

# House Bill 2195

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

## SUMMARY

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

Replaces requirement for authorization of vocational service provider organizations with requirement organizations register with Department of Consumer and Business Services. Allows insurers and self-insured employers to voluntarily extend payment of temporary disability payments to 21 months for injured workers receiving vocational rehabilitation services.

## A BILL FOR AN ACT

1  
2 Relating to vocational rehabilitation provided in workers' compensation claims; amending ORS  
3 656.262, 656.283, 656.313, 656.340 and 656.704.

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

5 **SECTION 1.** ORS 656.340 is amended to read:

6 656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be pro-  
7 vided to an injured worker who is eligible for assistance in returning to work.

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

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

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

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

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

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

28 (4) As soon as possible, and not more than 30 days after the contact required by subsection (1)  
29 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-  
30 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-

**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 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the  
 2 worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the  
 3 worker is not eligible, the worker may apply to the director for review of the decision as provided  
 4 in [ORS 656.283 (2)] **subsection (16) of this section**. A worker determined ineligible upon evalu-  
 5 ation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and  
 6 finally expired under standards prescribed by the director, may not be found eligible thereafter un-  
 7 less that eligibility determination is rejected by the director under [ORS 656.283 (2)] **subsection (16)**  
 8 **of this section** or the worker's condition worsens so as to constitute an aggravation claim under  
 9 ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for  
 10 such benefits arises from a worsening of the worker's condition that occurs after the expiration of  
 11 the worker's aggravation rights under ORS 656.273.

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

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

24 (b) As used in this subsection:

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

28 (B) "Suitable employment" means:

29 (i) Employment of the kind for which the worker has the necessary physical capacity, knowl-  
 30 edge, skills and abilities;

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

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

42 (7) Vocational evaluation, help in directly obtaining employment and training shall be available  
 43 under conditions prescribed by the director. The director may establish other conditions for pro-  
 44 viding vocational assistance, including those relating to the worker's availability for assistance,  
 45 participation in previous assistance programs connected with the same claim and the nature and

1 extent of assistance that may be provided. Such conditions shall give preference to direct employ-  
2 ment assistance over training.

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

6 (9) The director shall adopt rules providing:

7 (a) Standards for and methods of certifying individuals [*and authorizing vocational assistance*  
8 *providers*] qualified by education, training[, ] **and** experience [*and plan of operation*] to provide vo-  
9 cational assistance to injured workers;

10 **(b) Standards for registration of vocational assistance providers;**

11 [*b*] **(c)** Conditions and procedures under which the certification of an individual **to provide**  
12 **vocational assistance services** or the [*authorization*] **registration** of a vocational assistance pro-  
13 vider [*to provide vocational assistance services*] may be suspended or revoked for failure to maintain  
14 compliance with the certification or [*authorization*] **registration** standards;

15 [*c*] **(d)** Standards for the nature and extent of services a worker may receive, for plans for re-  
16 turn to work and for determining when the worker has returned to work; and

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

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

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

37 (12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary  
38 disability compensation for a maximum of 16 months[, *subject to extension to 21 months by order of*  
39 *the director for good cause shown*]. **The insurer or self-insured employer may voluntarily extend**  
40 **the payment of temporary disability compensation to a maximum of 21 months.** The costs  
41 related to vocational assistance training programs may be paid for periods longer than 21 months,  
42 but in no event may temporary disability benefits be paid for a period longer than 21 months.

43 (13) As used in this section, "vocational assistance provider" means a public or private organ-  
44 ization or agency [*which*] **that** provides vocational assistance to injured workers.

45 (14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the

1 same type or extent of assistance.

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

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

8 (15) A physical capacities evaluation shall be performed in conjunction with vocational assist-  
 9 ance or determination of eligibility for such assistance at the request of the insurer or self-insured  
 10 employer or worker. [*Such*] **The** request shall be made to the attending physician or nurse practi-  
 11 tioner authorized to provide compensable medical services under ORS 656.245. The attending physi-  
 12 cian or nurse practitioner, within 20 days of the request, shall perform a physical capacities  
 13 evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer  
 14 and the worker in writing that the injured worker is incapable of participating in a physical ca-  
 15 pacities evaluation.

