such benefits are
 28 sought.

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

30 **SECTION 3.** ORS 656.245 is amended to read:

31 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
 32 to be provided medical services for conditions caused in material part by the injury for such period
 33 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
 34 656.225, including such medical services as may be required after a determination of permanent
 35 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
 36 insurer or the self-insured employer shall cause to be provided only those medical services directed
 37 to medical conditions caused in major part by the injury.

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

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

45 (A) Services provided to a worker who has been determined to be permanently and totally dis-

1 abled.

2 (B) Prescription medications.

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

5 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

31 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
32 imbursement to receive care from the attending physician or nurse practitioner authorized to pro-
33 vide compensable medical services under this section shall not exceed the amount required to seek
34 care from an appropriate nurse practitioner or attending physician of the same specialty who is in
35 a medical community geographically closer to the worker's home. For the purposes of this para-
36 graph, all physicians and nurse practitioners within a metropolitan area are considered to be part
37 of the same medical community.

38 (2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
39 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
40 may subsequently change attending physician or nurse practitioner two times without approval from
41 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
42 insurer or self-insured employer may require the director's approval of the selection and, if re-
43 quested, the director shall determine with the advice of one or more physicians, whether the se-
44 lection by the worker shall be approved. The decision of the director is subject to review under
45 ORS 656.704. The worker also may choose an attending doctor or physician in another country or

1 in any state or territory or possession of the United States with the prior approval of the insurer
 2 or self-insured employer.

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

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

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

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

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

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

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

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

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

36 (a) Those workers who are subject to the contract shall receive medical services in the manner
 37 prescribed in the contract. Workers subject to the contract include those who are receiving medical
 38 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
 39 jury or medically stationary status, on or after the effective date of the contract. If the managed
 40 care organization determines that the change in provider would be medically detrimental to the
 41 worker, the worker shall not become subject to the contract until the worker is found to be med-
 42 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
 43 ganization determines that the change in provider is no longer medically detrimental, whichever
 44 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
 45 notice of the worker's enrollment in the managed care organization, or upon the third day after the

1 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
2 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
3 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
4 vide compensable medical services under this section under an expired or terminated managed care
5 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
6 and conditions regarding services performed under any subsequent managed care organization con-
7 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
8 primary residence is more than 100 miles outside the managed care organization's certified ge-
9 ographical area. Each such contract must comply with the certification standards provided in ORS
10 656.260. However, a worker may receive immediate emergency medical treatment that is
11 compensable from a medical service provider who is not a member of the managed care organization.
12 Insurers or self-insured employers who contract with a managed care organization for medical ser-
13 vices shall give notice to the workers of eligible medical service providers and such other informa-
14 tion regarding the contract and manner of receiving medical services as the director may prescribe.
15 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
16 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
17 as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

38 (5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize
39 physician assistants licensed by the Board of Medical Examiners for the State of Oregon who prac-
40 tice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the
41 payment of temporary disability compensation for injured workers for a period not to exceed 30 days
42 from the date of the first visit on the claim. In addition, the director, by rule, may authorize such
43 assistants who practice in areas served by a Type C rural hospital described in ORS 442.470 to au-
44 thorize such payment.

45 (6) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the

1 managed care organization, is authorized to provide the same level of services as a primary care
 2 physician as established by ORS 656.260 (4), if at the time the worker is enrolled in the managed
 3 care organization, the nurse practitioner maintains the worker's medical records and with whom the
 4 worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker
 5 to the managed care organization for any specialized treatment, including physical therapy, to be
 6 furnished by another provider that the worker may require and if that nurse practitioner agrees to
 7 comply with all the rules, terms and conditions regarding services performed by the managed care
 8 organization.

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

12 **SECTION 4.** ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and section
 13 4, chapter 26, Oregon Laws 2005, is amended to read:

14 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
 15 to be provided medical services for conditions caused in material part by the injury for such period
 16 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
 17 656.225, including such medical services as may be required after a determination of permanent
 18 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
 19 insurer or the self-insured employer shall cause to be provided only those medical services directed
 20 to medical conditions caused in major part by the injury.

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

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

28 (A) Services provided to a worker who has been determined to be permanently and totally dis-
 29 abled.

