LC 1578
2015 Regular Session
11/21/14 (CJC/ps)

D R A F T

SUMMARY

Modifies definitions of "compensable injury" and "preexisting condition" for purposes of workers' compensation claims. Specifies when diagnostic medical services are compensable. Requires written report or statement notifying employer of accident resulting in injury and filing of claim for compensation within one year after date of accident. Limits good cause exception for failure to provide notice of accident.

A BILL FOR AN ACT

Relating to compensability of workers' compensation claims; amending ORS 656.005, 656.245, 656.265 and 656.704.

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

SECTION 1. ORS 656.005 is amended to read:

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

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

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

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.

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

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

(4) "Carrier-insured employer" means an employer who provides workers' compensation coverage with the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

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

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

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

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

(B) If an otherwise compensable injury combines at any time with a pre-

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

(C) Benefits under this chapter, except for interim temporary disability compensation under ORS 656.262 (4), diagnostic services required under ORS 656.245 (1)(b) and services provided under a managed care contract, are payable only for conditions accepted by the insurer or self-insured employer pursuant to ORS 656.262 (6).

(b) "Compensable injury" does not include:

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

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

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

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

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

(8) "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's benefi-

ciaries by an insurer or self-insured employer pursuant to this chapter.

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

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

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

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

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

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

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

(i) Doctor or physician licensed by the State Board of Chiropractic Ex-

aminers for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

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

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

(c) Except as otherwise provided for workers subject to a managed care contract, "attending physician" does not include a physician who provides care in a hospital emergency room and refers the injured worker to a primary care physician for follow-up care and treatment.

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

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

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

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

(14) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compen-

sation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

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

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

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

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

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

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

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

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

only for the purpose of calculations based on payroll to determine premium for workers' compensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter.

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

(24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, congenital abnormality, personality disorder**, predisposition** or similar condition that contributes to disability or need for treatment, provided that**, for purposes of determining the compensability of industrial injury claims only**:

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2. ORS 656.245 is amended to read:

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

(b) Notwithstanding paragraph (a) of this subsection, medical services necessary to diagnose the worker's condition are compensable if the services are required to identify the existence and extent of conditions that may be causally related to the work exposure or injury.

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

(E) Services necessary to monitor the status, replacement or repair of

prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

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

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

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. However, an emergency room physician who is not authorized to serve as an attending

physician under ORS 656.005 (12)(c) may authorize temporary disability benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim.

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

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

(i) May provide compensable medical services for 180 days from the date of the first visit on the initial claim;

(ii) May authorize the payment of temporary disability benefits for a period not to exceed 180 days from the date of the first visit on the initial claim; and

(iii) When an injured worker treating with a nurse practitioner authorized to provide compensable services under this section becomes medically stationary within the 180-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse practitioner for the examination performed.

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the

rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to review under ORS 656.704.

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the physician or nurse practitioner agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must

comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

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

(b) A nurse practitioner authorized to provide medical services to a worker enrolled in the managed care organization may provide medical treatment to the worker if the treatment is determined to be medically appropriate according to the service utilization review process of the managed care organization and may authorize temporary disability payments as provided in subsection (2)(b)(D) of this section. However, the managed care organization may authorize the nurse practitioner to provide medical services and authorize temporary disability payments beyond the periods established in subsection (2)(b)(D) of this section.

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

SECTION 3. ORS 656.265 is amended to read:

656.265. (1) Notice of an accident resulting in an injury or death shall be

given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice.

(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A **written** report or **written** statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

(3) Notice shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services and referred to the insurer or self-insured employer.

(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given **and a claim for compensation is filed** within one year after the date of the accident and:

(a) The employer had knowledge of the injury or death;

(b) The worker died within 180 days after the date of the accident; or

(c) The worker or beneficiaries of the worker establish that the worker had good cause for failure to give notice within 90 days after the accident. **Good cause may be established only through proof that the failure to provide the notice required under this section was due to mistake, inadvertence, surprise or excusable neglect.**

(5) The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death.

(6) The director shall promulgate and prescribe uniform forms to be used by workers in reporting their injuries to their employers. These forms shall be supplied by all employers to injured workers upon request of the injured

worker or some other person on behalf of the worker. The failure of the worker to use a specified form shall not, in itself, defeat the claim of the worker if the worker has complied with the requirement that the claim be presented in writing.

SECTION 4. ORS 656.704 is amended to read:

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

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

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

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

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

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

(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245 [*(1)(c)*] **(1)(d)**, is not a matter concerning a claim.

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

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

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

(5) If a request for hearing or administrative review is filed with either the director or the board and it is determined that the request should have

been filed with the other, the dispute shall be transferred. Filing a request will be timely filed if the original filing was completed within the prescribed time.
