

House Bill 2092

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Pre-session filed (at the request of Governor John A. Kitzhaber 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**.

Clarifies exclusive remedy provisions of workers' compensation laws. Provides for administrative review of certain matters arising under workers' compensation laws and rules.

Modifies manner in which notice of compliance is made available to subject employers.

Eliminates requirement for consultation with certain professional licensing boards when rules are adopted concerning appropriateness of certain types of medical treatment. Allows medical service providers to seek resolution of medical service disputes through same process as workers, employers and insurers.

Restores authority of Director of Department of Consumer and Business Services to extend temporary disability compensation paid to workers in vocational training.

A BILL FOR AN ACT

1
2 Relating to workers' compensation; creating new provisions; and amending ORS 656.018, 656.054,
3 656.056, 656.245, 656.247, 656.260, 656.262, 656.327, 656.340 and 656.704.

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

5 **SECTION 1.** ORS 656.018 is amended to read:

6 656.018. (1)(a) The liability of every employer who satisfies the duty required by ORS 656.017 (1)
7 is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes
8 or similar conditions arising out of and in the course of employment that are sustained by subject
9 workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the em-
10 ployer on account of such conditions or claims resulting therefrom, specifically including claims for
11 contribution or indemnity asserted by third persons from whom damages are sought on account of
12 such conditions, except as specifically provided otherwise in this chapter.

13 (b) This subsection shall not apply to claims for indemnity or contribution asserted by a rail-
14 road, as defined in ORS 824.020, or by a corporation, individual or association of individuals which
15 is subject to regulation pursuant to ORS chapter 757 or 759.

16 (c) Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary
17 to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.

18 (2) The rights given to a subject worker and the beneficiaries of the subject worker under this
19 chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the
20 course of employment are in lieu of any remedies they might otherwise have for such injuries, dis-
21 eases, symptom complexes or similar conditions against the worker's employer under ORS 654.305
22 to 654.336 or other laws, common law or statute, except to the extent the worker is expressly given
23 the right under this chapter to bring suit against the employer of the worker for an injury, disease,
24 symptom complex or similar condition.

25 (3) The exemption from liability given an employer under this section is also extended to the
26 employer's insurer, the self-insured employer's claims administrator, the Department of Consumer
27 and Business Services, and the contracted agents, employees, officers and directors of the employer,

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 the employer's insurer, the self-insured employer's claims administrator and the department, except
 2 that the exemption from liability shall not apply:

3 (a) Where the injury, disease, symptom complex or similar condition is proximately caused by
 4 willful and unprovoked aggression by the person otherwise exempt under this subsection;

5 (b) Where the worker and the person otherwise exempt under this subsection are not engaged
 6 in the furtherance of a common enterprise or the accomplishment of the same or related objectives;
 7 or

8 (c) Where the injury, disease, symptom complex or similar condition is proximately caused by
 9 failure of the employer to comply with the notice posted pursuant to ORS 654.082.

10 (4) The exemption from liability given an employer under this section applies to a worker leasing
 11 company and the client to whom workers are provided when the worker leasing company and the
 12 client comply with ORS 656.850 (3).

13 (5)(a) The exemption from liability given an employer under this section applies to a temporary
 14 service provider, as that term is used in ORS 656.850, and also extends to the client to whom
 15 workers are provided when the temporary service provider complies with ORS 656.017.

16 (b) The exemption from liability given a client under paragraph (a) of this subsection is also
 17 extended to the client's insurer, the self-insured client's claims administrator, the department, and
 18 the contracted agents, employees, officers and directors of the client, the client's insurer, the self-
 19 insured client's claims administrator and the department, except that the exemption from liability
 20 shall not apply:

21 (A) When the injury, disease, symptom complex or similar condition is proximately caused by
 22 willful and unprovoked aggression by the person otherwise exempt under this subsection;

23 (B) When the worker and the person otherwise exempt under this subsection are not engaged
 24 in the furtherance of a common enterprise or the accomplishment of the same or related objectives;
 25 or

26 (C) When the injury, disease, symptom complex or similar condition is proximately caused by
 27 failure of the client to comply with the notice posted pursuant to ORS 654.082.