30 (B) Prescription medications.

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

33 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

1 (3) to aid in the review of such treatment. The decision of the director is subject to review under
 2 ORS 656.704.

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

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

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

14 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
 15 imbursement to receive care from the attending physician shall not exceed the amount required to
 16 seek care from an appropriate attending physician of the same specialty who is in a medical com-
 17 munity geographically closer to the worker's home. For the purposes of this paragraph, all physi-
 18 cians within a metropolitan area are considered to be part of the same medical community.

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

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

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

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

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

44 (4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer
 45 of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for

1 medical services required by this chapter to be provided to injured workers:

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

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

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

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

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

1 ployer if the claim is finally determined to be compensable.

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

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

13 **SECTION 5.** ORS 656.260 is amended to read:

14 656.260. (1) Any health care provider or group of medical service providers may make written
 15 application to the Director of the Department of Consumer and Business Services to become certi-
 16 fied to provide managed care to injured workers for injuries and diseases compensable under this
 17 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
 18 erated by an insurer or employer other than a health care provider to become certified to provide
 19 managed care.

20 (2) Each application for certification shall be accompanied by a reasonable fee prescribed by the
 21 director. A certificate is valid for such period as the director may prescribe unless sooner revoked
 22 or suspended.

23 (3) Application for certification shall be made in such form and manner and shall set forth such
 24 information regarding the proposed plan for providing services as the director may prescribe. The
 25 information shall include, but not be limited to:

26 (a) A list of the names of all individuals who will provide services under the managed care plan,
 27 together with appropriate evidence of compliance with any licensing or certification requirements
 28 for that individual to practice in this state.

29 (b) A description of the times, places and manner of providing services under the plan.

30 (c) A description of the times, places and manner of providing other related optional services
 31 the applicants wish to provide.

32 (d) Satisfactory evidence of ability to comply with any financial requirements to insure delivery
 33 of service in accordance with the plan which the director may prescribe.

34 (4) The director shall certify a health care provider or group of medical service providers to
 35 provide managed care under a plan if the director finds that the plan:

36 (a) Proposes to provide services that meet quality, continuity and other treatment standards
 37 reviewed and approved by the director and will provide all medical and health care services that
 38 may be required by this chapter in a manner that is timely, effective and convenient for the worker.

39 (b) Subject to any other provision of law, does not discriminate against or exclude from partic-
 40 ipation in the plan any category of medical service providers and includes an adequate number of
 41 each category of medical service providers to give workers adequate flexibility to choose medical
 42 service providers from among those individuals who provide services under the plan. However,
 43 nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to
 44 the granting of medical staff privileges.

45 (c) Provides appropriate financial incentives to reduce service costs and utilization without

1 sacrificing the quality of service.

2 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
 3 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
 4 or excessive treatment, to exclude from participation in the plan those individuals who violate these
 5 treatment standards and to provide for the resolution of such medical disputes as the director con-
 6 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
 7 zation and contract review committee shall be physicians licensed to practice medicine by the Board
 8 of Medical Examiners. As used in this paragraph:

9 (A) "Peer review" means evaluation or review of the performance of colleagues by a panel with
 10 similar types and degrees of expertise. Peer review requires participation of at least three physicians
 11 prior to final determination.

12 (B) "Service utilization review" means evaluation and determination of the reasonableness, ne-
 13 cessity and appropriateness of a worker's use of medical care resources and the provision of any
 14 needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service
 15 utilization review" includes prior authorization, concurrent review, retrospective review, discharge
 16 planning and case management activities.

17 (C) "Quality assurance" means activities to safeguard or improve the quality of medical care
 18 by assessing the quality of care or service and taking action to improve it.

19 (D) "Dispute resolution" includes the resolution of disputes arising under peer review, service
 20 utilization review and quality assurance activities between insurers, self-insured employers, workers
 21 and medical and health care service providers, as required under the certified plan.

22 (E) "Contract review" means the methods and processes whereby the managed care organization
 23 monitors and enforces its contracts with participating providers for matters other than matters
 24 enumerated in subparagraphs (A), (B) and (C) of this paragraph.

