

# D R A F T

## SUMMARY

Amends provisions of workers' compensation law related to payments of benefits, notice to workers, recovery of overpayments and errors in claims processing.

### A BILL FOR AN ACT

1  
2 Relating to workers' compensation benefits; amending ORS 656.262, 656.268  
3 and 656.319.

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

5 **SECTION 1.** ORS 656.262 is amended to read:

6 656.262. (1) Processing of claims and providing compensation for a worker  
7 shall be the responsibility of the insurer or self-insured employer. All em-  
8 ployers shall assist their insurers in processing claims as required in this  
9 chapter.

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

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

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

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

20 (C) Whether the employer recommends or opposes acceptance of the claim,

1 and the reasons therefor.

2 (D) The name and address of any health insurance provider for the in-  
3 jured worker.

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

5 (b) Failure to so report subjects the offending employer to a charge for  
6 reimbursing the insurer for any penalty the insurer is required to pay under  
7 subsection (11) of this section because of such failure. As used in this sub-  
8 section, "health insurance" has the meaning for that term provided in ORS  
9 731.162.

10 (4)(a) The first installment of temporary disability compensation shall be  
11 paid no later than the 14th day after the subject employer has notice or  
12 knowledge of the claim and of the worker's disability, if the attending phy-  
13 sician or nurse practitioner authorized to provide compensable medical ser-  
14 vices under ORS 656.245 authorizes the payment of temporary disability  
15 compensation. Thereafter, temporary disability compensation shall be paid  
16 at least once each two weeks, except where the Director of the Department  
17 of Consumer and Business Services determines that payment in installments  
18 should be made at some other interval. The director may by rule convert  
19 monthly benefit schedules to weekly or other periodic schedules.

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

26 (c) Notwithstanding any other provision of this chapter, when the holder  
27 of a public office is injured in the course and scope of that public office, full  
28 official salary paid to the holder of that public office shall be deemed timely  
29 payment of temporary disability payments pursuant to ORS 656.210 and  
30 656.212 during the time the wage payments are made. As used in this sub-  
31 section, "public office" has the meaning for that term provided in ORS

1 260.005.

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

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

19 (f) If the insurer or self-insured employer has requested and failed to re-  
20 ceive from the worker's attending physician or nurse practitioner authorized  
21 to provide compensable medical services under ORS 656.245 verification of  
22 the worker's inability to work resulting from the claimed injury or disease,  
23 medical services provided by the attending physician or nurse practitioner  
24 are not compensable until the attending physician or nurse practitioner  
25 submits such verification.

26 (g) Temporary disability compensation is not due and payable pursuant  
27 to ORS 656.268 after the worker's attending physician or nurse practitioner  
28 authorized to provide compensable medical services under ORS 656.245 ceases  
29 to authorize temporary disability or for any period of time not authorized  
30 by the attending physician or nurse practitioner. No authorization of tem-  
31 porary disability compensation by the attending physician or nurse practi-

1 tioner under ORS 656.268 shall be effective to retroactively authorize the  
2 payment of temporary disability more than [14 days prior to its issuance] **60**  
3 **days prior to notice provided under paragraph (j) of this subsection.**  
4 **This paragraph does not apply during periods in which compensability**  
5 **is in dispute.**

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

13 (i) The insurer or self-insured employer may unilaterally suspend payment  
14 of all compensation to a worker enrolled in a managed care organization if  
15 the worker continues to seek care from an attending physician or nurse  
16 practitioner authorized to provide compensable medical services under ORS  
17 656.245 that is not authorized by the managed care organization more than  
18 seven days after the mailing of notice by the insurer or self-insured employer.

19 **(j) The insurer or self-insured employer may not suspend temporary**  
20 **disability compensation without notifying the worker in writing that**  
21 **the temporary disability benefits will end. Notice provided under this**  
22 **paragraph must be mailed within five business days of receipt of in-**  
23 **formation that temporary disability benefits will end. The notice must**  
24 **state the reason for ending the temporary disability benefits.**

25 (5)(a) Payment of compensation under subsection (4) of this section or  
26 payment, in amounts per claim not to exceed the maximum amount estab-  
27 lished annually by the Director of the Department of Consumer and Business  
28 Services, for medical services for nondisabling claims, may be made by the  
29 subject employer if the employer so chooses. The making of such payments  
30 does not constitute a waiver or transfer of the insurer's duty to determine  
31 entitlement to benefits. If the employer chooses to make such payment, the

1 employer shall report the injury to the insurer in the same manner that  
2 other injuries are reported. However, an insurer shall not modify an  
3 employer's experience rating or otherwise make charges against the employer  
4 for any medical expenses paid by the employer pursuant to this subsection.

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

13 (c) The adjusted amount established under paragraph (b) of this sub-  
14 section shall be effective on January 1 following the establishment of the  
15 amount and shall apply to claims with a date of injury on or after the ef-  
16 fective date of the adjusted amount.

17 (6)(a) Written notice of acceptance or denial of the claim shall be fur-  
18 nished to the claimant by the insurer or self-insured employer within 60 days  
19 after the employer has notice or knowledge of the claim. Once the claim is  
20 accepted, the insurer or self-insured employer shall not revoke acceptance  
21 except as provided in this section. The insurer or self-insured employer may  
22 revoke acceptance and issue a denial at any time when the denial is for  
23 fraud, misrepresentation or other illegal activity by the worker. If the  
24 worker requests a hearing on any revocation of acceptance and denial al-  
25 leging fraud, misrepresentation or other illegal activity, the insurer or self-  
26 insured employer has the burden of proving, by a preponderance of the  
27 evidence, such fraud, misrepresentation or other illegal activity. Upon such  
28 proof, the worker then has the burden of proving, by a preponderance of the  
29 evidence, the compensability of the claim. If the insurer or self-insured em-  
30 ployer accepts a claim in good faith, in a case not involving fraud, misrep-  
31 resentation or other illegal activity by the worker, and later obtains evidence

1 that the claim is not compensable or evidence that the insurer or self-insured  
2 employer is not responsible for the claim, the insurer or self-insured em-  
3 ployer may revoke the claim acceptance and issue a formal notice of claim  
4 denial, if such revocation of acceptance and denial is issued no later than  
5 two years after the date of the initial acceptance. If the worker requests a  
6 hearing on such revocation of acceptance and denial, the insurer or self-  
7 insured employer must prove, by a preponderance of the evidence, that the  
8 claim is not compensable or that the insurer or self-insured employer is not  
9 responsible for the claim. Notwithstanding any other provision of this chap-  
10 ter, if a denial of a previously accepted claim is set aside by an Adminis-  
11 trative Law Judge, the Workers' Compensation Board or the court,  
12 temporary total disability benefits are payable from the date any such bene-  
13 fits were terminated under the denial. Except as provided in ORS 656.247,  
14 pending acceptance or denial of a claim, compensation payable to a claimant  
15 does not include the costs of medical benefits or funeral expenses. The  
16 insurer shall also furnish the employer a copy of the notice of acceptance.

17 (b) The notice of acceptance shall:

18 (A) Specify what conditions are compensable.

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

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

25 (D) Inform the claimant of employment reinstatement rights and respon-  
26 sibilities under ORS chapter 659A.

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

29 (F) Be modified by the insurer or self-insured employer from time to time  
30 as medical or other information changes a previously issued notice of ac-  
31 ceptance.

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

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

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

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

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

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

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

20 (10) Merely paying or providing compensation shall not be considered  
21 acceptance of a claim or an admission of liability, nor shall mere acceptance  
22 of such compensation be considered a waiver of the right to question the  
23 amount thereof. Payment of permanent disability benefits pursuant to a no-  
24 tice of closure, reconsideration order or litigation order, or the failure to  
25 appeal or seek review of such an order or notice of closure, shall not pre-  
26 clude an insurer or self-insured employer from subsequently contesting the  
27 compensability of the condition rated therein, unless the condition has been  
28 formally accepted.

29 (11)(a) If the insurer or self-insured employer unreasonably delays or un-  
30 reasonably refuses to pay compensation, attorney fees or costs, or unreason-  
31 ably delays acceptance or denial of a claim, the insurer or self-insured



1 employer shall be liable for an additional amount up to 25 percent of the  
2 amounts then due plus any attorney fees assessed under this section. The fees  
3 assessed by the director, an Administrative Law Judge, the board or the  
4 court under this section shall be reasonable attorney fees. In assessing fees,  
5 the director, an Administrative Law Judge, the board or the court shall  
6 consider the proportionate benefit to the injured worker. The board shall  
7 adopt rules for establishing the amount of the attorney fee, giving primary  
8 consideration to the results achieved and to the time devoted to the case.  
9 An attorney fee awarded pursuant to this subsection may not exceed \$4,000  
10 absent a showing of extraordinary circumstances. The maximum attorney fee  
11 awarded under this paragraph shall be adjusted annually on July 1 by the  
12 same percentage increase as made to the average weekly wage defined in  
13 ORS 656.211, if any. Notwithstanding any other provision of this chapter,  
14 the director shall have exclusive jurisdiction over proceedings regarding  
15 solely the assessment and payment of the additional amount and attorney  
16 fees described in this subsection. The action of the director and the review  
17 of the action taken by the director shall be subject to review under ORS  
18 656.704.