28 (6) Nothing in this chapter shall prohibit payment, voluntarily or otherwise, to injured workers
 29 or their beneficiaries in excess of the compensation required to be paid under this chapter.

30 (7) The exclusive remedy provisions and limitation on liability provisions of this chapter apply
 31 to all injuries and to diseases, symptom complexes or similar conditions of subject workers arising
 32 out of and in the course of employment whether or not they are determined to be compensable under
 33 this chapter.

34 **(8) Except as otherwise provided in this chapter, this chapter provides the exclusive**
 35 **remedy for resolution of disputes arising under the workers' compensation laws and rules**
 36 **of this state.**

37 **SECTION 2.** ORS 656.056 is amended to read:

38 656.056. (1) All subject employers shall display in a conspicuous manner about their works, and
 39 in a sufficient number of places reasonably to inform their workers of the fact, [*printed notices fur-*
 40 *nished by the Director of the Department of Consumer and Business Services*] **a notice** stating that
 41 they are subject to this chapter and the manner of their compliance with this chapter.

42 (2) [No] **An** employer who is not currently a subject employer [*shall*] **may not** post, or permit
 43 to remain on or about the place of business or premises of the employer, any notice that the em-
 44 ployer is subject to, and complying with, this chapter.

45 **(3) The Director of the Department of Consumer and Business Services shall prescribe**

1 **by rule the manner by which the notice required under subsection (1) of this section shall**
 2 **be provided to subject employers.**

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

4 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
 5 to be provided medical services for conditions caused in material part by the injury for such period
 6 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
 7 656.225, including such medical services as may be required after a determination of permanent
 8 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
 9 insurer or the self-insured employer shall cause to be provided only those medical services directed
 10 to medical conditions caused in major part by the injury.

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

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

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

20 (B) Prescription medications.

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

23 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

44 (d) When the medically stationary date in a disabling claim is established by the insurer or
 45 self-insured employer and is not based on the findings of the attending physician, the insurer or

1 self-insured employer is responsible for reimbursement to affected medical service providers for
2 otherwise compensable services rendered until the insurer or self-insured employer provides written
3 notice to the attending physician of the worker's medically stationary status.

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

11 (2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
12 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
13 may subsequently change attending physician or nurse practitioner two times without approval from
14 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
15 insurer or self-insured employer may require the director's approval of the selection. The decision
16 of the director is subject to review under ORS 656.704. The worker also may choose an attending
17 doctor or physician in another country or in any state or territory or possession of the United
18 States with the prior approval of the insurer or self-insured employer.

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

21 (A) A medical service provider who is not qualified to be an attending physician may provide
22 compensable medical service to an injured worker for a period of 30 days from the date of the first
23 visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an
24 attending physician. Thereafter, medical service provided to an injured worker without the written
25 authorization of an attending physician is not compensable.

26 (B) A medical service provider who is not an attending physician cannot authorize the payment
27 of temporary disability compensation. However, an emergency room physician who is not authorized
28 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
29 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
30 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
31 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

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

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

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

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

42 (iii) When an injured worker treating with a nurse practitioner authorized to provide
43 compensable services under this section becomes medically stationary within the 90-day period in
44 which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker
45 to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of

1 making findings regarding the worker's impairment for the purpose of evaluating the worker's disa-
2 bility. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a
3 possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an
4 attending physician and the insurer shall compensate the nurse practitioner for the examination
5 performed.