25 (e) Provides a program involving cooperative efforts by the workers, the employer and the
 26 managed care organizations to promote workplace health and safety consultative and other services
 27 and early return to work for injured workers.

28 (f) Provides a timely and accurate method of reporting to the director necessary information
 29 regarding medical and health care service cost and utilization to enable the director to determine
 30 the effectiveness of the plan.

31 (g) Authorizes workers to receive compensable medical treatment from a primary care physician
 32 who is not a member of the managed care organization, but who maintains the worker's medical
 33 records and with whom the worker has a documented history of treatment, if that primary care
 34 physician agrees to refer the worker to the managed care organization for any specialized treatment,
 35 including physical therapy, to be furnished by another provider that the worker may require and if
 36 that primary care physician agrees to comply with all the rules, terms and conditions regarding
 37 services performed by the managed care organization. Nothing in this paragraph is intended to limit
 38 the worker's right to change primary care physicians prior to the filing of a workers' compensation
 39 claim. As used in this paragraph, "primary care physician" means a physician who is qualified to
 40 be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner,
 41 a general practitioner, [or] an internal medicine practitioner **or a chiropractic practitioner.**

42 (h) Provides a written explanation for denial of participation in the managed care organization
 43 plan to any licensed health care provider that has been denied participation in the managed care
 44 organization plan.

45 (i) Does not prohibit the injured worker's attending physician from advocating for medical ser-

1 vices and temporary disability benefits for the injured worker that are supported by the medical
2 record.

3 (j) Complies with any other requirement the director determines is necessary to provide quality
4 medical services and health care to injured workers.

5 (5) The director shall refuse to certify or may revoke or suspend the certification of any health
6 care provider or group of medical service providers to provide managed care if the director finds
7 that:

8 (a) The plan for providing medical or health care services fails to meet the requirements of this
9 section.

10 (b) Service under the plan is not being provided in accordance with the terms of a certified plan.

11 (6) Any issue concerning the provision of medical services to injured workers subject to a
12 managed care contract and service utilization review, quality assurance, dispute resolution, contract
13 review and peer review activities as well as authorization of medical services to be provided by
14 other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the
15 director or the director's designated representatives. The decision of the director is subject to re-
16 view under ORS 656.704. Data generated by or received in connection with these activities, includ-
17 ing written reports, notes or records of any such activities, or of any review thereof, shall be
18 confidential, and shall not be disclosed except as considered necessary by the director in the ad-
19 ministration of this chapter. The director may report professional misconduct to an appropriate li-
20 censing board.

21 (7) No data generated by service utilization review, quality assurance, dispute resolution or peer
22 review activities and no physician profiles or data used to create physician profiles pursuant to this
23 section or a review thereof shall be used in any action, suit or proceeding except to the extent
24 considered necessary by the director in the administration of this chapter. The confidentiality pro-
25 visions of this section shall not apply in any action, suit or proceeding arising out of or related to
26 a contract between a managed care organization and a health care provider whose confidentiality
27 is protected by this section.

28 (8) A person participating in service utilization review, quality assurance, dispute resolution or
29 peer review activities pursuant to this section shall not be examined as to any communication made
30 in the course of such activities or the findings thereof, nor shall any person be subject to an action
31 for civil damages for affirmative actions taken or statements made in good faith.

32 (9) No person who participates in forming consortiums, collectively negotiating fees or otherwise
33 solicits or enters into contracts in a good faith effort to provide medical or health care services
34 according to the provisions of this section shall be examined or subject to administrative or civil
35 liability regarding any such participation except pursuant to the director's active supervision of
36 such activities and the managed care organization. Before engaging in such activities, the person
37 shall provide notice of intent to the director in a form prescribed by the director.

38 (10) The provisions of this section shall not affect the confidentiality or admission in evidence
39 of a claimant's medical treatment records.

40 (11) In consultation with the committees referred to in ORS 656.790 and 656.794, the director
41 shall adopt such rules as may be necessary to carry out the provisions of this section.

42 (12) As used in this section, ORS 656.245, 656.248 and 656.327, "medical service provider" means
43 a person duly licensed to practice one or more of the healing arts in any country or in any state
44 or territory or possession of the United States.

45 (13) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care or-

1 organization contract may designate any medical service provider or category of providers as attend-
 2 ing physicians.

