HB 2764-A7
(LC 361)
5/12/15 (CJC/ges/ps)

PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 2764

On page 1 of the printed A-engrossed bill, line 2, after "provisions" insert "and".

In line 3, after "656.388" insert a period and delete the rest of the line and line 4.

Delete lines 6 through 18 and delete pages 2 through 13 and insert:

"SECTION 1. ORS 656.012 is amended to read:

"656.012. (1) The Legislative Assembly finds that:

"(a) The performance of various industrial enterprises necessary to the enrichment and economic well-being of all the citizens of this state will inevitably involve injury to some of the workers employed in those enterprises;

"(b) The method provided by the common law for compensating injured workers involves long and costly litigation, without commensurate benefit to either the injured workers or the employers, and often requires the taxpayer to provide expensive care and support for the injured workers and their dependents; and

"(c) An exclusive, statutory system of compensation will provide the best societal measure of those injuries that bear a sufficient relationship to employment to merit incorporation of their costs into the stream of commerce.

"(2) In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

"(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income

benefits to injured workers and their dependents;

"(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable**, while providing for access to adequate representation for injured workers**;

"(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable;

"(d) To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents; and

"(e) To provide the sole and exclusive source and means by which subject workers, their beneficiaries and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions.

"(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner.

"**SECTION 2.** ORS 656.262 is amended to read:

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

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

"(3)(a) Employers shall, immediately and not later than five days after

notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:

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

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

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

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

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

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

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

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

made.

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

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

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

"(f) If the insurer or self-insured employer has requested and failed to receive from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician or nurse practi-

tioner are not compensable until the attending physician or nurse practitioner submits such verification.

"(g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 ceases to authorize temporary disability or for any period of time not authorized by the attending physician or nurse practitioner. No authorization of temporary disability compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance.

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

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

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

entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported. However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection.

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

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

"(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured em-

ployer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

"(b) The notice of acceptance shall:

"(A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

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

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

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

compensability of the condition rated therein, unless the condition has been formally accepted.

"(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, **attorney fees or costs,** or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be [*proportionate to the benefit to the injured worker*] **reasonable attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court shall consider the proportionate benefit to the injured worker**. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed [*$3,000*] **$4,000** absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

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

"(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim

settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

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

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

"(14)**(a)** Injured workers have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers shall submit to and shall fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. Injured workers who are represented by an attorney shall have the right to have the attorney present during any personal or telephonic interview or deposition. **If the injured worker is represented by an attorney, the insurer or self-insured employer shall pay the attorney a reasonable attorney fee based upon an hourly rate for actual time spent during the personal or telephonic interview or deposition. After consultation with the Board of Governors of the Oregon State Bar, the Workers' Compensation Board shall adopt rules for the establishment, assessment and enforcement of an hourly attorney fee rate specified in this subsection.**

"(b) [*However,*] If the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or self-insured employer within 14 days of the request for interview and the insurer or

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

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

"(16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more

than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (14) of this section.

"SECTION 3. ORS 656.277 is amended to read:

"656.277. (1)**(a)** A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order.

"**(b) If the worker is represented by an attorney and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may award the attorney a reasonable assessed attorney fee.**

"(2) A request by the worker that an accepted nondisabling injury was or has become disabling shall be made pursuant to ORS 656.273 as a claim for aggravation, provided the claim has been classified as nondisabling for at least one year after the date of acceptance.

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

"(a) When a notice of claim denial is filed;

"(b) When the status of the claim is as described in subsection (1) or (2) of this section; or

"(c) When otherwise required by the director.

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

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

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

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

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

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

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

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

"(3) If an insurer or self-insured employer denies the compensability of

all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. Except for medical services payable in accordance with ORS 656.247, after receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy. If the injured worker has no health insurance, such bills may be submitted to the injured worker. A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined.

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

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

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

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

fully reimbursed.