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

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

14 (a) Those workers who are subject to the contract shall receive medical services in the manner
15 prescribed in the contract. Workers subject to the contract include those who are receiving medical
16 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
17 jury or medically stationary status, on or after the effective date of the contract. If the managed
18 care organization determines that the change in provider would be medically detrimental to the
19 worker, the worker shall not become subject to the contract until the worker is found to be med-
20 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
21 ganization determines that the change in provider is no longer medically detrimental, whichever
22 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
23 notice of the worker's enrollment in the managed care organization, or upon the third day after the
24 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
25 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
26 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
27 vide compensable medical services under this section under an expired or terminated managed care
28 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
29 and conditions regarding services performed under any subsequent managed care organization con-
30 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
31 primary residence is more than 100 miles outside the managed care organization's certified ge-
32 ographical area. Each such contract must comply with the certification standards provided in ORS
33 656.260. However, a worker may receive immediate emergency medical treatment that is
34 compensable from a medical service provider who is not a member of the managed care organization.
35 Insurers or self-insured employers who contract with a managed care organization for medical ser-
36 vices shall give notice to the workers of eligible medical service providers and such other informa-
37 tion regarding the contract and manner of receiving medical services as the director may prescribe.
38 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
39 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
40 as a processing agent or the assigned claims agent and a managed care organization.

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

44 (B) If the insurer or self-insured employer gives notice that the worker is required to receive
45 treatment from the managed care organization, the insurer or self-insured employer must guarantee

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

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

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

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

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

28 **SECTION 4.** 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 **or person** dissatisfied with an action or order **of the director** regarding a matter
 34 **in which the party or person has participated and that is a matter** other than a matter con-
 35 cerning a claim under this chapter may request a hearing on the matter in writing to the director.
 36 The director shall refer the request for hearing to the Workers' Compensation Board for a hearing
 37 before an Administrative Law Judge. Review of an order issued by the Administrative Law Judge
 38 shall be by the director and the director shall issue a final order that is subject to judicial review
 39 as provided by ORS 183.480 to 183.497.

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

43 (3) **If a process for review of a matter other than a matter concerning a claim is not**
 44 **specifically provided for in this chapter, administrative review of the matter shall rest ex-**
 45 **clusively with the director. A party or person must request administrative review in writing**

1 **to the director. Review of the administrative order shall be as provided in subsection (2) of**
 2 **this section.**

3 [(3)(a)] (4)(a) For the purpose of determining the respective authority of the director and the
 4 board to conduct hearings, investigations and other proceedings under this chapter, and for deter-
 5 mining the procedure for the conduct and review thereof, matters concerning a claim under this
 6 chapter are those matters in which a worker's right to receive compensation, or the amount thereof,
 7 are directly in issue. However, subject to paragraph (b) of this subsection, such matters do not in-
 8 clude any disputes arising under ORS 656.245, 656.247, 656.248, 656.260 or 656.327, any other pro-
 9 visions directly relating to the provision of medical services to workers or any disputes arising
 10 under ORS 656.340 except as those provisions may otherwise provide.

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

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

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

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

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

31 [(4)] (5) Hearings under ORS 656.740 shall be conducted by an Administrative Law Judge from
 32 the board's Hearings Division.

33 [(5)] (6) If a request for hearing or administrative review is filed with either the director or the
 34 board and it is determined that the request should have been filed with the other, the dispute shall
 35 be transferred. Filing a request will be timely filed if the original filing was completed within the
 36 prescribed time.

37 **SECTION 5.** ORS 656.054 is amended to read:

38 656.054. (1) A compensable injury to a subject worker while in the employ of a noncomplying
 39 employer is compensable to the same extent as if the employer had complied with this chapter. The
 40 Director of the Department of Consumer and Business Services shall refer the claim for such an
 41 injury to an assigned claims agent within 60 days of the date the director has notice of the claim.
 42 At the time of referral of the claim, the director shall notify the employer in writing regarding the
 43 referral of the claim and the employer's right to object to the claim. A claim for compensation made
 44 by such a worker shall be processed by the assigned claims agent in the same manner as a claim
 45 made by a worker employed by a carrier-insured employer, except that the time within which the

1 first installment of compensation is to be paid, pursuant to ORS 656.262 (4), shall not begin to run
 2 until the director has referred the claim to the assigned claims agent. At any time within which
 3 the claim may be accepted or denied as provided in ORS 656.262, the employer may request a
 4 hearing to object to the claim. If an order becomes final holding the claim to be compensable, the
 5 employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid
 6 to the worker's attorney for services rendered in connection with the employer's objection to the
 7 claim.