16 **(16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers**  
 17 **requires a high degree of cooperation between all of the participants in the vocational as-**  
 18 **sistance process. Based on this finding, the Legislative Assembly concludes that disputes**  
 19 **regarding eligibility for and extent of vocational assistance services should be resolved**  
 20 **through nonadversarial procedures to the greatest extent possible consistent with constitu-**  
 21 **tional principles. The director shall adopt by rule a procedure for resolving vocational as-**  
 22 **sistance disputes in the manner provided in this subsection.**

23 **(b) If a worker is dissatisfied with an action of the insurer or self-insured employer re-**  
 24 **garding vocational assistance, the worker must apply to the director for administrative re-**  
 25 **view of the matter. Application for review must be made not later than the 60th day after**  
 26 **the date the worker was notified of the action. The director shall complete the review within**  
 27 **a reasonable time.**

28 **(c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement**  
 29 **shall be reduced to writing, and the director and the parties shall review the agreement and**  
 30 **either approve or disapprove it. The agreement is subject to reconsideration by the director**  
 31 **under limitations prescribed by the director, but is not subject to review by any other forum.**

32 **(d) If the worker's dissatisfaction is not resolved by agreement of the parties, the direc-**  
 33 **tor shall resolve the matter in a written order based on a record sufficient to permit review.**  
 34 **The order is subject to review under ORS 656.704. The request for a hearing must be filed**  
 35 **within 60 days of the date the order was issued. At the hearing, the order of the director**  
 36 **shall be modified only if it:**

37 **(A) Violates a statute or rule;**

38 **(B) Exceeds the statutory authority of the agency;**

39 **(C) Was made upon unlawful procedure; or**

40 **(D) Was characterized by abuse of discretion or clearly unwarranted exercise of dis-**  
 41 **cretion.**

42 **(e) For purposes of this subsection, the term "parties" does not include a noncomplying**  
 43 **employer.**

44 **SECTION 2.** ORS 656.283 is amended to read:

45 656.283. (1) Subject to ORS 656.319, any party or the Director of the Department of Consumer

1 and Business Services may at any time request a hearing on any matter concerning a claim, except  
 2 matters for which a procedure for resolving the dispute is provided in another statute, including  
 3 ORS 656.704.

4 *[(2)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a  
 5 high degree of cooperation between all of the participants in the vocational assistance process. Based  
 6 on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent  
 7 of vocational assistance services should be resolved through nonadversarial procedures to the greatest  
 8 extent possible consistent with constitutional principles. The director is hereby charged with the duty  
 9 of creating a procedure for resolving vocational assistance disputes in the manner provided in this  
 10 subsection.]*

11 *[(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding  
 12 vocational assistance, the worker must apply to the director for administrative review of the matter.  
 13 Such application must be made not later than the 60th day after the date the worker was notified of  
 14 the action. The director shall complete the review within a reasonable time. If the worker's dissatis-  
 15 faction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the di-  
 16 rector and the parties shall review the agreement and either approve or disapprove it. If the worker's  
 17 dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a  
 18 written order containing findings of fact and conclusions of law. The order shall be based on a record  
 19 sufficient to permit review under paragraph (c) of this subsection. For purposes of this subsection, the  
 20 term "parties" does not include a noncomplying employer.]*

21 *[(c) Director approval of an agreement resolving a vocational assistance matter shall be subject to  
 22 reconsideration by the director under limitations prescribed by the director, but shall not be subject to  
 23 review by any other forum. When the director issues an order after review under paragraph (b) of this  
 24 subsection, the order shall be subject to review under ORS 656.704. At the contested case hearing, the  
 25 decision of the director's administrative review shall be modified only if it:]*

26 *[(A) Violates a statute or rule;]*

27 *[(B) Exceeds the statutory authority of the agency;]*

28 *[(C) Was made upon unlawful procedure; or]*

29 *[(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.]*

30 *[(d) An appeal of the director's administrative review under paragraph (b) of this subsection must  
 31 be made within 60 days of the review issue date.]*

32 **[(3)] (2)** A request for hearing may be made by any writing, signed by or on behalf of the party  
 33 and including the address of the party, requesting the hearing, stating that a hearing is desired, and  
 34 mailed to the Workers' Compensation Board.