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

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

"SECTION 5. ORS 656.382 is amended to read:

"656.382. (1) If an insurer or self-insured employer refuses to pay compensation**, costs or attorney fees** due under an order of an Administrative Law Judge, **the** board or **the** court, or otherwise unreasonably resists the payment of compensation**, costs or attorney fees**, except as provided in ORS 656.385, the employer or insurer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

"(2) If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that **all or part of** the compensation awarded to a claimant should not

be disallowed or reduced, or, through the assistance of an attorney, that an order rescinding a notice of closure should not be reversed or **all or part of** the compensation awarded by a reconsideration order issued under ORS 656.268 should not be reduced or disallowed, the employer or insurer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or [*the*] court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal.

"(3) If an employer or insurer raises attorney fees, penalties or costs as a separate issue in a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court initiated by the employer or insurer under this section, and the Administrative Law Judge, board or court finds that the attorney fees, penalties or costs awarded to the claimant should not be disallowed or reduced, the Administrative Law Judge, board or court shall award reasonable additional attorney fees to the attorney for the claimant for efforts in defending the fee, penalty or costs.

"(4) If an employer or insurer initiates an appeal to the board or Court of Appeals and the matter is briefed, but the employer or insurer withdraws the appeal prior to a decision by the board or court, resulting in the claimant's prevailing in the matter, the claimant's attorney is entitled to a reasonable attorney fee for efforts in briefing the matter to the board or court.

"[*(3)*] **(5)** If upon reaching a decision on a request for hearing initiated by an employer it is found by the Administrative Law Judge that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the Administrative Law Judge may order the employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances.

"SECTION 6. ORS 656.385 is amended to read:

"656.385. (1) In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced, the Director of the Department of Consumer and Business Services**,** [*or*] the Administrative Law Judge**, the board or the court** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director**,** [*or*] an Administrative Law Judge**, the board or the court**, the director**,** [*or*] Administrative Law Judge**, board or court** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department**, board or court**. The attorney fee assessed under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed [*$3,000*] **$4,000** absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this subsection shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any.

"(2) If an insurer or self-insured employer refuses to pay compensation due under**, or attorney fees related to,** ORS 656.245, 656.247, 656.260, 656.327 or 656.340 pursuant to an order of the director, an Administrative Law Judge**, the board** or the court or otherwise unreasonably resists the payment of such compensation **or attorney fees**, the insurer or self-insured employer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (3) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

"(3) If a request for a contested case hearing, review on appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an insurer or self-insured employer, and the director, Administrative Law Judge**, board** or court finds that **all or part of** the compensation awarded under ORS 656.245, 656.247, 656.260, 656.327 or 656.340 to a claimant**, or attorney fees under this section,** should not be disallowed or reduced, the insurer or self-insured employer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the director, [*the*] Administrative Law Judge**, board** or [*the*] court for legal representation by an attorney for the claimant at the contested case hearing, review on appeal or cross-appeal.

"(4) If upon reaching a final contested case decision where such contested case was initiated by an insurer or self-insured employer it is found that the insurer or self-insured employer initiated the contested case hearing for the purpose of delay or other vexatious reason or without reasonable ground, the director**,** [*or*] Administrative Law Judge**, board or court** may order the insurer or self-insured employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances.

"(5) Penalties and attorney fees awarded pursuant to this section by the director, an Administrative Law Judge**, the board** or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant.

"SECTION 7. ORS 656.386 is amended to read:

"656.386. (1)(a) In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the

Administrative Law Judge or board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.

"(b) For purposes of this section, a 'denied claim' is:

"(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

"(B) A claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262 (6)(d), which the insurer or self-insured employer does not respond to within 60 days;

"(C) A claim for an aggravation made pursuant to ORS 656.273 (2) or for a new medical condition made pursuant to ORS 656.267, which the insurer or self-insured employer does not respond to within 60 days; or

"(D) A claim for an initial injury or occupational disease to which the insurer or self-insured employer does not respond within 60 days.

"(c) A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in timely fashion. Attorney fees provided for in this subsection shall be paid by the insurer or self-insured employer.

"(2)(a) If a claimant finally prevails against a denial as provided in subsection (1) of this section, the court, board or Administrative Law Judge may order payment of the claimant's reasonable expenses and costs for records, expert opinions and witness fees.