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

23 (12)(a) If payment is due on a disputed claim settlement authorized by  
24 ORS 656.289 and the insurer or self-insured employer has failed to make the  
25 payment in accordance with the requirements specified in the disputed claim  
26 settlement, the claimant or the claimant's attorney shall clearly notify the  
27 insurer or self-insured employer in writing that the payment is past due. If  
28 the required payment is not made within five business days after receipt of  
29 the notice by the insurer or self-insured employer, the director may assess  
30 a penalty and attorney fee in accordance with a matrix adopted by the di-  
31 rector by rule.

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

6 (13) The insurer may authorize an employer to pay compensation to in-  
7 jured workers and shall reimburse employers for compensation so paid.

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

21 (b) If the attorney is not willing or available to participate in an inter-  
22 view at a time reasonably chosen by the insurer or self-insured employer  
23 within 14 days of the request for interview and the insurer or self-insured  
24 employer has cause to believe that the attorney's unwillingness or unavail-  
25 ability is unreasonable and is preventing the worker from complying within  
26 14 days of the request for interview, the insurer or self-insured employer  
27 shall notify the director. If the director determines that the attorney's un-  
28 willingness or unavailability is unreasonable, the director shall assess a civil  
29 penalty against the attorney of not more than \$1,000.

30 (15) If the director finds that a worker fails to reasonably cooperate with  
31 an investigation involving an initial claim to establish a compensable injury

1 or an aggravation claim to reopen the claim for a worsened condition, the  
2 director shall suspend all or part of the payment of compensation after notice  
3 to the worker. If the worker does not cooperate for an additional 30 days  
4 after the notice, the insurer or self-insured employer may deny the claim  
5 because of the worker's failure to cooperate. The obligation of the insurer  
6 or self-insured employer to accept or deny the claim within 60 days is sus-  
7 pended during the time of the worker's noncooperation. After such a denial,  
8 the worker shall not be granted a hearing or other proceeding under this  
9 chapter on the merits of the claim unless the worker first requests and es-  
10 tablishes at an expedited hearing under ORS 656.291 that the worker fully  
11 and completely cooperated with the investigation, that the worker failed to  
12 cooperate for reasons beyond the worker's control or that the investigative  
13 demands were unreasonable. If the Administrative Law Judge finds that the  
14 worker has not fully cooperated, the Administrative Law Judge shall affirm  
15 the denial, and the worker's claim for injury shall remain denied. If the  
16 Administrative Law Judge finds that the worker has cooperated, or that the  
17 investigative demands were unreasonable, the Administrative Law Judge  
18 shall set aside the denial, order the reinstatement of interim compensation  
19 if appropriate and remand the claim to the insurer or self-insured employer  
20 to accept or deny the claim.

21 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge  
22 assigned a request for hearing for a claim for compensation involving more  
23 than one potentially responsible employer or insurer may specify what is  
24 required of an injured worker to reasonably cooperate with the investigation  
25 of the claim as required by subsection (14) of this section.

26 **SECTION 2.** ORS 656.262, as amended by section 1, chapter 47, Oregon  
27 Laws 2021, is amended to read:

28 656.262. (1) Processing of claims and providing compensation for a worker  
29 shall be the responsibility of the insurer or self-insured employer. All em-  
30 ployers shall assist their insurers in processing claims as required in this  
31 chapter.

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

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

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

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

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

13 (D) The name and address of any health insurance provider for the in-  
14 jured worker.

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

16 (b) Failure to so report subjects the offending employer to a charge for  
17 reimbursing the insurer for any penalty the insurer is required to pay under  
18 subsection (11) of this section because of such failure. As used in this sub-  
19 section, "health insurance" has the meaning for that term provided in ORS  
20 731.162.

21 (4)(a) The first installment of temporary disability compensation shall be  
22 paid no later than the 14th day after the subject employer has notice or  
23 knowledge of the claim and of the worker's disability, if the attending phy-  
24 sician or nurse practitioner authorized to provide compensable medical ser-  
25 vices under ORS 656.245 authorizes the payment of temporary disability  
26 compensation. Thereafter, temporary disability compensation shall be paid  
27 at least once each two weeks, except where the Director of the Department  
28 of Consumer and Business Services determines that payment in installments  
29 should be made at some other interval. The director may by rule convert  
30 monthly benefit schedules to weekly or other periodic schedules.

31 (b) Notwithstanding any other provision of this chapter, if a self-insured

1 employer pays to an injured worker who becomes disabled the same wage at  
2 the same pay interval that the worker received at the time of injury, such  
3 payment shall be deemed timely payment of temporary disability payments  
4 pursuant to ORS 656.210 and 656.212 during the time the wage payments are  
5 made.

6 (c) Notwithstanding any other provision of this chapter, when the holder  
7 of a public office is injured in the course and scope of that public office, full  
8 official salary paid to the holder of that public office shall be deemed timely  
9 payment of temporary disability payments pursuant to ORS 656.210 and  
10 656.212 during the time the wage payments are made. As used in this sub-  
11 section, "public office" has the meaning for that term provided in ORS  
12 260.005.

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

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

30 (f) If the insurer or self-insured employer has requested and failed to re-  
31 ceive from the worker's attending physician or nurse practitioner authorized

1 to provide compensable medical services under ORS 656.245 verification of  
2 the worker's inability to work resulting from the claimed injury or disease,  
3 medical services provided by the attending physician or nurse practitioner  
4 are not compensable until the attending physician or nurse practitioner  
5 submits such verification.

6 (g) Temporary disability compensation is not due and payable pursuant  
7 to ORS 656.268 after the worker's attending physician or nurse practitioner  
8 authorized to provide compensable medical services under ORS 656.245 ceases  
9 to authorize temporary disability or for any period of time not authorized  
10 by the attending physician or nurse practitioner. No authorization of tem-  
11 porary disability compensation by the attending physician or nurse practi-  
12 tioner under ORS 656.268 shall be effective to retroactively authorize the  
13 payment of temporary disability more than *[14 days prior to its issuance]* **60**  
14 **days prior to notice provided under paragraph (j) of this subsection.**  
15 **This paragraph does not apply during periods in which compensability**  
16 **is in dispute.**

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

24 (i) The insurer or self-insured employer may unilaterally suspend payment  
25 of all compensation to a worker enrolled in a managed care organization if  
26 the worker continues to seek care from an attending physician or nurse  
27 practitioner authorized to provide compensable medical services under ORS  
28 656.245 that is not authorized by the managed care organization more than  
29 seven days after the mailing of notice by the insurer or self-insured employer.

30 **(j) The insurer or self-insured employer may not suspend temporary**  
31 **disability compensation without notifying the worker in writing that**

1 **the temporary disability benefits will end. Notice provided under this**  
2 **paragraph must be mailed within five business days of receipt of in-**  
3 **formation that temporary disability benefits will end. The notice must**  
4 **state the reason for ending the temporary disability benefits.**

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

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

24 (c) The adjusted amount established under paragraph (b) of this sub-  
25 section shall be effective on January 1 following the establishment of the  
26 amount and shall apply to claims with a date of injury on or after the ef-  
27 fective date of the adjusted amount.

28 (6)(a) Written notice of acceptance or denial of the claim shall be fur-  
29 nished to the claimant by the insurer or self-insured employer within 60 days  
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5 leging fraud, misrepresentation or other illegal activity, the insurer or self-  
6 insured employer has the burden of proving, by a preponderance of the  
7 evidence, such fraud, misrepresentation or other illegal activity. Upon such  
8 proof, the worker then has the burden of proving, by a preponderance of the  
9 evidence, the compensability of the claim. If the insurer or self-insured em-  
10 ployer accepts a claim in good faith, in a case not involving fraud, misrep-  
11 resentation or other illegal activity by the worker, and later obtains evidence  
12 that the claim is not compensable or evidence that the insurer or self-insured  
13 employer is not responsible for the claim, the insurer or self-insured em-  
14 ployer may revoke the claim acceptance and issue a formal notice of claim  
15 denial, if such revocation of acceptance and denial is issued no later than  
16 two years after the date of the initial acceptance. If the worker requests a  
17 hearing on such revocation of acceptance and denial, the insurer or self-  
18 insured employer must prove, by a preponderance of the evidence, that the  
19 claim is not compensable or that the insurer or self-insured employer is not  
20 responsible for the claim. Notwithstanding any other provision of this chap-  
21 ter, if a denial of a previously accepted claim is set aside by an Adminis-  
22 trative Law Judge, the Workers' Compensation Board or the court,  
23 temporary total disability benefits are payable from the date any such bene-  
24 fits were terminated under the denial. Except as provided in ORS 656.247,  
25 pending acceptance or denial of a claim, compensation payable to a claimant  
26 does not include the costs of medical benefits or funeral expenses. The  
27 insurer shall also furnish the employer a copy of the notice of acceptance.