35 **[(4)] (3)(a)** The board shall refer the request for hearing to an Administrative Law Judge for  
 36 determination as expeditiously as possible. The hearing shall be scheduled for a date not more than  
 37 90 days after receipt by the board of the request for hearing. The hearing may not be postponed:

38 (A) Except in extraordinary circumstances beyond the control of the requesting party; and

39 (B) For more than 120 days after the date of the postponed hearing.

40 (b) When a hearing set pursuant to paragraph (a) of this subsection is postponed because of the  
 41 need to join one or more potentially responsible employers or insurers, the assigned Administrative  
 42 Law Judge shall reschedule the hearing as expeditiously as possible after all potentially responsible  
 43 employers and insurers have been joined in the proceeding and the medical record has been fully  
 44 developed. The board shall adopt rules for hearings on claims involving one or more potentially re-  
 45 sponsible employers and insurers that:

1 (A) Require the parties to participate in any prehearing conferences required to expedite the  
 2 hearing; and

3 (B) Authorize the Administrative Law Judge conducting the hearing to:

4 (i) Establish a prehearing schedule for investigation of the claim, including but not limited to  
 5 the interviewing of the claimant;

6 (ii) Make prehearing rulings necessary to promote full discovery and completion of the medical  
 7 record required for determination of the issues arising from the claim; and

8 (iii) Specify what is required of the claimant to meet the obligation to reasonably cooperate with  
 9 the investigation of claims.

10 (c) Nothing in paragraph (b) of this subsection alters the obligation of an insurer or self-insured  
 11 employer to accept or deny a claim for compensation as required under this chapter.

12 (d) If a hearing has been postponed in accordance with paragraph (b) of this subsection:

13 (A) The director may not consider the timeliness of a denial issued in the claim that is the  
 14 subject of the hearing for the purpose of imposing a penalty against an insurer or self-insured em-  
 15 ployer that is potentially responsible for the claim; and

16 (B) The 120-day maximum postponement established under paragraph (a) of this subsection for  
 17 rescheduling a hearing does not apply.

18 [(5)(a)] (4)(a) At least 60 days' prior notice of the time and place of hearing shall be given to  
 19 all parties in interest by mail. Hearings shall be held in the county where the worker resided at the  
 20 time of the injury or such other place selected by the Administrative Law Judge.

21 (b) The 60-day prior notice required by paragraph (a) of this subsection:

22 (A) May be waived by agreement of the parties and the board if waiver of the notice will result  
 23 in an earlier date for the hearing.

24 (B) Does not apply to hearings in cases assigned to the Expedited Claim Service under ORS  
 25 656.291, cases involving stayed compensation under ORS 656.313 (1)(b) and requests for hearing that  
 26 are consolidated with an existing case with an existing hearing date.

27 [(6)] (5) A record of all proceedings at the hearing shall be kept but need not be transcribed  
 28 unless a party requests a review of the order of the Administrative Law Judge. Transcription shall  
 29 be in written form as provided by ORS 656.295 (3).

30 [(7)] (6) Except as otherwise provided in this section and rules of procedure established by the  
 31 board, the Administrative Law Judge is not bound by common law or statutory rules of evidence  
 32 or by technical or formal rules of procedure, and may conduct the hearing in any manner that will  
 33 achieve substantial justice. Neither the board nor an Administrative Law Judge may prevent a party  
 34 from withholding impeachment evidence until the opposing party's case in chief has been presented,  
 35 at which time the impeachment evidence may be used. Impeachment evidence consisting of medical  
 36 or vocational reports not used during the course of a hearing must be provided to any opposing  
 37 party at the conclusion of the presentation of evidence and before closing arguments are presented.  
 38 Impeachment evidence other than medical or vocational reports that is not presented as evidence  
 39 at hearing is not subject to disclosure. Evaluation of the worker's disability by the Administrative  
 40 Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268.  
 41 Any finding of fact regarding the worker's impairment must be established by medical evidence that  
 42 is supported by objective findings. The Administrative Law Judge shall apply to the hearing of the  
 43 claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS  
 44 656.726. Evidence on an issue regarding a notice of closure that was not submitted at the reconsid-  
 45 eration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a

1 party to the reconsideration may not be raised at hearing unless the issue arises out of the recon-  
 2 sideration order itself. However, nothing in this section shall be construed to prevent or limit the  
 3 right of a worker, insurer or self-insured employer to present the reconsideration record at hearing  
 4 to establish by a preponderance of that evidence that the standards adopted pursuant to ORS  
 5 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the recon-  
 6 sideration order pursuant to ORS 656.268. If the Administrative Law Judge finds that the claim has  
 7 been closed prematurely, the Administrative Law Judge shall issue an order rescinding the notice  
 8 of closure.