"(b) The court, board or Administrative Law Judge shall determine the reasonableness of witness fees, expenses and costs for the purpose of paragraph (a) of this subsection.

"(c) Payments for witness fees, expenses and costs ordered under this subsection shall be made by the insurer or self-insured employer and are in

addition to compensation payable to the claimant.

"(d) Payments for witness fees, expenses and costs ordered under this subsection may not exceed $1,500 unless the claimant demonstrates extraordinary circumstances justifying payment of a greater amount.

"(3) If a claimant requests claim reclassification as provided in ORS 656.277 and the insurer or self-insured employer does not respond within 14 days of the request, or if the **claimant,** insurer or self-insured employer requests a hearing, review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court and the Director of the Department of Consumer and Business Services, Administrative Law Judge, board or [*the*] court finally determines that the claim should be classified as disabling, the director, Administrative Law Judge, board or [*the*] court may assess a reasonable attorney fee.

"**(4) In disputes involving a claim for costs, if the claimant prevails on the claim for any increase of costs, the Administrative Law Judge, board, Court of Appeals or Supreme Court shall award a reasonable assessed attorney fee to the claimant's attorney.**

"[*(4)*] **(5)** In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter.

"SECTION 8. ORS 656.388 is amended to read:

"656.388. (1) No claim or payment for legal services by an attorney representing the worker or for any other services rendered before an Administrative Law Judge or the Workers' Compensation Board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Administrative Law Judge or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law

Judge, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307 (5), 656.308 (2), 656.382 or 656.386. No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization[*or Director of the Department of Consumer and Business Services except for representation at the contested case hearing*].

"(2) Any claim for payment to a claimant's attorney by the claimant so approved shall, in the manner and to the extent fixed by the Administrative Law Judge, board or such court, be a lien upon compensation.

"(3) If an injured worker signs an attorney fee agreement with an attorney for representation on a claim made pursuant to this chapter and additional compensation is awarded to the worker or a settlement agreement is consummated on the claim after the fee agreement is signed and it is shown that the attorney with whom the fee agreement was signed was instrumental in obtaining the additional compensation or settling the claim, the Administrative Law Judge or the board shall grant the attorney a lien for attorney fees out of the additional compensation awarded or proceeds of the settlement in accordance with rules adopted by the board governing the payment of attorney fees.

"(4) The board shall, after consultation with the Board of Governors of the Oregon State Bar, establish a schedule of fees for attorneys representing a worker and representing an insurer or self-insured employer, under this chapter. **The Workers' Compensation Board shall review all attorney fee schedules biennially for adjustment.**

"(5) The board shall, in establishing the schedule of attorney fees awarded under this chapter, consider the contingent nature of the practice of workers' compensation law and the necessity of allowing the broadest access to attorneys by injured workers and shall give consideration to fees earned by attorneys for insurers and self-insured employers.

"[*(5)*] **(6)** The board shall approve no claim for legal services by an attorney representing a claimant to be paid by the claimant if fees have been awarded to the claimant or the attorney of the claimant in connection with the same proceeding under ORS 656.268.

"[*(6)*] **(7)** Insurers and self-insured employers shall make an annual report to the Director of the Department of Consumer and Business Services reporting attorney salaries and other costs of legal services incurred pursuant to this chapter. The report shall be in such form and shall contain such information as the director prescribes.

"SECTION 9. Section 10 of this 2015 Act is added to and made a part of ORS chapter 656.

"SECTION 10. The claimant's attorney shall be allowed a reasonable assessed attorney fee if:

"(1) The claimant's attorney is instrumental in obtaining temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 prior to a decision by an Administrative Law Judge; or

"(2) The claimant finally prevails in a dispute over temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 after a request for hearing has been filed.

"SECTION 11. Section 10 of this 2015 Act and the amendments to ORS 656.012, 656.262, 656.277, 656.313, 656.382, 656.385, 656.386 and 656.388 by sections 1 to 8 of this 2015 Act apply to orders issued and attorney fees incurred on or after the effective date of this 2015 Act, regardless of the date on which the claim was filed.".