28 (b) The notice of acceptance shall:

29 (A) Specify what conditions are compensable.

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



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

5 (D) Inform the claimant of employment reinstatement rights and respon-  
6 sibilities under ORS chapter 659A.

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

9 (F) Be modified by the insurer or self-insured employer from time to time  
10 as medical or other information changes a previously issued notice of ac-  
11 ceptance.

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

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

30 (7)(a) After claim acceptance, written notice of acceptance or denial of  
31 claims for aggravation or new medical or omitted condition claims properly

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

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

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

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

23 (9) If an insurer or any other duly authorized agent of the employer for  
24 such purpose, on record with the Director of the Department of Consumer  
25 and Business Services denies a claim for compensation, written notice of  
26 such denial, stating the reason for the denial, and informing the worker of  
27 the Expedited Claim Service and of hearing rights under ORS 656.283, shall  
28 be given to the claimant. The insurer shall issue a copy of the notice of de-  
29 nial to the employer. The insurer shall notify the director of the denial in  
30 the manner the director prescribes by rule. The worker may request a hear-  
31 ing pursuant to ORS 656.319.

1 (10) Merely paying or providing compensation shall not be considered  
2 acceptance of a claim or an admission of liability, nor shall mere acceptance  
3 of such compensation be considered a waiver of the right to question the  
4 amount thereof. Payment of permanent disability benefits pursuant to a no-  
5 tice of closure, reconsideration order or litigation order, or the failure to  
6 appeal or seek review of such an order or notice of closure, shall not pre-  
7 clude an insurer or self-insured employer from subsequently contesting the  
8 compensability of the condition rated therein, unless the condition has been  
9 formally accepted.

10 (11)(a) If the insurer or self-insured employer unreasonably delays or un-  
11 reasonably refuses to pay compensation, attorney fees or costs, or unreason-  
12 ably delays acceptance or denial of a claim, the insurer or self-insured  
13 employer shall be liable for an additional amount up to 25 percent of the  
14 amounts then due plus any attorney fees assessed under this section. The fees  
15 assessed by the director, an Administrative Law Judge, the board or the  
16 court under this section shall be reasonable attorney fees. In assessing fees,  
17 the director, an Administrative Law Judge, the board or the court shall  
18 consider the proportionate benefit to the injured worker. The board shall  
19 adopt rules for establishing the amount of the attorney fee, giving primary  
20 consideration to the results achieved and to the time devoted to the case.  
21 An attorney fee awarded pursuant to this subsection may not exceed \$4,000  
22 absent a showing of extraordinary circumstances. The maximum attorney fee  
23 awarded under this paragraph shall be adjusted annually on July 1 by the  
24 same percentage increase as made to the average weekly wage defined in  
25 ORS 656.211, if any. Notwithstanding any other provision of this chapter,  
26 the director shall have exclusive jurisdiction over proceedings regarding  
27 solely the assessment and payment of the additional amount and attorney  
28 fees described in this subsection. The action of the director and the review  
29 of the action taken by the director shall be subject to review under ORS  
30 656.704.

31 (b) When the director does not have exclusive jurisdiction over pro-

1 ceedings regarding the assessment and payment of the additional amount and  
2 attorney fees described in this subsection, the provisions of this subsection  
3 shall apply in the other proceeding.

4 (12)(a) If payment is due on a disputed claim settlement authorized by  
5 ORS 656.289 and the insurer or self-insured employer has failed to make the  
6 payment in accordance with the requirements specified in the disputed claim  
7 settlement, the claimant or the claimant's attorney shall clearly notify the  
8 insurer or self-insured employer in writing that the payment is past due. If  
9 the required payment is not made within five business days after receipt of  
10 the notice by the insurer or self-insured employer, the director may assess  
11 a penalty and attorney fee in accordance with a matrix adopted by the di-  
12 rector by rule.

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

18 (13) The insurer may authorize an employer to pay compensation to in-  
19 jured workers and shall reimburse employers for compensation so paid.

20 (14)(a) Injured workers have the duty to cooperate and assist the insurer  
21 or self-insured employer in the investigation of claims for compensation. In-  
22 jured workers shall submit to and shall fully cooperate with personal and  
23 telephonic interviews and other formal or informal information gathering  
24 techniques. Injured workers who are represented by an attorney shall have  
25 the right to have the attorney present during any personal or telephonic  
26 interview or deposition. If the injured worker is represented by an attorney,  
27 the insurer or self-insured employer shall pay the attorney a reasonable at-  
28 torney fee based upon an hourly rate for actual time spent during the per-  
29 sonal or telephonic interview or deposition. After consultation with the  
30 Board of Governors of the Oregon State Bar, the Workers' Compensation  
31 Board shall adopt rules for the establishment, assessment and enforcement

1 of an hourly attorney fee rate specified in this subsection.

2 (b) If the attorney is not willing or available to participate in an inter-  
3 view at a time reasonably chosen by the insurer or self-insured employer  
4 within 14 days of the request for interview and the insurer or self-insured  
5 employer has cause to believe that the attorney's unwillingness or unavail-  
6 ability is unreasonable and is preventing the worker from complying within  
7 14 days of the request for interview, the insurer or self-insured employer  
8 shall notify the director. If the director determines that the attorney's un-  
9 willingness or unavailability is unreasonable, the director shall assess a civil  
10 penalty against the attorney of not more than \$1,000.

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

1 to accept or deny the claim.

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

7 **SECTION 3.** ORS 656.268 is amended to read:

8 656.268. (1) One purpose of this chapter is to restore the injured worker  
9 as soon as possible and as near as possible to a condition of self support and  
10 maintenance as an able-bodied worker. The insurer or self-insured employer  
11 shall close the worker's claim, as prescribed by the Director of the Depart-  
12 ment of Consumer and Business Services, and determine the extent of the  
13 worker's permanent disability, provided the worker is not enrolled and ac-  
14 tively engaged in training according to rules adopted by the director pursu-  
15 ant to ORS 656.340 and 656.726, when:

16 (a) The worker has become medically stationary and there is sufficient  
17 information to determine permanent disability.[;] **Notwithstanding any**  
18 **other provision of this chapter, no statement from the physician shall**  
19 **be effective to establish medically stationary status more than 60 days**  
20 **before the worker, or the worker's attorney, if represented, is notified**  
21 **that the worker has become medically stationary.**

22 (b) The accepted injury is no longer the major contributing cause of the  
23 worker's combined or consequential condition or conditions pursuant to ORS  
24 656.005 (7). When the claim is closed because the accepted injury is no longer  
25 the major contributing cause of the worker's combined or consequential  
26 condition or conditions, and there is sufficient information to determine  
27 permanent disability, the likely permanent disability that would have been  
28 due to the current accepted condition shall be estimated.[;]

29 (c) Without the approval of the attending physician or nurse practitioner  
30 authorized to provide compensable medical services under ORS 656.245, the  
31 worker fails to seek medical treatment for a period of 30 days or the worker

1 fails to attend a closing examination, unless the worker affirmatively estab-  
2 lishes that such failure is attributable to reasons beyond the worker's  
3 control.[: *or*]

4 (d) An insurer or self-insured employer finds that a worker who has been  
5 receiving permanent total disability benefits has materially improved and is  
6 capable of regularly performing work at a gainful and suitable occupation.

7 (2) If the worker is enrolled and actively engaged in training according  
8 to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disa-  
9 bility compensation shall be proportionately reduced by any sums earned  
10 during the training.

11 (3) A copy of all medical reports and reports of vocational rehabilitation  
12 agencies or counselors shall be furnished to the worker, if requested by the  
13 worker.