9 ~~[(8)]~~ (7) Any party shall be entitled to issuance and service of subpoenas under the provisions  
 10 of ORS 656.726 (2)(c). Any party or representative of the party may serve such subpoenas.

11 ~~[(9)]~~ (8) After a party requests a hearing and before the hearing commences, the board, by rule,  
 12 may require the requesting party, if represented by an attorney, to notify the Administrative Law  
 13 Judge in writing that the attorney has conferred with the other party and that settlement has been  
 14 achieved, subject to board approval, or that settlement cannot be achieved.

15 **SECTION 3.** ORS 656.262 is amended to read:

16 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-  
 17 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing  
 18 claims as required in this chapter.

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

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

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

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

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

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

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

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

35 (4)(a) The first installment of temporary disability compensation shall be paid no later than the  
 36 14th day after the subject employer has notice or knowledge of the claim, if the attending physician  
 37 or nurse practitioner authorized to provide compensable medical services under ORS 656.245 au-  
 38 thORIZES the payment of temporary disability compensation. Thereafter, temporary disability com-  
 39 pensation shall be paid at least once each two weeks, except where the Director of the Department  
 40 of Consumer and Business Services determines that payment in installments should be made at some  
 41 other interval. The director may by rule convert monthly benefit schedules to weekly or other pe-  
 42 riodic schedules.

43 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an  
 44 injured worker who becomes disabled the same wage at the same pay interval that the worker re-  
 45 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability

1 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

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

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

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

20 (f) If the insurer or self-insured employer has requested and failed to receive from the worker’s  
21 attending physician or nurse practitioner authorized to provide compensable medical services under  
22 ORS 656.245 verification of the worker’s inability to work resulting from the claimed injury or dis-  
23 ease, medical services provided by the attending physician or nurse practitioner are not  
24 compensable until the attending physician or nurse practitioner 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 or nurse practitioner authorized to provide compensable medical ser-  
27 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-  
28 thorized by the attending physician or nurse practitioner. No authorization of temporary disability  
29 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective  
30 to retroactively authorize the payment of temporary disability more than 14 days prior to its issu-  
31 ance.

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

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

42 (5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per  
43 claim not to exceed the maximum amount established annually by the Director of the Department  
44 of Consumer and Business Services, for medical services for nondisabling claims, may be made by  
45 the subject employer if the employer so chooses. The making of such payments does not constitute



1 a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer  
 2 chooses to make such payment, the employer shall report the injury to the insurer in the same  
 3 manner that other injuries are reported. However, an insurer shall not modify an employer's expe-  
 4 rience rating or otherwise make charges against the employer for any medical expenses paid by the  
 5 employer pursuant to this subsection.

6 (b) To establish the maximum amount an employer may pay for medical services for nondisabling  
 7 claims under paragraph (a) of this subsection, the director shall use \$1,500 as the base compensation  
 8 amount and shall adjust the base compensation amount annually to reflect changes in the United  
 9 States City Average Consumer Price Index for All Urban Consumers for Medical Care for July of  
 10 each year as published by the Bureau of Labor Statistics of the United States Department of Labor.  
 11 The adjustment shall be rounded to the nearest multiple of \$100.

12 (c) The adjusted amount established under paragraph (b) of this subsection shall be effective on  
 13 January 1 following the establishment of the amount and shall apply to claims with a date of injury  
 14 on or after the effective date of the adjusted amount.

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

39 (b) The notice of acceptance shall:

40 (A) Specify what conditions are compensable.

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

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

45 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS

1 chapter 659A.

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

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

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

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

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

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

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

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

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

45 (10) Merely paying or providing compensation shall not be considered acceptance of a claim or

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

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

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

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

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

36 (14) If the director finds that a worker fails to reasonably cooperate with an investigation in-  
37 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the  
38 claim for a worsened condition, the director shall suspend all or part of the payment of compen-  
39 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after  
40 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure  
41 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim  
42 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the  
43 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the  
44 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291  
45 that the worker fully and completely cooperated with the investigation, that the worker failed to

1 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-  
 2 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-  
 3 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain  
 4 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-  
 5 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order  
 6 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or  
 7 self-insured employer to accept or deny the claim.