8 (2) In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all
 9 costs to the Workers' Benefit Fund incurred under subsection (1) of this section shall be a liability
 10 of the noncomplying employer. Such costs include compensation, disputed claim settlements pursuant
 11 to ORS 656.289 and claim disposition agreements pursuant to ORS 656.236, whether or not the non-
 12 complying employer agrees and executes such documents, reasonable administrative costs and claims
 13 processing costs provided by contract, attorney fees related to compensability issues and any attor-
 14 ney fees awarded to the claimant, but do not include assessments for reserves in the Workers'
 15 Benefit Fund. The director shall recover such costs from the employer. The director periodically
 16 shall pay the assigned claims agent from the Workers' Benefit Fund for any costs the assigned
 17 claims agent incurs under this section in accordance with the terms of the contract. When the di-
 18 rector prevails in any action brought pursuant to this subsection, the director is entitled to recover
 19 from the noncomplying employer court costs and attorney fees incurred by the director.

20 (3) Periodically, or upon the request of a noncomplying employer in a particular claim, the di-
 21 rector shall audit the files of the State Accident Insurance Fund Corporation and any assigned
 22 claims agents to validate the amount reimbursed pursuant to subsection (2) of this section. The
 23 conditions for granting or denying of reimbursement shall be specified in the contract with the as-
 24 signed claims agent. The contract at least shall provide for denial of reimbursement if, upon such
 25 audit, any of the following are found to apply:

26 (a) Compensation has been paid as a result of untimely, inaccurate, or improper claims pro-
 27 cessing;

28 (b) Compensation has been paid negligently for treatment of any condition unrelated to the
 29 compensable condition;

30 (c) The compensability of an accepted claim is questionable and the rationale for acceptance has
 31 not been reasonably documented in accordance with generally accepted claims management proce-
 32 dures;

33 (d) The separate payments of compensation have not been documented in accordance with gen-
 34 erally accepted accounting procedures; or

35 (e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236
 36 without the prior approval of the director.

37 (4) The State Accident Insurance Fund Corporation and any assigned claims agent may request
 38 [review] a **hearing** under ORS 656.704 of any disapproval of reimbursement made by the director
 39 under this section.

40 (5) Claims of injured workers of noncomplying employers may be assigned and reassigned by the
 41 director for claims processing regardless of the date of the worker's injury.

42 (6) In selecting an assigned claims agent, the director must consider the assigned claims agent's
 43 ability to deliver timely and appropriate benefits to injured workers, the ability to control both
 44 claims cost and administrative cost and such other factors as the director considers appropriate.

45 (7) If no qualified entity agrees to be an assigned claims agent, the director may require one or

1 more of the three highest premium producing insurers to be assigned claims agents.
 2 Notwithstanding any other provision of law, the director's selection of assigned claims agents shall
 3 be made at the sole discretion of the director. Such selections shall not be subject to review by any
 4 court or other administrative body.

5 (8) Any assigned claims agent, except the State Accident Insurance Fund Corporation, may em-
 6 ploy legal counsel of its choice for representation under this section.

7 (9) As used in this section, "assigned claims agent" means an insurer, casualty adjuster or a
 8 third party administrator with whom the director contracts to manage claims of injured workers of
 9 noncomplying employers.

10 **SECTION 6.** ORS 656.247 is amended to read:

11 656.247. (1) Except for medical services provided to workers subject to ORS 656.245 (4)(b)(B),
 12 payment for medical services provided to a subject worker in response to an initial claim for a
 13 work-related injury or occupational disease from the date of the employer's notice or knowledge of
 14 the claim until the date the claim is accepted or denied shall be payable in accordance with sub-
 15 section (4) of this section if the expenses are for:

16 (a) Diagnostic services required to identify appropriate treatment or to prevent disability;

17 (b) Medication required to alleviate pain; or

18 (c) Services required to stabilize the worker's claimed condition and to prevent further disabil-
 19 ity.