3 (14) If a worker, insurer, self-insured employer or the attending physician is dissatisfied with an
 4 action of the managed care organization regarding the provision of medical services pursuant to this
 5 chapter, peer review, service utilization review or quality assurance activities, that person or entity
 6 must first apply to the director for administrative review of the matter before requesting a hearing.
 7 Such application must be made not later than the 60th day after the date the managed care organ-
 8 ization has completed and issued its final decision.

9 (15) Upon a request for administrative review, the director shall create a documentary record
 10 sufficient for judicial review. The director shall complete administrative review and issue a pro-
 11 posed order within a reasonable time. The proposed order of the director issued pursuant to this
 12 section shall become final and not subject to further review unless a written request for a hearing
 13 is filed with the director within 30 days of the mailing of the order to all parties.

14 (16) At the contested case hearing, the order may be modified only if it is not supported by
 15 substantial evidence in the record or reflects an error of law. No new medical evidence or issues
 16 shall be admitted. The dispute may also be remanded to the managed care organization for further
 17 evidence taking, correction or other necessary action if the Administrative Law Judge or director
 18 determines the record has been improperly, incompletely or otherwise insufficiently developed. De-
 19 cisions by the director regarding medical disputes are subject to review under ORS 656.704.

20 (17) Any person who is dissatisfied with an action of a managed care organization other than
 21 regarding the provision of medical services pursuant to this chapter, peer review, service utilization
 22 review or quality assurance activities may request review under ORS 656.704.

23 (18) Notwithstanding any other provision of law, original jurisdiction over contract review dis-
 24 putes is with the director. The director may resolve the matter by issuing an order subject to re-
 25 view under ORS 656.704, or the director may determine that the matter in dispute would be best
 26 addressed in another forum and so inform the parties.

27 (19) The director shall conduct such investigations, audits and other administrative oversight in
 28 regard to managed care as the director deems necessary to carry out the purposes of this chapter.

29 **SECTION 6.** ORS 656.262 is amended to read:

30 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 31 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 32 claims as required in this chapter.

33 (2) The compensation due under this chapter shall be paid periodically, promptly and directly
 34 to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except
 35 where the right to compensation is denied by the insurer or self-insured employer.

36 (3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any
 37 claims or accidents which may result in a compensable injury claim, report the same to their
 38 insurer. The report shall include:

- 39 (A) The date, time, cause and nature of the accident and injuries.
- 40 (B) Whether the accident arose out of and in the course of employment.
- 41 (C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
- 42 therefor.
- 43 (D) The name and address of any health insurance provider for the injured worker.
- 44 (E) Any other details the insurer may require.

45 (b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer

1 for any penalty the insurer is required to pay under subsection (11) of this section because of such
2 failure. As used in this subsection, "health insurance" has the meaning for that term provided in
3 ORS 731.162.

4 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
5 14th day after the subject employer has notice or knowledge of the claim, if the attending physician
6 or nurse practitioner authorized to provide compensable medical services under ORS 656.245 au-
7 thorizes the payment of temporary disability compensation. Thereafter, temporary disability com-
8 pensation shall be paid at least once each two weeks, except where the Director of the Department
9 of Consumer and Business Services determines that payment in installments should be made at some
10 other interval. The director may by rule convert monthly benefit schedules to weekly or other pe-
11 riodic schedules.

12 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an
13 injured worker who becomes disabled the same wage at the same pay interval that the worker re-
14 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability
15 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

16 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
17 injured in the course and scope of that public office, full official salary paid to the holder of that
18 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
19 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public
20 office" has the meaning for that term provided in ORS 260.005.

21 (d) Temporary disability compensation is not due and payable for any period of time for which
22 the insurer or self-insured employer has requested from the worker's attending physician or nurse
23 practitioner authorized to provide compensable medical services under ORS 656.245 verification of
24 the worker's inability to work resulting from the claimed injury or disease and the physician or
25 nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable
26 to receive treatment for reasons beyond the worker's control.

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

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

39 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
40 worker's attending physician or nurse practitioner authorized to provide compensable medical ser-
41 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
42 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
43 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
44 to retroactively authorize the payment of temporary disability more than 14 days prior to its issu-
45 ance.