8 (15) In accordance with ORS [656.283 (4)] **656.283 (3)**, the Administrative Law Judge assigned a  
 9 request for hearing for a claim for compensation involving more than one potentially responsible  
 10 employer or insurer may specify what is required of an injured worker to reasonably cooperate with  
 11 the investigation of the claim as required by subsection (13) of this section.

12 **SECTION 4.** ORS 656.313 is amended to read:

13 656.313. (1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration  
 14 order before the Hearings Division, a request for Workers' Compensation Board review or court  
 15 appeal or request for review of an order of the Director of the Department of Consumer and Busi-  
 16 ness Services regarding vocational assistance stays payment of the compensation appealed, except  
 17 for:

18 (A) Temporary disability benefits that accrue from the date of the order appealed from until  
 19 closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first  
 20 occurs;

21 (B) Permanent total disability benefits that accrue from the date of the order appealed from until  
 22 the order appealed from is reversed;

23 (C) Death benefits payable to a surviving spouse prior to remarriage, to children or dependents  
 24 that accrue from the date of the order appealed from until the order appealed from is reversed; and

25 (D) Vocational benefits ordered by the director pursuant to ORS [656.283 (2)] **656.340 (16)**. If a  
 26 denial of vocational benefits is upheld by a final order, the insurer or self-insured employer shall  
 27 be reimbursed from the Workers' Benefit Fund pursuant to ORS 656.605 for all costs incurred in  
 28 providing vocational benefits as a result of the order that was appealed.

29 (b) If ultimately found payable under a final order, benefits withheld under this subsection shall  
 30 accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through  
 31 the date of payment. The board shall expedite review of appeals in which payment of compensation  
 32 has been stayed under this section.

33 (2) If the board or court subsequently orders that compensation to the claimant should not have  
 34 been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not  
 35 be obligated to repay any such compensation which was paid pending the review or appeal.

36 (3) If an insurer or self-insured employer denies the compensability of all or any portion of a  
 37 claim submitted for medical services, the insurer or self-insured employer shall send notice of the  
 38 denial to each provider of such medical services and to any provider of health insurance for the  
 39 injured worker. Except for medical services payable in accordance with ORS 656.247, after receiving  
 40 notice of the denial, a medical service provider may submit medical reports and bills for the disputed  
 41 medical services to the provider of health insurance for the injured worker. The health insurance  
 42 provider shall pay all such bills in accordance with the limits, terms and conditions of the policy.  
 43 If the injured worker has no health insurance, such bills may be submitted to the injured worker.  
 44 A provider of disputed medical services shall make no further effort to collect disputed medical  
 45 service bills from the injured worker until the issue of compensability of the medical services has

1 been finally determined.

2 (4) Except for medical services payable in accordance with ORS 656.247:

3 (a) When the compensability issue has been finally determined or when disposition or settlement  
 4 of the claim has been made pursuant to ORS 656.236 or 656.289 (4), the insurer or self-insured em-  
 5 ployer shall notify each affected service provider and health insurance provider of the results of the  
 6 disposition or settlement.

7 (b) If the services are determined to be compensable, the insurer or self-insured employer shall  
 8 reimburse each health insurance provider for the amount of claims paid by the health insurance  
 9 provider pursuant to this section. Such reimbursement shall be in addition to compensation or  
 10 medical benefits the worker receives. Medical service reimbursement shall be paid directly to the  
 11 health insurance provider.

12 (c) If the services are settled pursuant to ORS 656.289 (4), the insurer or self-insured employer  
 13 shall reimburse, out of the settlement proceeds, each medical service provider for billings received  
 14 by the insurer or self-insured employer on and before the date on which the terms of settlement are  
 15 agreed as specified in the settlement document that are not otherwise partially or fully reimbursed.