20 (2) Notwithstanding subsection (1) of this section, no payment shall be due from the insurer or
 21 self-insured employer if the insurer or self-insured employer denies the claim within 14 days of the
 22 date of the employer's notice or knowledge of the claim.

23 (3)(a) Disputes about whether the medical services provided to treat the claimed work-related
 24 injury or occupational disease under subsection (1) of this section are excessive, inappropriate or
 25 ineffectual or are consistent with the criteria in subsection (1) of this section shall be resolved by
 26 the Director of the Department of Consumer and Business Services. The director may order a med-
 27 ical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review
 28 of such services. If a party is dissatisfied with the order of the director, the dissatisfied party may
 29 request *[review]* a **hearing** under ORS 656.704 within 60 days of the date of the director's order. The
 30 order of the director may be modified only if it is not supported by substantial evidence in the re-
 31 cord or if it reflects an error of law.

32 (b) Disputes about the amount of the fee or nonpayment of bills for medical treatment and ser-
 33 vices pursuant to this section shall be resolved pursuant to ORS 656.248.

34 (c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS
 35 656.289 (4), all medical services payable under subsection (1) of this section that are provided on or
 36 before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer
 37 or self-insured employer shall notify each affected service provider of the results of the settlement.

38 (4)(a) If the claim in which medical services are provided under subsection (1) of this section is
 39 accepted, the insurer or self-insured employer shall make payment for such medical services subject
 40 to the limitations and conditions of this chapter.

41 (b) If the claim in which medical services are provided under subsection (1) of this section is
 42 denied and a health benefit plan provides benefits to the worker, the health benefit plan shall be the
 43 first payer of the expenses for medical services according to the terms, conditions and benefits of
 44 the plan. Except as provided by subsection (2) of this section, after payment by the health benefit
 45 plan, the workers' compensation insurer or self-insured employer shall pay any balance remaining

1 for such services subject to the limitations and conditions of this chapter.

2 (c) As used in this subsection, “health benefit plan” has the meaning given that term in ORS
3 743.730.

4 (5) An insurer or self-insured employer may recover expenses for medical services paid under
5 subsection (1) of this section as an overpayment as provided by ORS 656.268 (13)(a).

6 **SECTION 7.** ORS 656.260 is amended to read:

7 656.260. (1) Any health care provider or group of medical service providers may make written
8 application to the Director of the Department of Consumer and Business Services to become certi-
9 fied to provide managed care to injured workers for injuries and diseases compensable under this
10 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
11 erated by an insurer or employer other than a health care provider to become certified to provide
12 managed care.

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

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

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

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

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

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

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

29 (a) Proposes to provide medical and health care services required by this chapter in a manner
30 that:

31 (A) Meets quality, continuity and other treatment standards adopted by the health care provider
32 or group of medical service providers in accordance with processes approved by the director; and

33 (B) Is timely, effective and convenient for the worker.

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

40 (c) Provides appropriate financial incentives to reduce service costs and utilization without
41 sacrificing the quality of service.

42 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
43 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
44 or excessive treatment, to exclude from participation in the plan those individuals who violate these
45 treatment standards and to provide for the resolution of such medical disputes as the director con-

1 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
2 zation and contract review committee shall be physicians licensed to practice medicine by the
3 Oregon Medical Board. As used in this paragraph:

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

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

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

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

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

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

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

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

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

40 (i) Does not prohibit the injured worker's attending physician from advocating for medical ser-
41 vices and temporary disability benefits for the injured worker that are supported by the medical
42 record.

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

45 (5) The director shall refuse to certify or may revoke or suspend the certification of any health

1 care provider or group of medical service providers to provide managed care if the director finds
2 that:

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

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

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

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

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

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

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

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

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

40 (13) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care or-
41 ganization contract may designate any medical service provider or category of providers as attend-
42 ing physicians.