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

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

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

20 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
 21 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
 22 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
 23 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
 24 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
 25 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
 26 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
 27 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
 28 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
 29 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
 30 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
 31 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
 32 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
 33 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
 34 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
 35 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
 36 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
 37 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
 38 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
 39 Law Judge, the Workers’ Compensation Board or the court, temporary total disability benefits are
 40 payable from the date any such benefits were terminated under the denial. Except as provided in
 41 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
 42 include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer
 43 a copy of the notice of acceptance.

44 (b) The notice of acceptance shall:

45 (A) Specify what conditions are compensable.

1 (B) Advise the claimant whether the claim is considered disabling or nondisabling.

2 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
 3 rights concerning nondisabling injuries, including the right to object to a decision that the injury
 4 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

5 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
 6 chapter 659A.

7 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
 8 ment Assistance Program under ORS 656.622.

9 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
 10 information changes a previously issued notice of acceptance.

11 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
 12 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
 13 the insurer or self-insured employer from later denying the combined or consequential condition if
 14 the otherwise compensable injury ceases to be the major contributing cause of the combined or
 15 consequential condition.

16 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
 17 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
 18 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
 19 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
 20 revise the notice or to make other written clarification in response. A worker who fails to comply
 21 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
 22 hearing or other proceeding on the claim a de facto denial of a condition based on information in
 23 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
 24 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

25 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
 26 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be
 27 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
 28 or self-insured employer receives written notice of such claims. A worker who fails to comply with
 29 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
 30 any hearing or other proceeding on the claim a de facto denial of a condition based on information
 31 in the notice of acceptance from the insurer or self-insured employer.

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

35 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
 36 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
 37 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
 38 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
 39 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
 40 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
 41 garding that condition.

42 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
 43 ceptance or denial to the noncomplying employer.

44 (9) If an insurer or any other duly authorized agent of the employer for such purpose, on record
 45 with the Director of the Department of Consumer and Business Services denies a claim for com-

1 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
2 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the
3 claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the
4 insurer. The worker may request a hearing pursuant to ORS 656.319.

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

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

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

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

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

41 (14) If the director finds that a worker fails to reasonably cooperate with an investigation in-
42 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the
43 claim for a worsened condition, the director shall suspend all or part of the payment of compen-
44 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after
45 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure

1 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim
 2 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the
 3 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the
 4 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291
 5 that the worker fully and completely cooperated with the investigation, that the worker failed to
 6 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-
 7 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-
 8 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain
 9 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-
 10 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order
 11 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or
 12 self-insured employer to accept or deny the claim.

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

17 **SECTION 7.** ORS 656.262, as amended by section 10, chapter 811, Oregon Laws 2003, section
 18 10, chapter 26, Oregon Laws 2005, section 2, chapter 511, Oregon Laws 2005, and section 3, chapter
 19 588, Oregon Laws 2005, is amended to read:

20 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 21 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 22 claims as required in this chapter.

23 (2) The compensation due under this chapter shall be paid periodically, promptly and directly
 24 to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except
 25 where the right to compensation is denied by the insurer or self-insured employer.

26 (3)(a) Employers shall, immediately and not later than five days after notice or knowledge of any
 27 claims or accidents which may result in a compensable injury claim, report the same to their
 28 insurer. The report shall include:

29 (A) The date, time, cause and nature of the accident and injuries.

30 (B) Whether the accident arose out of and in the course of employment.

31 (C) Whether the employer recommends or opposes acceptance of the claim, and the reasons
 32 therefor.

33 (D) The name and address of any health insurance provider for the injured worker.

34 (E) Any other details the insurer may require.

35 (b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
 36 for any penalty the insurer is required to pay under subsection (11) of this section because of such
 37 failure. As used in this subsection, "health insurance" has the meaning for that term provided in
 38 ORS 731.162.

39 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
 40 14th day after the subject employer has notice or knowledge of the claim, if the attending physician
 41 authorizes the payment of temporary disability compensation. Thereafter, temporary disability com-
 42 pensation shall be paid at least once each two weeks, except where the Director of the Department
 43 of Consumer and Business Services determines that payment in installments should be made at some
 44 other interval. The director may by rule convert monthly benefit schedules to weekly or other pe-
 45 riodic schedules.