14 (4) Temporary total disability benefits shall continue until whichever of  
15 the following events first occurs:

16 (a) The worker returns to regular or modified employment;

17 (b) The attending physician or nurse practitioner who has authorized  
18 temporary disability benefits for the worker under ORS 656.245 advises the  
19 worker and documents in writing that the worker is released to return to  
20 regular employment;

21 (c) The attending physician or nurse practitioner who has authorized  
22 temporary disability benefits for the worker under ORS 656.245 advises the  
23 worker and documents in writing that the worker is released to return to  
24 modified employment, such employment is offered in writing to the worker  
25 and the worker fails to begin such employment. However, an offer of modi-  
26 fied employment may be refused by the worker without the termination of  
27 temporary total disability benefits if the offer:

28 (A) Requires a commute that is beyond the physical capacity of the  
29 worker according to the worker's attending physician or the nurse practi-  
30 tioner who may authorize temporary disability under ORS 656.245;

31 (B) Is at a work site more than 50 miles one way from where the worker

1 was injured unless the site is less than 50 miles from the worker's residence  
2 or the intent of the parties at the time of hire or as established by the pat-  
3 tern of employment prior to the injury was that the employer had multiple  
4 or mobile work sites and the worker could be assigned to any such site;

5 (C) Is not with the employer at injury;

6 (D) Is not at a work site of the employer at injury;

7 (E) Is not consistent with the existing written shift change policy or is  
8 not consistent with common practice of the employer at injury or aggra-  
9 vation; or

10 (F) Is not consistent with an existing shift change provision of an appli-  
11 cable collective bargaining agreement;

12 (d) Any other event that causes temporary disability benefits to be law-  
13 fully suspended, withheld or terminated under ORS 656.262 (4) or other pro-  
14 visions of this chapter; or

15 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection,  
16 the attending physician or nurse practitioner who has authorized temporary  
17 disability benefits under ORS 656.245 for a home care worker or a personal  
18 support worker who has been made a subject worker pursuant to ORS 656.039  
19 advises the home care worker or personal support worker and documents in  
20 writing that the home care worker or personal support worker is released  
21 to return to modified employment, appropriate modified employment is of-  
22 fered in writing by the Home Care Commission or a designee of the com-  
23 mission to the home care worker or personal support worker for any client  
24 of the Department of Human Services who employs a home care worker or  
25 personal support worker and the worker fails to begin the employment.

26 (5)(a) Findings by the insurer or self-insured employer regarding the ex-  
27 tent of the worker's disability in closure of the claim shall be pursuant to  
28 the standards prescribed by the director.

29 (b) The insurer or self-insured employer shall issue a notice of closure of  
30 the claim to the worker, to the worker's attorney if the worker is repres-  
31 ented, and to the director. If the worker is deceased at the time the notice



1 of closure is issued, the insurer or self-insured employer shall mail the  
2 worker's copy of the notice of closure, addressed to the estate of the worker,  
3 to the worker's last known address and may mail copies of the notice of  
4 closure to any known or potential beneficiaries to the estate of the deceased  
5 worker.

6 (c) The notice of closure must inform:

7 (A) The parties, in boldfaced type, of the proper manner in which to pro-  
8 ceed if they are dissatisfied with the terms of the notice of closure;

9 (B) The worker of:

10 (i) The amount of any further compensation, including permanent disa-  
11 bility compensation to be awarded;

12 (ii) The duration of temporary total or temporary partial disability com-  
13 pensation;

14 (iii) The right of the worker or beneficiaries of the worker who were  
15 mailed a copy of the notice of closure under paragraph (b) of this subsection  
16 to request reconsideration by the director under this section within 60 days  
17 of the date of the notice of closure;

18 (iv) The right of beneficiaries who were not mailed a copy of the notice  
19 of closure under paragraph (b) of this subsection to request reconsideration  
20 by the director under this section within one year of the date the notice of  
21 closure was mailed to the estate of the worker under paragraph (b) of this  
22 subsection;

23 (v) The right of the insurer or self-insured employer to request reconsid-  
24 eration by the director under this section within seven days of the date of  
25 the notice of closure;

26 (vi) The aggravation rights; and

27 (vii) Any other information as the director may require; and

28 (C) Any beneficiaries of death benefits to which they may be entitled  
29 pursuant to ORS 656.204 and 656.208.

30 (d) If the insurer or self-insured employer has not issued a notice of clo-  
31 sure, the worker may request closure. Within 10 days of receipt of a written

1 request from the worker, the insurer or self-insured employer shall issue a  
2 notice of closure if the requirements of this section have been met or a no-  
3 tice of refusal to close if the requirements of this section have not been met.

4 A notice of refusal to close shall advise the worker of:

5 (A) The decision not to close;

6 (B) The right of the worker to request a hearing pursuant to ORS 656.283  
7 within 60 days of the date of the notice of refusal to close;

8 (C) The right to be represented by an attorney; and

9 (D) Any other information as the director may require.

10 (e) If a worker, a worker's beneficiary, an insurer or a self-insured em-  
11 ployer objects to the notice of closure, the objecting party first must request  
12 reconsideration by the director under this section. A worker's request for  
13 reconsideration must be made within 60 days of the date of the notice of  
14 closure. If the worker is deceased at the time the notice of closure is issued,  
15 a request for reconsideration by a beneficiary of the worker who was mailed  
16 a copy of the notice of closure under paragraph (b) of this subsection must  
17 be made within 60 days of the date of the notice of closure. A request for  
18 reconsideration by a beneficiary to the estate of a deceased worker who was  
19 not mailed a copy of the notice of closure under paragraph (b) of this sub-  
20 section must be made within one year of the date the notice of closure was  
21 mailed to the estate of the worker under paragraph (b) of this subsection.  
22 A request for reconsideration by an insurer or self-insured employer may be  
23 based only on disagreement with the findings used to rate impairment and  
24 must be made within seven days of the date of the notice of closure.

25 (f) If an insurer or self-insured employer has closed a claim or refused to  
26 close a claim pursuant to this section, if the correctness of that notice of  
27 closure or refusal to close is at issue in a hearing on the claim and if a  
28 finding is made at the hearing that the notice of closure or refusal to close  
29 was not reasonable, a penalty shall be assessed against the insurer or self-  
30 insured employer and paid to the worker in an amount equal to 25 percent  
31 of all compensation determined to be then due the claimant.

1 (g) If, upon reconsideration of a claim closed by an insurer or self-insured  
2 employer, the director orders an increase by 25 percent or more of the  
3 amount of compensation to be paid to the worker for permanent disability  
4 and the worker is found upon reconsideration to be at least 20 percent per-  
5 manently disabled, a penalty shall be assessed against the insurer or self-  
6 insured employer and paid to the worker in an amount equal to 25 percent  
7 of all compensation determined to be then due the claimant. If the increase  
8 in compensation results from information that the insurer or self-insured  
9 employer demonstrates the insurer or self-insured employer could not rea-  
10 sonably have known at the time of claim closure, from new information ob-  
11 tained through a medical arbiter examination or from a determination order  
12 issued by the director that addresses the extent of the worker's permanent  
13 disability that is not based on the standards adopted pursuant to ORS 656.726  
14 (4)(f), the penalty shall not be assessed.

15 (6)(a) Notwithstanding any other provision of law, only one reconsider-  
16 ation proceeding may be held on each notice of closure. At the reconsider-  
17 ation proceeding:

18 (A) A deposition arranged by the worker, limited to the testimony and  
19 cross-examination of the worker about the worker's condition at the time of  
20 claim closure, shall become part of the reconsideration record. The deposi-  
21 tion must be conducted subject to the opportunity for cross-examination by  
22 the insurer or self-insured employer and in accordance with rules adopted  
23 by the director. The cost of the court reporter, interpreter services, if nec-  
24 essary, and one original of the transcript of the deposition for the Depart-  
25 ment of Consumer and Business Services and one copy of the transcript of  
26 the deposition for each party shall be paid by the insurer or self-insured  
27 employer. The reconsideration proceeding may not be postponed to receive  
28 a deposition taken under this subparagraph. A deposition taken in accord-  
29 ance with this subparagraph may be received as evidence at a hearing even  
30 if the deposition is not prepared in time for use in the reconsideration pro-  
31 ceeding.

1 (B) Pursuant to rules adopted by the director, the worker or the insurer  
2 or self-insured employer may correct information in the record that is erro-  
3 neous and may submit any medical evidence that should have been but was  
4 not submitted by the attending physician or nurse practitioner authorized to  
5 provide compensable medical services under ORS 656.245 at the time of claim  
6 closure.

7 (C) If the director determines that a claim was not closed in accordance  
8 with subsection (1) of this section, the director may rescind the closure.

9 (b) If necessary, the director may require additional medical or other in-  
10 formation with respect to the claims and may postpone the reconsideration  
11 for not more than 60 additional calendar days.