43 (14) If a worker, insurer, self-insured employer or the attending physician is dissatisfied with an
44 action of the managed care organization regarding the provision of medical services pursuant to this
45 chapter, peer review, service utilization review or quality assurance activities, that person or entity

1 must first apply to the director for administrative review of the matter before requesting a hearing.
2 Such application must be made not later than the 60th day after the date the managed care organ-
3 ization has completed and issued its final decision.

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

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

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

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

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

24 **SECTION 8.** ORS 656.262 is amended to read:

25 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
26 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
27 claims as required in this chapter.

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

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

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

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

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

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

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

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

44 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
45 14th day after the subject employer has notice or knowledge of the claim, if the attending physician

1 or nurse practitioner authorized to provide compensable medical services under ORS 656.245 au-
2 thORIZES the payment of temporary disability compensation. Thereafter, temporary disability com-
3 pensation shall be paid at least once each two weeks, except where the Director of the Department
4 of Consumer and Business Services determines that payment in installments should be made at some
5 other interval. The director may by rule convert monthly benefit schedules to weekly or other pe-
6 riodic schedules.

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

11 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
12 injured in the course and scope of that public office, full official salary paid to the holder of that
13 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
14 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public
15 office" has the meaning for that term provided in ORS 260.005.

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

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

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

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

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

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

6 (5)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per
7 claim not to exceed the maximum amount established annually by the Director of the Department
8 of Consumer and Business Services, for medical services for nondisabling claims, may be made by
9 the subject employer if the employer so chooses. The making of such payments does not constitute
10 a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer
11 chooses to make such payment, the employer shall report the injury to the insurer in the same
12 manner that other injuries are reported. However, an insurer shall not modify an employer's expe-
13 rience rating or otherwise make charges against the employer for any medical expenses paid by the
14 employer pursuant to this subsection.

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

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

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

1 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
2 a copy of the notice of acceptance.

3 (b) The notice of acceptance shall:

4 (A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
17 pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-
18 insured employer shall be liable for an additional amount up to 25 percent of the amounts then due
19 plus any attorney fees assessed under this section. The fees assessed by the director, an Adminis-
20 trative Law Judge, the board or the court under this section shall be proportionate to the benefit
21 to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee,
22 giving primary consideration to the results achieved and to the time devoted to the case. An attor-
23 ney fee awarded pursuant to this subsection may not exceed \$3,000 absent a showing of extraor-
24 dinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted
25 annually on July 1 by the same percentage increase as made to the average weekly wage defined
26 in ORS 656.211, if any. Notwithstanding any other provision of this chapter, the director shall have
27 exclusive jurisdiction over proceedings regarding solely the assessment and payment of the addi-
28 tional amount and attorney fees described in this subsection. The action of the director [*and the*
29 *review of the action taken by the director*] shall be subject to review under ORS 656.704.

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

33 (12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the
34 insurer or self-insured employer has failed to make the payment in accordance with the requirements
35 specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly no-
36 tify the insurer or self-insured employer in writing that the payment is past due. If the required
37 payment is not made within five business days after receipt of the notice by the insurer or self-
38 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
39 adopted by the director by rule.

40 (b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney
41 fees authorized under this subsection. The matrix shall provide for penalties based on a percentage
42 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of
43 the settlement proceeds allocated to the claimant's attorney as an attorney fee.

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

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

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

30 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for
31 hearing for a claim for compensation involving more than one potentially responsible employer or
32 insurer may specify what is required of an injured worker to reasonably cooperate with the inves-
33 tigation of the claim as required by subsection (14) of this section.

34 **SECTION 9.** ORS 656.327 is amended to read:

35 656.327. (1)(a) If an injured worker, an insurer or self-insured employer or the Director of the
36 Department of Consumer and Business Services believes that the medical treatment, not subject to
37 ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to re-
38 ceive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of
39 medical services, the injured worker, insurer or self-insured employer must request administrative
40 review of the treatment by the director prior to requesting a hearing on the issue and so notify the
41 parties.