1 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an
 2 injured worker who becomes disabled the same wage at the same pay interval that the worker re-
 3 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability
 4 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

5 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
 6 injured in the course and scope of that public office, full official salary paid to the holder of that
 7 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
 8 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, “public
 9 office” has the meaning for that term provided in ORS 260.005.

10 (d) Temporary disability compensation is not due and payable for any period of time for which
 11 the insurer or self-insured employer has requested from the worker’s attending physician verification
 12 of the worker’s inability to work resulting from the claimed injury or disease and the physician
 13 cannot verify the worker’s inability to work, unless the worker has been unable to receive treatment
 14 for reasons beyond the worker’s control.

15 (e) If a worker fails to appear at an appointment with the worker’s attending physician, the
 16 insurer or self-insured employer shall notify the worker by certified mail that temporary disability
 17 benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the
 18 worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may sus-
 19 pend payment of temporary disability benefits to the worker until the worker appears at a subse-
 20 quent rescheduled appointment.

21 (f) If the insurer or self-insured employer has requested and failed to receive from the worker’s
 22 attending physician verification of the worker’s inability to work resulting from the claimed injury
 23 or disease, medical services provided by the attending physician are not compensable until the at-
 24 tending physician submits such verification.

25 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
 26 worker’s attending physician ceases to authorize temporary disability or for any period of time not
 27 authorized by the attending physician. No authorization of temporary disability compensation by the
 28 attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of
 29 temporary disability more than 14 days prior to its issuance.

30 (h) The worker’s disability may be authorized only by a person described in ORS 656.005
 31 (12)(b)[(B)] or **by a person described in ORS 656.245 (5)** for the period of time permitted by *[those*
 32 *sections]* **ORS 656.245 (5)**. The insurer or self-insured employer may unilaterally suspend payment
 33 of temporary disability benefits to the worker at the expiration of the period until temporary disa-
 34 bility is reauthorized by an attending physician.

35 (i) The insurer or self-insured employer may unilaterally suspend payment of all compensation
 36 to a worker enrolled in a managed care organization if the worker continues to seek care from an
 37 attending physician that is not authorized by the managed care organization more than seven days
 38 after the mailing of notice by the insurer or self-insured employer.

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

1 suant to this subsection.

2 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
3 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
4 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
5 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
6 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
7 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
8 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
9 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
10 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
11 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
12 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
13 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
14 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
15 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
16 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
17 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
18 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
19 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
20 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
21 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
22 payable from the date any such benefits were terminated under the denial. Except as provided in
23 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
24 include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer
25 a copy of the notice of acceptance.

26 (b) The notice of acceptance shall:

27 (A) Specify what conditions are compensable.

28 (B) Advise the claimant whether the claim is considered disabling or nondisabling.

29 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
30 rights concerning nondisabling injuries, including the right to object to a decision that the injury
31 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

32 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
33 chapter 659A.

34 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
35 ment Assistance Program under ORS 656.622.

36 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
37 information changes a previously issued notice of acceptance.

38 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
39 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude
40 the insurer or self-insured employer from later denying the combined or consequential condition if
41 the otherwise compensable injury ceases to be the major contributing cause of the combined or
42 consequential condition.

43 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
44 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
45 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The

1 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
2 revise the notice or to make other written clarification in response. A worker who fails to comply
3 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
4 hearing or other proceeding on the claim a de facto denial of a condition based on information in
5 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
6 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

7 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
8 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be
9 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
10 or self-insured employer receives written notice of such claims. A worker who fails to comply with
11 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
12 any hearing or other proceeding on the claim a de facto denial of a condition based on information
13 in the notice of acceptance from the insurer or self-insured employer.

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

17 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
18 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
19 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
20 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
21 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
22 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
23 garding that condition.

24 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
25 ceptance or denial to the noncomplying employer.