12 (c) In any reconsideration proceeding under this section in which the  
13 worker was represented by an attorney, the director shall order the insurer  
14 or self-insured employer to pay to the attorney, out of the additional com-  
15 pensation awarded, an amount equal to 10 percent of any additional com-  
16 pensation awarded to the worker.

17 (d) Except as provided in subsection (7) of this section, the reconsider-  
18 ation proceeding shall be completed within 18 working days from the date  
19 the reconsideration proceeding begins, and shall be performed by a special  
20 evaluation appellate unit within the department. The deadline of 18 working  
21 days may be postponed by an additional 60 calendar days if within the 18  
22 working days the department mails notice of review by a medical arbiter. If  
23 an order on reconsideration has not been mailed on or before 18 working  
24 days from the date the reconsideration proceeding begins, or within 18  
25 working days plus the additional 60 calendar days where a notice for medical  
26 arbiter review was timely mailed or the director postponed the reconsider-  
27 ation pursuant to paragraph (b) of this subsection, or within such additional  
28 time as provided in subsection (8) of this section when reconsideration is  
29 postponed further because the worker has failed to cooperate in the medical  
30 arbiter examination, reconsideration shall be deemed denied and any further  
31 proceedings shall occur as though an order on reconsideration affirming the

1 notice of closure was mailed on the date the order was due to issue.

2 (e) The period for completing the reconsideration proceeding described in  
3 paragraph (d) of this subsection begins upon receipt by the director of a  
4 worker's or a beneficiary's request for reconsideration pursuant to subsection  
5 (5)(e) of this section. If the insurer or self-insured employer requests recon-  
6 sideration, the period for reconsideration begins upon the earlier of the date  
7 of the request for reconsideration by the worker or beneficiary, the date of  
8 receipt of a waiver from the worker or beneficiary of the right to request  
9 reconsideration or the date of expiration of the right of the worker or ben-  
10 eficiary to request reconsideration. If a party elects not to file a separate  
11 request for reconsideration, the party does not waive the right to fully par-  
12 ticipate in the reconsideration proceeding, including the right to proceed  
13 with the reconsideration if the initiating party withdraws the request for  
14 reconsideration.

15 (f) Any medical arbiter report may be received as evidence at a hearing  
16 even if the report is not prepared in time for use in the reconsideration  
17 proceeding.

18 (g) If any party objects to the reconsideration order, the party may re-  
19 quest a hearing under ORS 656.283 within 30 days from the date of the re-  
20 consideration order.

21 (7)(a) The director may delay the reconsideration proceeding and toll the  
22 reconsideration timeline established under subsection (6) of this section for  
23 up to 45 calendar days if:

24 (A) A request for reconsideration of a notice of closure has been made to  
25 the director within 60 days of the date of the notice of closure;

26 (B) The parties are actively engaged in settlement negotiations that in-  
27 clude issues in dispute at reconsideration;

28 (C) The parties agree to the delay; and

29 (D) Both parties notify the director before the 18th working day after the  
30 reconsideration proceeding has begun that they request a delay under this  
31 subsection.

1 (b) A delay of the reconsideration proceeding granted by the director un-  
2 der this subsection expires:

3 (A) If a party requests the director to resume the reconsideration pro-  
4 ceeding before the expiration of the delay period;

5 (B) If the parties reach a settlement and the director receives a copy of  
6 the approved settlement documents before the expiration of the delay period;  
7 or

8 (C) On the next calendar day following the expiration of the delay period  
9 authorized by the director.

10 (c) Upon expiration of a delay granted under this subsection, the timeline  
11 for the completion of the reconsideration proceeding shall resume as if the  
12 delay had never been granted.

13 (d) Compensation due the worker shall continue to be paid during the  
14 period of delay authorized under this subsection.

15 (e) The director may authorize only one delay period for each reconsid-  
16 eration proceeding.

17 (8)(a) If the basis for objection to a notice of closure issued under this  
18 section is disagreement with the impairment used in rating of the worker's  
19 disability, the director shall refer the claim to a medical arbiter appointed  
20 by the director.

21 (b) If the director determines that insufficient medical information is  
22 available to determine disability, the director may appoint, and refer the  
23 claim to, a medical arbiter.

24 (c) At the request of either of the parties, the director shall appoint a  
25 panel of as many as three medical arbiters in accordance with criteria that  
26 the director sets by rule.

27 (d) The arbiter, or panel of medical arbiters, must be chosen from among  
28 a list of physicians qualified to be attending physicians referred to in ORS  
29 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon  
30 Medical Board and the committee referred to in ORS 656.790.

31 (e)(A) The medical arbiter or panel of medical arbiters may examine the

1 worker and perform such tests as may be reasonable and necessary to es-  
2 tablish the worker's impairment.

3 (B) If the director determines that the worker failed to attend the exam-  
4 ination without good cause or failed to cooperate with the medical arbiter,  
5 or panel of medical arbiters, the director shall postpone the reconsideration  
6 proceedings for up to 60 days from the date of the determination that the  
7 worker failed to attend or cooperate, and shall suspend all disability benefits  
8 resulting from this or any prior opening of the claim until such time as the  
9 worker attends and cooperates with the examination or the request for re-  
10 consideration is withdrawn. Any additional evidence regarding good cause  
11 must be submitted prior to the conclusion of the 60-day postponement period.

12 (C) At the conclusion of the 60-day postponement period, if the worker  
13 has not attended and cooperated with a medical arbiter examination or es-  
14 tablished good cause, the worker may not attend a medical arbiter examina-  
15 tion for this claim closure. The reconsideration record must be closed, and  
16 the director shall issue an order on reconsideration based upon the existing  
17 record.

18 (D) All disability benefits suspended under this subsection, including all  
19 disability benefits awarded in the order on reconsideration, or by an Ad-  
20 ministrative Law Judge, the Workers' Compensation Board or upon court  
21 review, are not due and payable to the worker.

22 (f) The insurer or self-insured employer shall pay the costs of examination  
23 and review by the medical arbiter or panel of medical arbiters.

24 (g) The findings of the medical arbiter or panel of medical arbiters must  
25 be submitted to the director for reconsideration of the notice of closure.

26 (h) After reconsideration, no subsequent medical evidence of the worker's  
27 impairment is admissible before the director, the Workers' Compensation  
28 Board or the courts for purposes of making findings of impairment on the  
29 claim closure.

30 (i)(A) If the basis for objection to a notice of closure issued under this  
31 section is a disagreement with the impairment used in rating the worker's

1 disability, and the director determines that the worker is not medically sta-  
2 tionary at the time of the reconsideration or that the closure was not made  
3 pursuant to this section, the director is not required to appoint a medical  
4 arbiter before completing the reconsideration proceeding.

5 (B) If the worker's condition has substantially changed since the notice  
6 of closure, upon the consent of all the parties to the claim, the director shall  
7 postpone the proceeding until the worker's condition is appropriate for claim  
8 closure under subsection (1) of this section.

9 (9) No hearing shall be held on any issue that was not raised and pre-  
10 served before the director at reconsideration. However, issues arising out of  
11 the reconsideration order may be addressed and resolved at hearing.

12 (10) If, after the notice of closure issued pursuant to this section, the  
13 worker becomes enrolled and actively engaged in training according to rules  
14 adopted pursuant to ORS 656.340 and 656.726, any permanent disability pay-  
15 ments due for work disability under the closure shall be suspended, and the  
16 worker shall receive temporary disability compensation and any permanent  
17 disability payments due for impairment while the worker is enrolled and  
18 actively engaged in the training. When the worker ceases to be enrolled and  
19 actively engaged in the training, the insurer or self-insured employer shall  
20 again close the claim pursuant to this section if the worker is medically  
21 stationary or if the worker's accepted injury is no longer the major contrib-  
22 uting cause of the worker's combined or consequential condition or condi-  
23 tions pursuant to ORS 656.005 (7). The closure shall include the duration of  
24 temporary total or temporary partial disability compensation. Permanent  
25 disability compensation shall be redetermined for work disability only. If the  
26 worker has returned to work or the worker's attending physician has re-  
27 leased the worker to return to regular or modified employment, the insurer  
28 or self-insured employer shall again close the claim. This notice of closure  
29 may be appealed only in the same manner as are other notices of closure  
30 under this section.

31 (11) If the attending physician or nurse practitioner authorized to provide



1 compensable medical services under ORS 656.245 has approved the worker's  
2 return to work and there is a labor dispute in progress at the place of em-  
3 ployment, the worker may refuse to return to that employment without loss  
4 of reemployment rights or any vocational assistance provided by this chap-  
5 ter.

6 (12) Any notice of closure made under this section may include necessary  
7 adjustments in compensation paid or payable prior to the notice of closure,  
8 including disallowance of permanent disability payments prematurely made,  
9 crediting temporary disability payments against current or future permanent  
10 or temporary disability awards or payments and requiring the payment of  
11 temporary disability payments which were payable but not paid.

