HOUSE AMENDMENTS TO HOUSE BILL 2756

By COMMITTEE ON BUSINESS AND LABOR

April 11

On page 1 of the printed bill, line 2, after the semicolon delete the rest of the line and line 3 and insert "creating new provisions; amending ORS 656.005, 656.245 and 656.262; and declaring an emergency.".

Delete lines 5 through 31 and delete pages 2 through 8 and insert:

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

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

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

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

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

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

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

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

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

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

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

"(B) If an otherwise compensable injury combines at any time with a preexisting condition to

cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

"[*(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a*]

"**(B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first, to any of the medical service providers listed in this subparagraph, a:**

"**(i)** Doctor or physician licensed by the State Board of Chiropractic Examiners for the State

of Oregon **under ORS chapter 684** or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States[.]**;**

"(ii) Podiatric physician and surgeon licensed by the Board of Medical Examiners for the State of Oregon under ORS 677.805 to 677.840 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

"(iii) Physician assistant licensed by the Board of Medical Examiners for the State of Oregon in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory or possession of the United States; or

"(iv) Doctor of naturopathy or naturopathic physician licensed by the Board of Naturopathic Examiners licensed under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

"(c) 'Consulting physician' means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 regarding treatment of a worker's compensable injury.

"(13)(a) 'Employer' means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, who contracts to pay a remuneration for and secures the right to direct and control the services of any person.

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

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

"(14) 'Guaranty contract insurer' and 'insurer' mean the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

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

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

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

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

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

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

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

"(22) 'Payroll' means a record of wages payable to workers for their services and includes commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. However, 'payroll' does not include overtime pay,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"[*(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a*]

"**(B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first, to any of the medical service providers listed in this subparagraph, a:**

"(i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon **under ORS chapter 684** or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States[.]**;**

"(ii) Podiatric physician and surgeon licensed by the Board of Medical Examiners for the State of Oregon under ORS 677.805 to 677.840 or a similarly licensed doctor or physician in

any country or in any state, territory or possession of the United States;

"(iii) Physician assistant licensed by the Board of Medical Examiners for the State of Oregon in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory or possession of the United States; or

"(iv) Doctor of naturopathy or naturopathic physician licensed by the Board of Naturopathic Examiners licensed under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

"(c) 'Consulting physician' means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury.

"(13)(a) 'Employer' means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, who contracts to pay a remuneration for and secures the right to direct and control the services of any person.

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

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

"(14) 'Guaranty contract insurer' and 'insurer' mean the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

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

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

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

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

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

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

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

"(22) 'Payroll' means a record of wages payable to workers for their services and includes commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. However, 'payroll' does not include overtime pay, vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments to reward workers for safe working practices. Bonus pay is limited to payments which are not anticipated under the contract of employment and which are paid at the sole discretion of the employer. The exclusion from payroll of bonus payments to reward workers for safe working practices is only for the purpose of calculations based on payroll to determine premium for workers' com-

pensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

"(30) 'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant. For the purpose of determining entitlement to temporary

disability benefits or permanent total disability benefits under this chapter, 'worker' does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

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

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

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

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

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

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

"(B) Prescription medications.

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

"(D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(iii) When an injured worker treating with a nurse practitioner authorized to provide

compensable services under this section becomes medically stationary within the 90-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS [*656.005*] **656.005 (12)(b)(A)** for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse practitioner for the examination performed.

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

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

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

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

vices from the managed care organization.

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

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

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

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

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

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

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

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

directed to medical conditions caused in major part by the injury.

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

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

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

"(B) Prescription medications.

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

"(D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

"(2)(a) The worker may choose an attending doctor or physician within the State of Oregon. The

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

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

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

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

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

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

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

"(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician under an expired or terminated managed care organization contract if

the physician agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

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

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

"**SECTION 5.** ORS 656.262, as amended by section 10, chapter 811, Oregon Laws 2003, section 10, chapter 26, Oregon Laws 2005, section 2, chapter 511, Oregon Laws 2005, and section 3, chapter

588, Oregon Laws 2005, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

"(e) If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may sus-

pend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment.

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

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

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

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

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

"(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that

the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

"(b) The notice of acceptance shall:

"(A) Specify what conditions are compensable.

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

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

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

"(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

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

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

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

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

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

"(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-

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

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

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

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

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

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

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

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

and is preventing the worker from complying within 14 days of the request for interview, the insurer or self-insured employer shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

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

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

"**SECTION 6. Section 7 of this 2007 Act is added to and made a part of ORS chapter 656.**

"**SECTION 7. (1) The Director of the Department of Consumer and Business Services shall develop and make available to medical service providers informational materials about the workers' compensation system including, but not limited to, the management of indemnity claims, standards for the authorization of temporary disability benefits, return to work responsibilities and programs, and workers' compensation rules and procedures for medical service providers.**

"(2) Prior to providing compensable medical services or authorizing temporary disability benefits under ORS 656.245, a medical service provider must certify, in a form acceptable to the director, that the medical service provider has reviewed the materials developed under this section.

"(3) As used in this section, 'medical service provider' means a:

"(a) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

"(b) Podiatric physician and surgeon licensed by the Board of Medical Examiners for the State of Oregon under ORS 677.805 to 677.840 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

"(c) Physician assistant licensed by the Board of Medical Examiners for the State of Oregon in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant

in any country or in any state, territory or possession of the United States; or

"(d) Doctor of naturopathy or naturopathic physician licensed by the Board of Naturopathic Examiners licensed under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

"**SECTION 8. The amendments to ORS 656.005, 656.245 and 656.262 by sections 1 to 5 of this 2007 Act and section 7 of this 2007 Act become operative on January 2, 2008.**

"**SECTION 9. The Director of the Department of Consumer and Business Services may take any action necessary before the operative date of the amendments to ORS 656.005, 656.245 and 656.262 by sections 1 to 5 of this 2007 Act and of section 7 of this 2007 Act to enable the director to exercise, on and after the operative date of those sections, all the duties, functions and powers conferred on the director by this 2007 Act.**

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