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

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

39 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
40 pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-
41 insured employer shall be liable for an additional amount up to 25 percent of the amounts then due
42 plus any attorney fees assessed under this section. The fees assessed by the director, an Adminis-
43 trative Law Judge, the board or the court under this section shall be proportionate to the benefit
44 to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee,
45 giving primary consideration to the results achieved and to the time devoted to the case. An attor-

1 ney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraor-
 2 dinary circumstances. Notwithstanding any other provision of this chapter, the director shall have
 3 exclusive jurisdiction over proceedings regarding solely the assessment and payment of the addi-
 4 tional amount and attorney fees described in this subsection. The action of the director and the re-
 5 view of the action taken by the director shall be subject to review under ORS 656.704.

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

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

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

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

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

44 **SECTION 8.** ORS 656.268 is amended to read:

45 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and

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

6 (a) The worker has become medically stationary and there is sufficient information to determine
 7 permanent disability;

8 (b) The accepted injury is no longer the major contributing cause of the worker's combined or
 9 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
 10 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
 11 quential condition or conditions, and there is sufficient information to determine permanent disabil-
 12 ity, the likely permanent disability that would have been due to the current accepted condition shall
 13 be estimated;

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

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

21 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
 22 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
 23 duced by any sums earned during the training.

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

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

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

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

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

37 (A) Requires a commute that is beyond the physical capacity of the worker according to the
 38 worker's attending physician or the nurse practitioner who may authorize temporary disability un-
 39 der ORS 656.245;

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

44 (C) Is not with the employer at injury;

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

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

3 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
 4 gaining agreement; or

5 (d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
 6 or terminated under ORS 656.262 (4) or other provisions of this chapter.

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

11 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
 12 isfied with the terms of the notice;

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

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

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

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

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

42 (e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
 43 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
 44 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
 45 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and

1 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
2 the claimant. If the increase in compensation results from information that the insurer or self-
3 insured employer demonstrates the insurer or self-insured employer could not reasonably have
4 known at the time of claim closure, from new information obtained through a medical arbiter ex-
5 amination or from the adoption of a temporary emergency rule, the penalty shall not be assessed.

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

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

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

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

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

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

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

42 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
43 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
44 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
45 the period for reconsideration begins upon the earlier of the date of the request for reconsideration

1 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
 2 not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration
 3 if the initiating party withdraws the request for reconsideration.
 4

5
 6 (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.
 7

8 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS 9 656.283 within 30 days from the date of the reconsideration order.

10 (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
 11 a medical arbiter appointed by the director.
 12

13 (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
 14 arbiter appointed by the director.
 15

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

17 (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
 18 director in consultation with the Board of Medical Examiners for the State of Oregon, **the State Board of Chiropractic Examiners** and the committee referred to in ORS 656.790.
 19
 20

21 (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.
 22

23 (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
 24 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
 25 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
 26 good cause must be submitted prior to the conclusion of the 60-day postponement period.
 27
 28

29 (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
 30 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
 31 upon the existing record.
 32
 33
 34

35 (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.
 36
 37

38 (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.
 39

40 (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.
 41

42 (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
 43 findings of impairment on the claim closure.
 44

45 (i)(A) When the basis for objection to a notice of closure issued under this section is a disa-

1 greement with the impairment used in rating the worker's disability, and the director determines
2 that the worker is not medically stationary at the time of the reconsideration or that the closure
3 was not made pursuant to this section, the director is not required to appoint a medical arbiter prior
4 to the completion of the reconsideration proceeding.

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

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

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

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

29 (11) Any notice of closure made under this section may include necessary adjustments in com-
30 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
31 bility payments prematurely made, crediting temporary disability payments against current or future
32 permanent or temporary disability awards or payments and requiring the payment of temporary
33 disability payments which were payable but not paid.

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

43 (13)(a) An insurer or self-insured employer may offset any compensation payable to the worker
44 to recover an overpayment from a claim with the same insurer or self-insured employer. When
45 overpayments are recovered from temporary disability or permanent total disability benefits, the

1 amount recovered from each payment shall not exceed 25 percent of the payment, without prior
 2 authorization from the worker.

3 (b) An insurer or self-insured employer may suspend and offset any compensation payable to the
 4 beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused
 5 by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the
 6 death of the worker.