12 (13) An insurer or self-insured employer may take a credit or offset of  
13 previously paid workers' compensation benefits or payments against any  
14 further workers' compensation benefits or payments due a worker from that  
15 insurer or self-insured employer when the worker admits to having obtained  
16 the previously paid benefits or payments through fraud, or a civil judgment  
17 or criminal conviction is entered against the worker for having obtained the  
18 previously paid benefits through fraud. Benefits or payments obtained  
19 through fraud by a worker may not be included in any data used for  
20 ratemaking or individual employer rating or dividend calculations by an  
21 insurer, a rating organization licensed pursuant to ORS chapter 737, the  
22 State Accident Insurance Fund Corporation or the director.

23 (14)(a) An insurer or self-insured employer may offset any compensation  
24 payable to the worker to recover an overpayment from a claim with the same  
25 insurer or self-insured employer. When overpayments are recovered from  
26 temporary disability or permanent total disability benefits, the amount re-  
27 covered from each payment shall not exceed 25 percent of the payment,  
28 without prior authorization from the worker.

29 (b) An insurer or self-insured employer may suspend and offset any com-  
30 pensation payable to the beneficiary of the worker, and recover an overpay-  
31 ment of permanent total disability benefits caused by the failure of the

1 worker's beneficiaries to notify the insurer or self-insured employer about  
2 the death of the worker.

3 (15) Conditions that are direct medical sequelae to the original accepted  
4 condition shall be included in rating permanent disability of the claim unless  
5 they have been specifically denied.

6 **(16) Except as provided under subsection (13) of this section, an**  
7 **insurer or self-insured employer may not recover an overpayment**  
8 **from a worker's permanent disability compensation for overpayments,**  
9 **offsets or credits of wage loss in an amount that exceeds 50 percent**  
10 **of the worker's total award.**

11 **SECTION 4.** ORS 656.268, as amended by section 2, chapter 47, Oregon  
12 Laws 2021, is amended to read:

13 656.268. (1) One purpose of this chapter is to restore the injured worker  
14 as soon as possible and as near as possible to a condition of self support and  
15 maintenance as an able-bodied worker. The insurer or self-insured employer  
16 shall close the worker's claim, as prescribed by the Director of the Depart-  
17 ment of Consumer and Business Services, and determine the extent of the  
18 worker's permanent disability, provided the worker is not enrolled and ac-  
19 tively engaged in training according to rules adopted by the director pursu-  
20 ant to ORS 656.340 and 656.726, when:

21 (a) The worker has become medically stationary and there is sufficient  
22 information to determine permanent disability. **Notwithstanding any**  
23 **other provision of this chapter, no statement from the physician shall**  
24 **be effective to establish medically stationary status more than 60 days**  
25 **before the worker, or the worker's attorney, if represented, is notified**  
26 **that the worker has become medically stationary.[:]**

27 (b) The accepted injury is no longer the major contributing cause of the  
28 worker's combined or consequential condition or conditions pursuant to ORS  
29 656.005 (7). When the claim is closed because the accepted injury is no longer  
30 the major contributing cause of the worker's combined or consequential  
31 condition or conditions, and there is sufficient information to determine

1 permanent disability, the likely permanent disability that would have been  
2 due to the current accepted condition shall be estimated.[;]

3 (c) Without the approval of the attending physician or nurse practitioner  
4 authorized to provide compensable medical services under ORS 656.245, the  
5 worker fails to seek medical treatment for a period of 30 days or the worker  
6 fails to attend a closing examination, unless the worker affirmatively estab-  
7 lishes that such failure is attributable to reasons beyond the worker's  
8 control.[; *or*]

9 (d) An insurer or self-insured employer finds that a worker who has been  
10 receiving permanent total disability benefits has materially improved and is  
11 capable of regularly performing work at a gainful and suitable occupation.

12 (2) If the worker is enrolled and actively engaged in training according  
13 to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disa-  
14 bility compensation shall be proportionately reduced by any sums earned  
15 during the training.

16 (3) A copy of all medical reports and reports of vocational rehabilitation  
17 agencies or counselors shall be furnished to the worker, if requested by the  
18 worker.

19 (4) Temporary total disability benefits shall continue until whichever of  
20 the following events first occurs:

21 (a) The worker returns to regular or modified employment;

22 (b) The attending physician or nurse practitioner who has authorized  
23 temporary disability benefits for the worker under ORS 656.245 advises the  
24 worker and documents in writing that the worker is released to return to  
25 regular employment;

26 (c) The attending physician or nurse practitioner who has authorized  
27 temporary disability benefits for the worker under ORS 656.245 advises the  
28 worker and documents in writing that the worker is released to return to  
29 modified employment, such employment is offered in writing to the worker  
30 and the worker fails to begin such employment. However, an offer of modi-  
31 fied employment may be refused by the worker without the termination of

1 temporary total disability benefits if the offer:

2 (A) Requires a commute that is beyond the physical capacity of the  
3 worker according to the worker's attending physician or the nurse practi-  
4 tioner who may authorize temporary disability under ORS 656.245;

5 (B) Is at a work site more than 50 miles one way from where the worker  
6 was injured unless the site is less than 50 miles from the worker's residence  
7 or the intent of the parties at the time of hire or as established by the pat-  
8 tern of employment prior to the injury was that the employer had multiple  
9 or mobile work sites and the worker could be assigned to any such site;

10 (C) Is not with the employer at injury;

11 (D) Is not at a work site of the employer at injury;

12 (E) Is not consistent with the existing written shift change policy or is  
13 not consistent with common practice of the employer at injury or aggra-  
14 vation; or

15 (F) Is not consistent with an existing shift change provision of an appli-  
16 cable collective bargaining agreement;

17 (d) Any other event that causes temporary disability benefits to be law-  
18 fully suspended, withheld or terminated under ORS 656.262 (4) or other pro-  
19 visions of this chapter; or

20 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection,  
21 the attending physician or nurse practitioner who has authorized temporary  
22 disability benefits under ORS 656.245 for a home care worker or a personal  
23 support worker who has been made a subject worker pursuant to ORS 656.039  
24 advises the home care worker or personal support worker and documents in  
25 writing that the home care worker or personal support worker is released  
26 to return to modified employment, appropriate modified employment is of-  
27 fered in writing by the Home Care Commission or a designee of the com-  
28 mission to the home care worker or personal support worker for any client  
29 of the Department of Human Services who employs a home care worker or  
30 personal support worker and the worker fails to begin the employment.

31 (5)(a) Findings by the insurer or self-insured employer regarding the ex-

1 tent of the worker's disability in closure of the claim shall be pursuant to  
2 the standards prescribed by the director.

3 (b) The insurer or self-insured employer shall issue a notice of closure of  
4 the claim to the worker and to the worker's attorney if the worker is re-  
5 presented. The insurer or self-insured employer shall notify the director of  
6 the closure in the manner the director prescribes by rule. If the worker is  
7 deceased at the time the notice of closure is issued, the insurer or self-  
8 insured employer shall mail the worker's copy of the notice of closure, ad-  
9 dressed to the estate of the worker, to the worker's last known address and  
10 may mail copies of the notice of closure to any known or potential benefi-  
11 ciaries to the estate of the deceased worker.

12 (c) The notice of closure must inform:

13 (A) The parties, in boldfaced type, of the proper manner in which to pro-  
14 ceed if they are dissatisfied with the terms of the notice of closure;

15 (B) The worker of:

16 (i) The amount of any further compensation, including permanent disa-  
17 bility compensation to be awarded;

18 (ii) The duration of temporary total or temporary partial disability com-  
19 pensation;

20 (iii) The right of the worker or beneficiaries of the worker who were  
21 mailed a copy of the notice of closure under paragraph (b) of this subsection  
22 to request reconsideration by the director under this section within 60 days  
23 of the date of the notice of closure;

24 (iv) The right of beneficiaries who were not mailed a copy of the notice  
25 of closure under paragraph (b) of this subsection to request reconsideration  
26 by the director under this section within one year of the date the notice of  
27 closure was mailed to the estate of the worker under paragraph (b) of this  
28 subsection;

29 (v) The right of the insurer or self-insured employer to request reconsid-  
30 eration by the director under this section within seven days of the date of  
31 the notice of closure;

1 (vi) The aggravation rights; and

2 (vii) Any other information as the director may require; and

3 (C) Any beneficiaries of death benefits to which they may be entitled  
4 pursuant to ORS 656.204 and 656.208.