42 (b) Unless the director issues an order finding that no bona fide medical services dispute exists,
43 the director shall review the matter as provided in this section. Appeal of an order finding that no
44 bona fide medical services dispute exists shall be made directly to the Workers' Compensation Board
45 within 30 days after issuance of the order. The board shall set aside or remand the order only if the

1 board finds that the order is not supported by substantial evidence in the record. Substantial evi-
2 dence exists to support a finding in the order when the record, reviewed as a whole, would permit
3 a reasonable person to make that finding. The decision of the board is not subject to review by any
4 other court or administrative agency.

5 (c) The insurer or self-insured employer shall not deny the claim for medical services nor shall
6 the worker request a hearing on any issue under this section until the director issues an order un-
7 der subsection (2) of this section.

8 (2) The director shall review medical information and records regarding the treatment. The di-
9 rector may cause an appropriate medical service provider to perform reasonable and appropriate
10 tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS
11 656.325 (1), the worker may refuse a test without sanction. Review of the medical treatment shall
12 be completed and the director shall issue an order within 60 days of the request for review. The
13 director shall create a documentary record sufficient for purposes of judicial review. If the worker,
14 insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissat-
15 isfied party may request *[review]* a **hearing** under ORS 656.704. The administrative order may be
16 modified at hearing only if it is not supported by substantial evidence in the record or if it reflects
17 an error of law. No new medical evidence or issues shall be admitted. The worker is not obligated
18 to pay for medical treatment determined not to be compensable under this subsection.

19 (3) Upon request of either party, the director may delegate to a physician or a panel of physi-
20 cians the review of medical treatment under this section. At least one member of any such panel
21 shall be a practitioner of the healing art of the medical service provider whose treatment is being
22 reviewed. No member of any such panel shall be a physician whose treatment is the subject of re-
23 view. The panel shall be chosen in such manner as the director may prescribe, in consultation with
24 the committee referred to in ORS 656.790. The physician or panel shall submit findings to the di-
25 rector within the time limits as prescribed by the director.

26 (4) The physician or the panel of physicians and the medical arbiter or panel of medical arbiters
27 appointed pursuant to ORS 656.268 acting pursuant to the authority of the director are agents of the
28 Department of Consumer and Business Services and are subject to the provisions of ORS 30.260 to
29 30.300. The findings of the physician or panel of physicians, the medical arbiter or panel of medical
30 arbiters, all of the records and all communications to or before a panel or arbiter are privileged and
31 are not discoverable or admissible in any proceeding other than those proceedings under this chap-
32 ter. No member of a panel or a medical arbiter shall be examined or subject to administrative or
33 civil liability regarding participation in or the findings of the panel or medical arbiter or any matter
34 before the panel or medical arbiter other than in proceedings under this chapter.

35 (5) The costs of review of medical treatment by the physician or panel of physicians pursuant
36 to this section and costs incurred by the worker in attending any examination required under this
37 section, including child care, transportation, lodging and meals, shall be paid by the insurer or
38 self-insured employer.

39 **SECTION 10.** ORS 656.340 is amended to read:

40 656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be pro-
41 vided to an injured worker who is eligible for assistance in returning to work.

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

45 (A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical

1 or investigation report, notification from the worker, or otherwise; or

2 (B) The time the worker is medically stationary, if the worker has not returned to or been re-
 3 leased for the worker's regular employment or has not returned to other suitable employment with
 4 the employer at the time of injury or aggravation and the worker is not receiving vocational as-
 5 sistance.

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

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

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

18 (4) As soon as possible, and not more than 30 days after the contact required by subsection (1)
 19 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-
 20 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-
 21 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the
 22 worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the
 23 worker is not eligible, the worker may apply to the director for review of the decision as provided
 24 in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection
 25 (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under stan-
 26 dards prescribed by the director, may not be found eligible thereafter unless that eligibility deter-
 27 mination is rejected by the director under subsection (16) of this section or the worker's condition
 28 worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to
 29 vocational assistance benefits when possible eligibility for such benefits arises from a worsening of
 30 the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS
 31 656.273.

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

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

44 (b) As used in this subsection:

45 (A) A "substantial handicap to employment" exists when the worker, because of the injury or

1 aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed
2 in suitable employment.