16 (d) Reimbursement under this section shall be made only for medical services related to the  
 17 claim that would be compensable under this chapter if the claim were compensable and shall be  
 18 made at one-half the amount provided under ORS 656.248. In no event shall reimbursement made to  
 19 medical service providers exceed 40 percent of the total present value of the settlement amount,  
 20 except with the consent of the worker. If the settlement proceeds are insufficient to allow each  
 21 medical service provider the reimbursement amount authorized under this subsection, the insurer  
 22 or self-insured employer shall reduce each provider's reimbursement by the same proportional  
 23 amount. Reimbursement under this section shall not prevent a medical service provider or health  
 24 insurance provider from recovering the balance of amounts owing for such services directly from the  
 25 worker.

26 (5) As used in this section, "health insurance" has the meaning for that term provided in ORS  
 27 731.162.

28 **SECTION 5.** ORS 656.704 is amended to read:

29 656.704. (1) Actions and orders of the Director of the Department of Consumer and Business  
 30 Services regarding matters concerning a claim under this chapter, and administrative and judicial  
 31 review of those matters, are subject to the procedural provisions of this chapter and such procedural  
 32 rules as the Workers' Compensation Board may prescribe.

33 (2)(a) A party dissatisfied with an action or order regarding a matter other than a matter con-  
 34 cerning a claim under this chapter may request a hearing on the matter in writing to the director.  
 35 The director shall refer the request for hearing to the Workers' Compensation Board for a hearing  
 36 before an Administrative Law Judge. Review of an order issued by the Administrative Law Judge  
 37 shall be by the director and the director shall issue a final order that is subject to judicial review  
 38 as provided by ORS 183.480 to 183.497.

39 (b) The director shall prescribe the classes of orders issued under this subsection by Adminis-  
 40 trative Law Judges and other personnel that are final, appealable orders and those orders that are  
 41 preliminary orders subject to revision by the director.

42 (3)(a) For the purpose of determining the respective authority of the director and the board to  
 43 conduct hearings, investigations and other proceedings under this chapter, and for determining the  
 44 procedure for the conduct and review thereof, matters concerning a claim under this chapter are  
 45 those matters in which a worker's right to receive compensation, or the amount thereof, are directly

1 in issue. However, subject to paragraph (b) of this subsection, such matters do not include any dis-  
 2 putes arising under ORS 656.245, 656.247, 656.248, 656.260 or 656.327, any other provisions directly  
 3 relating to the provision of medical services to workers or any disputes arising under ORS 656.340  
 4 except as those provisions may otherwise provide.

5 (b) The respective authority of the board and the director to resolve medical service disputes  
 6 shall be determined according to the following principles:

7 (A) Any dispute that requires a determination of the compensability of the medical condition for  
 8 which medical services are proposed is a matter concerning a claim.

9 (B) Any dispute that requires a determination of whether medical services are excessive, inap-  
 10 propriate, ineffectual or in violation of the rules regarding the performance of medical services, or  
 11 a determination of whether medical services for an accepted condition qualify as compensable med-  
 12 ical services among those listed in ORS 656.245 (1)(c), is not a matter concerning a claim.

13 (C) Any dispute that requires a determination of whether a sufficient causal relationship exists  
 14 between medical services and an accepted claim to establish compensability is a matter concerning  
 15 a claim.

16 (c) Notwithstanding ORS [~~656.283 (4)~~] **656.283 (3)**, if parties to a hearing scheduled before an  
 17 Administrative Law Judge are involved in a dispute regarding both matters concerning a claim and  
 18 matters not concerning a claim, the Administrative Law Judge may defer any action on the matter  
 19 concerning a claim until the director has completed an administrative review of the matters other  
 20 than those concerning a claim. The director shall mail a copy of the administrative order to the  
 21 parties and to the Administrative Law Judge. A party may request a hearing on the order of the  
 22 director. At the request of a party or by the own motion of the Administrative Law Judge, the  
 23 hearings on the separate matters may be consolidated. The Administrative Law Judge shall issue  
 24 an order for those matters concerning a claim and a separate order for matters other than those  
 25 concerning a claim.

26 (4) Hearings under ORS 656.740 shall be conducted by an Administrative Law Judge from the  
 27 board's Hearings Division.

28 (5) If a request for hearing or administrative review is filed with either the director or the board  
 29 and it is determined that the request should have been filed with the other, the dispute shall be  
 30 transferred. Filing a request will be timely filed if the original filing was completed within the pre-  
 31 scribed time.

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