5 (d) If the insurer or self-insured employer has not issued a notice of clo-  
6 sure, the worker may request closure. Within 10 days of receipt of a written  
7 request from the worker, the insurer or self-insured employer shall issue a  
8 notice of closure if the requirements of this section have been met or a no-  
9 tice of refusal to close if the requirements of this section have not been met.  
10 A notice of refusal to close shall advise the worker of:

11 (A) The decision not to close;

12 (B) The right of the worker to request a hearing pursuant to ORS 656.283  
13 within 60 days of the date of the notice of refusal to close;

14 (C) The right to be represented by an attorney; and

15 (D) Any other information as the director may require.

16 (e) If a worker, a worker's beneficiary, an insurer or a self-insured em-  
17 ployer objects to the notice of closure, the objecting party first must request  
18 reconsideration by the director under this section. A worker's request for  
19 reconsideration must be made within 60 days of the date of the notice of  
20 closure. If the worker is deceased at the time the notice of closure is issued,  
21 a request for reconsideration by a beneficiary of the worker who was mailed  
22 a copy of the notice of closure under paragraph (b) of this subsection must  
23 be made within 60 days of the date of the notice of closure. A request for  
24 reconsideration by a beneficiary to the estate of a deceased worker who was  
25 not mailed a copy of the notice of closure under paragraph (b) of this sub-  
26 section must be made within one year of the date the notice of closure was  
27 mailed to the estate of the worker under paragraph (b) of this subsection.  
28 A request for reconsideration by an insurer or self-insured employer may be  
29 based only on disagreement with the findings used to rate impairment and  
30 must be made within seven days of the date of the notice of closure.

31 (f) If an insurer or self-insured employer has closed a claim or refused to

1 close a claim pursuant to this section, if the correctness of that notice of  
2 closure or refusal to close is at issue in a hearing on the claim and if a  
3 finding is made at the hearing that the notice of closure or refusal to close  
4 was not reasonable, a penalty shall be assessed against the insurer or self-  
5 insured employer and paid to the worker in an amount equal to 25 percent  
6 of all compensation determined to be then due the claimant.

7 (g) If, upon reconsideration of a claim closed by an insurer or self-insured  
8 employer, the director orders an increase by 25 percent or more of the  
9 amount of compensation to be paid to the worker for permanent disability  
10 and the worker is found upon reconsideration to be at least 20 percent per-  
11 manently disabled, a penalty shall be assessed against the insurer or self-  
12 insured employer and paid to the worker in an amount equal to 25 percent  
13 of all compensation determined to be then due the claimant. If the increase  
14 in compensation results from information that the insurer or self-insured  
15 employer demonstrates the insurer or self-insured employer could not rea-  
16 sonably have known at the time of claim closure, from new information ob-  
17 tained through a medical arbiter examination or from a determination order  
18 issued by the director that addresses the extent of the worker's permanent  
19 disability that is not based on the standards adopted pursuant to ORS 656.726  
20 (4)(f), the penalty shall not be assessed.

21 (6)(a) Notwithstanding any other provision of law, only one reconsider-  
22 ation proceeding may be held on each notice of closure. At the reconsider-  
23 ation proceeding:

24 (A) A deposition arranged by the worker, limited to the testimony and  
25 cross-examination of the worker about the worker's condition at the time of  
26 claim closure, shall become part of the reconsideration record. The deposi-  
27 tion must be conducted subject to the opportunity for cross-examination by  
28 the insurer or self-insured employer and in accordance with rules adopted  
29 by the director. The cost of the court reporter, interpreter services, if nec-  
30 essary, and one original of the transcript of the deposition for the Depart-  
31 ment of Consumer and Business Services and one copy of the transcript of

1 the deposition for each party shall be paid by the insurer or self-insured  
2 employer. The reconsideration proceeding may not be postponed to receive  
3 a deposition taken under this subparagraph. A deposition taken in accord-  
4 ance with this subparagraph may be received as evidence at a hearing even  
5 if the deposition is not prepared in time for use in the reconsideration pro-  
6 ceeding.

7 (B) Pursuant to rules adopted by the director, the worker or the insurer  
8 or self-insured employer may correct information in the record that is erro-  
9 neous and may submit any medical evidence that should have been but was  
10 not submitted by the attending physician or nurse practitioner authorized to  
11 provide compensable medical services under ORS 656.245 at the time of claim  
12 closure.

13 (C) If the director determines that a claim was not closed in accordance  
14 with subsection (1) of this section, the director may rescind the closure.

15 (b) If necessary, the director may require additional medical or other in-  
16 formation with respect to the claims and may postpone the reconsideration  
17 for not more than 60 additional calendar days.

18 (c) In any reconsideration proceeding under this section in which the  
19 worker was represented by an attorney, the director shall order the insurer  
20 or self-insured employer to pay to the attorney, out of the additional com-  
21 pensation awarded, an amount equal to 10 percent of any additional com-  
22 pensation awarded to the worker.

23 (d) Except as provided in subsection (7) of this section, the reconsider-  
24 ation proceeding shall be completed within 18 working days from the date  
25 the reconsideration proceeding begins, and shall be performed by a special  
26 evaluation appellate unit within the department. The deadline of 18 working  
27 days may be postponed by an additional 60 calendar days if within the 18  
28 working days the department mails notice of review by a medical arbiter. If  
29 an order on reconsideration has not been mailed on or before 18 working  
30 days from the date the reconsideration proceeding begins, or within 18  
31 working days plus the additional 60 calendar days where a notice for medical



1 arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional  
2 time as provided in subsection (8) of this section when reconsideration is  
3 postponed further because the worker has failed to cooperate in the medical  
4 arbiter examination, reconsideration shall be deemed denied and any further  
5 proceedings shall occur as though an order on reconsideration affirming the  
6 notice of closure was mailed on the date the order was due to issue.  
7

8 (e) The period for completing the reconsideration proceeding described in  
9 paragraph (d) of this subsection begins upon receipt by the director of a  
10 worker's or a beneficiary's request for reconsideration pursuant to subsection  
11 (5)(e) of this section. If the insurer or self-insured employer requests recon-  
12 sideration, the period for reconsideration begins upon the earlier of the date  
13 of the request for reconsideration by the worker or beneficiary, the date of  
14 receipt of a waiver from the worker or beneficiary of the right to request  
15 reconsideration or the date of expiration of the right of the worker or ben-  
16 eficiary to request reconsideration. If a party elects not to file a separate  
17 request for reconsideration, the party does not waive the right to fully par-  
18 ticipate in the reconsideration proceeding, including the right to proceed  
19 with the reconsideration if the initiating party withdraws the request for  
20 reconsideration.

21 (f) Any medical arbiter report may be received as evidence at a hearing  
22 even if the report is not prepared in time for use in the reconsideration  
23 proceeding.

24 (g) If any party objects to the reconsideration order, the party may re-  
25 quest a hearing under ORS 656.283 within 30 days from the date of the re-  
26 consideration order.

27 (7)(a) The director may delay the reconsideration proceeding and toll the  
28 reconsideration timeline established under subsection (6) of this section for  
29 up to 45 calendar days if:

30 (A) A request for reconsideration of a notice of closure has been made to  
31 the director within 60 days of the date of the notice of closure;

1 (B) The parties are actively engaged in settlement negotiations that in-  
2 clude issues in dispute at reconsideration;

3 (C) The parties agree to the delay; and

4 (D) Both parties notify the director before the 18th working day after the  
5 reconsideration proceeding has begun that they request a delay under this  
6 subsection.

7 (b) A delay of the reconsideration proceeding granted by the director un-  
8 der this subsection expires:

9 (A) If a party requests the director to resume the reconsideration pro-  
10 ceeding before the expiration of the delay period;

11 (B) If the parties reach a settlement and the director receives a copy of  
12 the approved settlement documents before the expiration of the delay period;  
13 or

14 (C) On the next calendar day following the expiration of the delay period  
15 authorized by the director.

16 (c) Upon expiration of a delay granted under this subsection, the timeline  
17 for the completion of the reconsideration proceeding shall resume as if the  
18 delay had never been granted.

19 (d) Compensation due the worker shall continue to be paid during the  
20 period of delay authorized under this subsection.

21 (e) The director may authorize only one delay period for each reconsid-  
22 eration proceeding.

23 (8)(a) If the basis for objection to a notice of closure issued under this  
24 section is disagreement with the impairment used in rating of the worker's  
25 disability, the director shall refer the claim to a medical arbiter appointed  
26 by the director.

27 (b) If the director determines that insufficient medical information is  
28 available to determine disability, the director may appoint, and refer the  
29 claim to, a medical arbiter.

30 (c) At the request of either of the parties, the director shall appoint a  
31 panel of as many as three medical arbiters in accordance with criteria that

1 the director sets by rule.