3 (B) "Suitable employment" means:

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

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

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

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

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

26 (9) The director shall adopt rules providing:

27 (a) Standards for and methods of certifying individuals qualified by education, training and ex-
28 perience to provide vocational assistance to injured workers;

29 (b) Standards for registration of vocational assistance providers;

30 (c) Conditions and procedures under which the certification of an individual to provide voca-
31 tional assistance services or the registration of a vocational assistance provider may be suspended
32 or revoked for failure to maintain compliance with the certification or registration standards;

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

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

40 (10) Insurers and self-insured employers shall maintain records and make reports to the director
41 of vocational assistance actions at times and in the manner as the director may prescribe. The re-
42 quirements prescribed shall be for the purpose of assisting the Department of Consumer and Busi-
43 ness Services in monitoring compliance with this section to insure that workers receive timely and
44 appropriate vocational assistance. The director shall minimize to the greatest extent possible the
45 number, extent and kinds of reports required. The director shall compile a list of organizations or

1 agencies registered to provide vocational assistance. A current list shall be distributed by the di-
2 rector to all insurers and self-insured employers. The insurer shall send the list to each worker with
3 the notice of eligibility.

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

10 (12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary
11 disability compensation for a maximum of 16 months. The insurer or self-insured employer may vol-
12 untarily extend the payment of temporary disability compensation to a maximum of 21 months. **The**
13 **director may order the payment of temporary disability compensation for up to 21 months**
14 **upon good cause shown by the injured worker.** The costs related to vocational assistance train-
15 ing programs may be paid for periods longer than 21 months, but in no event may temporary disa-
16 bility benefits be paid for a period longer than 21 months.

17 (13) As used in this section, "vocational assistance provider" means a public or private organ-
18 ization or agency that provides vocational assistance to injured workers.

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

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

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

27 (15) A physical capacities evaluation shall be performed in conjunction with vocational assist-
28 ance or determination of eligibility for such assistance at the request of the insurer or self-insured
29 employer or worker. The request shall be made to the attending physician or nurse practitioner
30 authorized to provide compensable medical services under ORS 656.245. The attending physician or
31 nurse practitioner, within 20 days of the request, shall perform a physical capacities evaluation or
32 refer the worker for such evaluation or advise the insurer or self-insured employer and the worker
33 in writing that the injured worker is incapable of participating in a physical capacities evaluation.

34 (16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires
35 a high degree of cooperation between all of the participants in the vocational assistance process.
36 Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and
37 extent of vocational assistance services should be resolved through nonadversarial procedures to the
38 greatest extent possible consistent with constitutional principles. The director shall adopt by rule
39 a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

40 (b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding
41 vocational assistance, the worker must apply to the director for administrative review of the matter.
42 Application for review must be made not later than the 60th day after the date the worker was
43 notified of the action. The director shall complete the review within a reasonable time.

44 (c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall
45 be reduced to writing, and the director and the parties shall review the agreement and either ap-

1 prove or disapprove it. The agreement is subject to reconsideration by the director under limitations
2 prescribed by the director, but is not subject to review by any other forum.

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

7 (A) Violates a statute or rule;

8 (B) Exceeds the statutory authority of the agency;

9 (C) Was made upon unlawful procedure; or

10 (D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

11 (e) For purposes of this subsection, the term "parties" does not include a noncomplying em-
12 ployer.

13 **SECTION 11. (1) The amendments to ORS 656.340 by section 10 of this 2011 Act apply to**
14 **all claims by workers who are eligible for or actively engaged in vocational training on or**
15 **after the effective date of this 2011 Act.**

16 **(2)(a) The amendments to ORS 656.704 by section 4 of this 2011 Act apply to causes of**
17 **actions existing or arising on or after the effective date of this 2011 Act.**

18 **(b) Notwithstanding paragraph (a) of this subsection, the amendments to ORS 656.704 by**
19 **section 4 of this 2011 Act do not apply to any matter for which an order has become final**
20 **prior to the effective date of this 2011 Act.**

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