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

9 **SECTION 9.** ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12,
 10 chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461,
 11 Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

12 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
 13 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
 14 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
 15 Department of Consumer and Business Services, and determine the extent of the worker's permanent
 16 disability, provided the worker is not enrolled and actively engaged in training according to rules
 17 adopted by the director pursuant to ORS 656.340 and 656.726, when:

18 (a) The worker has become medically stationary and there is sufficient information to determine
 19 permanent impairment;

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

26 (c) Without the approval of the attending physician, the worker fails to seek medical treatment
 27 for a period of 30 days or the worker fails to attend a closing examination, unless the worker
 28 affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or

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

32 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
 33 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
 34 duced by any sums earned during the training.

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

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

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

40 (b) The attending physician advises the worker and documents in writing that the worker is
 41 released to return to regular employment;

42 (c) The attending physician advises the worker and documents in writing that the worker is
 43 released to return to modified employment, such employment is offered in writing to the worker and
 44 the worker fails to begin such employment. However, an offer of modified employment may be re-
 45 fused by the worker without the termination of temporary total disability benefits if the offer:

1 (A) Requires a commute that is beyond the physical capacity of the worker according to the
 2 worker's attending physician;

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

7 (C) Is not with the employer at injury;

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

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

11 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
 12 gaining agreement; or

13 (d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
 14 or terminated under ORS 656.262 (4) or other provisions of this chapter.

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

19 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
 20 isfied with the terms of the notice;

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

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

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

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

44 (d) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant
 45 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing

1 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close
2 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid
3 to the worker in an amount equal to 25 percent of all compensation determined to be then due the
4 claimant.

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

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

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

27 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
28 may correct information in the record that is erroneous and may submit any medical evidence that
29 should have been but was not submitted by the attending physician at the time of claim closure.

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

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

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

38 (d) The reconsideration proceeding shall be completed within 18 working days from the date the
39 reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit
40 within the department. The deadline of 18 working days may be postponed by an additional 60 cal-
41 endar days if within the 18 working days the department mails notice of review by a medical arbiter.
42 If an order on reconsideration has not been mailed on or before 18 working days from the date the
43 reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days
44 where a notice for medical arbiter review was timely mailed or the director postponed the recon-
45 sideration pursuant to paragraph (b) of this subsection, or within such additional time as provided

1 in subsection (7) of this section when reconsideration is postponed further because the worker has
2 failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and
3 any further proceedings shall occur as though an order on reconsideration affirming the notice of
4 closure was mailed on the date the order was due to issue.

5 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
6 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
7 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
8 the period for reconsideration begins upon the earlier of the date of the request for reconsideration
9 by the worker, the date of receipt of a waiver from the worker of the right to request reconsideration
10 or the date of expiration of the right of the worker to request reconsideration. If a party elects
11 not to file a separate request for reconsideration, the party does not waive the right to fully participate
12 in the reconsideration proceeding, including the right to proceed with the reconsideration
13 if the initiating party withdraws the request for reconsideration.

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

16 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
17 656.283 within 30 days from the date of the reconsideration order.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (10) If the attending physician has approved the worker's return to work and there is a labor
 34 dispute in progress at the place of employment, the worker may refuse to return to that employment
 35 without loss of reemployment rights or any vocational assistance provided by this chapter.

36 (11) Any notice of closure made under this section may include necessary adjustments in com-
 37 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
 38 bility payments prematurely made, crediting temporary disability payments against current or future
 39 permanent or temporary disability awards or payments and requiring the payment of temporary
 40 disability payments which were payable but not paid.

41 (12) An insurer or self-insured employer may take a credit or offset of previously paid workers'
 42 compensation benefits or payments against any further workers' compensation benefits or payments
 43 due a worker from that insurer or self-insured employer when the worker admits to having obtained
 44 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
 45 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-

1 fits or payments obtained through fraud by a worker shall not be included in any data used for
2 ratemaking or individual employer rating or dividend calculations by a guaranty contract insurer,
3 a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund
4 Corporation or the director.

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

10 (b) An insurer or self-insured employer may suspend and offset any compensation payable to the
11 beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused
12 by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the
13 death of the worker.

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

16 **SECTION 10. This 2007 Act being necessary for the immediate preservation of the public**
17 **peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect**
18 **on its passage.**

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