2 (d) The arbiter, or panel of medical arbiters, must be chosen from among  
3 a list of physicians qualified to be attending physicians referred to in ORS  
4 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon  
5 Medical Board and the committee referred to in ORS 656.790.

6 (e)(A) The medical arbiter or panel of medical arbiters may examine the  
7 worker and perform such tests as may be reasonable and necessary to es-  
8 tablish the worker's impairment.

9 (B) If the director determines that the worker failed to attend the exam-  
10 ination without good cause or failed to cooperate with the medical arbiter,  
11 or panel of medical arbiters, the director shall postpone the reconsideration  
12 proceedings for up to 60 days from the date of the determination that the  
13 worker failed to attend or cooperate, and shall suspend all disability benefits  
14 resulting from this or any prior opening of the claim until such time as the  
15 worker attends and cooperates with the examination or the request for re-  
16 consideration is withdrawn. Any additional evidence regarding good cause  
17 must be submitted prior to the conclusion of the 60-day postponement period.

18 (C) At the conclusion of the 60-day postponement period, if the worker  
19 has not attended and cooperated with a medical arbiter examination or es-  
20 tablished good cause, the worker may not attend a medical arbiter examina-  
21 tion for this claim closure. The reconsideration record must be closed, and  
22 the director shall issue an order on reconsideration based upon the existing  
23 record.

24 (D) All disability benefits suspended under this subsection, including all  
25 disability benefits awarded in the order on reconsideration, or by an Ad-  
26 ministrative Law Judge, the Workers' Compensation Board or upon court  
27 review, are not due and payable to the worker.

28 (f) The insurer or self-insured employer shall pay the costs of examination  
29 and review by the medical arbiter or panel of medical arbiters.

30 (g) The findings of the medical arbiter or panel of medical arbiters must  
31 be submitted to the director for reconsideration of the notice of closure.

1 (h) After reconsideration, no subsequent medical evidence of the worker's  
2 impairment is admissible before the director, the Workers' Compensation  
3 Board or the courts for purposes of making findings of impairment on the  
4 claim closure.

5 (i)(A) If the basis for objection to a notice of closure issued under this  
6 section is a disagreement with the impairment used in rating the worker's  
7 disability, and the director determines that the worker is not medically sta-  
8 tionary at the time of the reconsideration or that the closure was not made  
9 pursuant to this section, the director is not required to appoint a medical  
10 arbiter before completing the reconsideration proceeding.

11 (B) If the worker's condition has substantially changed since the notice  
12 of closure, upon the consent of all the parties to the claim, the director shall  
13 postpone the proceeding until the worker's condition is appropriate for claim  
14 closure under subsection (1) of this section.

15 (9) No hearing shall be held on any issue that was not raised and pre-  
16 served before the director at reconsideration. However, issues arising out of  
17 the reconsideration order may be addressed and resolved at hearing.

18 (10) If, after the notice of closure issued pursuant to this section, the  
19 worker becomes enrolled and actively engaged in training according to rules  
20 adopted pursuant to ORS 656.340 and 656.726, any permanent disability pay-  
21 ments due for work disability under the closure shall be suspended, and the  
22 worker shall receive temporary disability compensation and any permanent  
23 disability payments due for impairment while the worker is enrolled and  
24 actively engaged in the training. When the worker ceases to be enrolled and  
25 actively engaged in the training, the insurer or self-insured employer shall  
26 again close the claim pursuant to this section if the worker is medically  
27 stationary or if the worker's accepted injury is no longer the major contrib-  
28 uting cause of the worker's combined or consequential condition or condi-  
29 tions pursuant to ORS 656.005 (7). The closure shall include the duration of  
30 temporary total or temporary partial disability compensation. Permanent  
31 disability compensation shall be redetermined for work disability only. If the

1 worker has returned to work or the worker's attending physician has re-  
2 leased the worker to return to regular or modified employment, the insurer  
3 or self-insured employer shall again close the claim. This notice of closure  
4 may be appealed only in the same manner as are other notices of closure  
5 under this section.

6 (11) If the attending physician or nurse practitioner authorized to provide  
7 compensable medical services under ORS 656.245 has approved the worker's  
8 return to work and there is a labor dispute in progress at the place of em-  
9 ployment, the worker may refuse to return to that employment without loss  
10 of reemployment rights or any vocational assistance provided by this chap-  
11 ter.

12 (12) Any notice of closure made under this section may include necessary  
13 adjustments in compensation paid or payable prior to the notice of closure,  
14 including disallowance of permanent disability payments prematurely made,  
15 crediting temporary disability payments against current or future permanent  
16 or temporary disability awards or payments and requiring the payment of  
17 temporary disability payments which were payable but not paid.

18 (13) An insurer or self-insured employer may take a credit or offset of  
19 previously paid workers' compensation benefits or payments against any  
20 further workers' compensation benefits or payments due a worker from that  
21 insurer or self-insured employer when the worker admits to having obtained  
22 the previously paid benefits or payments through fraud, or a civil judgment  
23 or criminal conviction is entered against the worker for having obtained the  
24 previously paid benefits through fraud. Benefits or payments obtained  
25 through fraud by a worker may not be included in any data used for  
26 ratemaking or individual employer rating or dividend calculations by an  
27 insurer, a rating organization licensed pursuant to ORS chapter 737, the  
28 State Accident Insurance Fund Corporation or the director.

29 (14)(a) An insurer or self-insured employer may offset any compensation  
30 payable to the worker to recover an overpayment from a claim with the same  
31 insurer or self-insured employer. When overpayments are recovered from

1 temporary disability or permanent total disability benefits, the amount re-  
2 covered from each payment shall not exceed 25 percent of the payment,  
3 without prior authorization from the worker.

4 (b) An insurer or self-insured employer may suspend and offset any com-  
5 pensation payable to the beneficiary of the worker, and recover an overpay-  
6 ment of permanent total disability benefits caused by the failure of the  
7 worker's beneficiaries to notify the insurer or self-insured employer about  
8 the death of the worker.

9 (15) Conditions that are direct medical sequelae to the original accepted  
10 condition shall be included in rating permanent disability of the claim unless  
11 they have been specifically denied.

12 **(16) Except as provided under subsection (13) of this section, an**  
13 **insurer or self-insured employer may not recover an overpayment**  
14 **from a worker's permanent disability compensation for overpayments,**  
15 **offsets or credits of wage loss in an amount that exceeds 50 percent**  
16 **of the worker's total award.**

17 **SECTION 5.** ORS 656.319 is amended to read:

18 656.319. (1) With respect to objection by a claimant to denial of a claim  
19 for compensation under ORS 656.262, a hearing thereon shall not be granted  
20 and the claim shall not be enforceable unless:

21 (a) A request for hearing is filed not later than the 60th day after the  
22 mailing of the denial to the claimant; or

23 (b) The request is filed not later than the 180th day after mailing of the  
24 denial and the claimant establishes at a hearing that there was good cause  
25 for failure to file the request by the 60th day after mailing of the denial.

26 (2) Notwithstanding subsection (1) of this section, a hearing shall be  
27 granted even if a request therefor is filed after the time specified in sub-  
28 section (1) of this section if the claimant can show lack of mental compe-  
29 tency to file the request within that time. The period for filing under this  
30 subsection shall not be extended more than five years by lack of mental  
31 competency, nor shall it extend in any case longer than one year after the

1 claimant regains mental competency.

2 (3) With respect to subsection (2) of this section, lack of mental compe-  
3 tency shall apply only to an individual suffering from such mental disorder,  
4 mental illness or nervous disorder as is required for commitment or volun-  
5 tary admission to a treatment facility pursuant to ORS 426.005 to 426.223 and  
6 426.241 to 426.380 and the rules of the Oregon Health Authority.

7 (4) With respect to objections to a reconsideration order under ORS  
8 656.268, a hearing on such objections shall not be granted unless a request  
9 for hearing is filed within 30 days after the copies of the reconsideration  
10 order were mailed to the parties.

11 (5) With respect to objection by a claimant to a notice of refusal to close  
12 a claim under ORS 656.268, a hearing on the objection shall not be granted  
13 unless the request for hearing is filed within 60 days after copies of the no-  
14 tice of refusal to close were mailed to the parties.

15 *[(6) A hearing for failure to process or an allegation that the claim was*  
16 *processed incorrectly shall not be granted unless the request for hearing is*  
17 *filed within two years after the alleged action or inaction occurred.]*

18 [(7)] (6) With respect to objection by a claimant to a notice of closure  
19 issued under ORS 656.206, a hearing on the objection shall not be granted  
20 unless the request for hearing is filed within 60 days after the notice of  
21 closure was mailed to the claimant.

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