

HOUSE AMENDMENTS TO HOUSE BILL 4138

By COMMITTEE ON RULES

February 21

1 On page 1 of the printed bill, line 2, after the semicolon delete the rest of the line and insert
2 “creating new provisions; and amending ORS 656.262 and 656.268.”.

3 Delete lines 4 through 31 and delete pages 2 through 26 and insert:

4 “**SECTION 1.** ORS 656.262 is amended to read:

5 “656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
6 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
7 claims as required in this chapter.

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

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

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

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

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

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

19 “(E) Any other details the insurer may require.

20 “(b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
21 for any penalty the insurer is required to pay under subsection (11) of this section because of such
22 failure. As used in this subsection, ‘health insurance’ has the meaning for that term provided in ORS
23 731.162.

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

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

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

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

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

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

24 “(g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after
25 the worker’s attending physician or nurse practitioner authorized to provide compensable medical
26 services under ORS 656.245 ceases to authorize temporary disability or for any period of time not
27 authorized by the attending physician or nurse practitioner. No authorization of temporary disability
28 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
29 to retroactively authorize the payment of temporary disability more than [14] 45 days prior to its
30 issuance.

31 “(B) Subparagraph (A) of this paragraph does not apply:

32 “(i) During periods in which there is a denial under the jurisdiction of the Workers’
33 Compensation Board that affects the worker’s ability to obtain authorization of temporary
34 disability;

35 “(ii) During periods in which there is a dispute over the identity of, or treatment by, an
36 attending physician or nurse practitioner that affects the worker’s ability to obtain authori-
37 zation of temporary disability; or

38 “(iii) When notice has not been given pursuant to paragraph (j) of this subsection.

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

44 “(i) The insurer or self-insured employer may unilaterally suspend payment of all compensation
45 to a worker enrolled in a managed care organization if the worker continues to seek care from an

1 attending physician or nurse practitioner authorized to provide compensable medical services under
2 ORS 656.245 that is not authorized by the managed care organization more than seven days after
3 the mailing of notice by the insurer or self-insured employer.

4 **“(j)(A) The insurer or self-insured employer may not end temporary disability benefits**
5 **until written notice has been mailed or delivered to the worker and the worker’s attorney,**
6 **if the worker is represented. The notice must state the reason that temporary disability**
7 **benefits are no longer due and payable.**

8 **“(B) The worker’s attending physician or nurse practitioner may retroactively authorize**
9 **temporary disability for up to 45 days prior to the date of the notice.**

10 **“(C) If the notice required under subparagraph (A) of this paragraph is given more than**
11 **45 days after the worker was no longer eligible for benefits, the attending physician or nurse**
12 **practitioner may retroactively authorize temporary disability back to the date on which**
13 **benefits were no longer due and payable, provided the authorization is made within 30 days**
14 **following the earlier of the date of mailing or delivery of the written notice that the eligibility**
15 **ended to the worker and the worker’s attorney, if the worker is represented.**

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

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

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

34 **“(6)(a)** Written notice of acceptance or denial of the claim shall be furnished to the claimant by
35 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
36 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
37 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
38 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
39 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
40 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
41 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
42 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
43 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
44 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
45 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer

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

13 “(b) The notice of acceptance shall:

14 “(A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

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

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

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

26 “(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
27 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
28 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the
29 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
30 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable
31 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court
32 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-
33 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and
34 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed
35 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under
36 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the
37 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this
38 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-
39 ment and payment of the additional amount and attorney fees described in this subsection. The
40 action of the director and the review of the action taken by the director shall be subject to review
41 under ORS 656.704.

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

45 “(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the

1 insurer or self-insured employer has failed to make the payment in accordance with the requirements
2 specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly no-
3 tify the insurer or self-insured employer in writing that the payment is past due. If the required
4 payment is not made within five business days after receipt of the notice by the insurer or self-
5 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
6 adopted by the director by rule.

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

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

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

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

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

1 self-insured employer to accept or deny the claim.

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

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

8 “656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
9 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
10 claims as required in this chapter.

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

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

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

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

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

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

22 “(E) Any other details the insurer may require.

23 “(b) Failure to so report subjects the offending employer to a charge for reimbursing the insurer
24 for any penalty the insurer is required to pay under subsection (11) of this section because of such
25 failure. As used in this subsection, ‘health insurance’ has the meaning for that term provided in ORS
26 731.162.

27 “(4)(a) The first installment of temporary disability compensation shall be paid no later than the
28 14th day after the subject employer has notice or knowledge of the claim and of the worker’s disa-
29 bility, if the attending physician or nurse practitioner authorized to provide compensable medical
30 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-
31 after, temporary disability compensation shall be paid at least once each two weeks, except where
32 the Director of the Department of Consumer and Business Services determines that payment in in-
33 stallments should be made at some other interval. The director may by rule convert monthly benefit
34 schedules to weekly or other periodic schedules.

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

39 “(c) Notwithstanding any other provision of this chapter, when the holder of a public office is
40 injured in the course and scope of that public office, full official salary paid to the holder of that
41 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
42 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, ‘public
43 office’ has the meaning for that term provided in ORS 260.005.

44 “(d) Temporary disability compensation is not due and payable for any period of time for which
45 the insurer or self-insured employer has requested from the worker’s attending physician or nurse

1 practitioner authorized 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 and the physician or
3 nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable
4 to receive treatment for reasons beyond the worker's control.

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

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

17 "(g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after
18 the worker's attending physician or nurse practitioner authorized to provide compensable medical
19 services under ORS 656.245 ceases to authorize temporary disability or for any period of time not
20 authorized by the attending physician or nurse practitioner. No authorization of temporary disability
21 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
22 to retroactively authorize the payment of temporary disability more than [14] 45 days prior to its
23 issuance.

24 "**(B) Subparagraph (A) of this paragraph does not apply:**

25 "**(i) During periods in which there is a denial under the jurisdiction of the Workers'**
26 **Compensation Board that affects the worker's ability to obtain authorization of temporary**
27 **disability;**

28 "**(ii) During periods in which there is a dispute over the identity of, or treatment by, an**
29 **attending physician or nurse practitioner that affects the worker's ability to obtain authori-**
30 **zation of temporary disability; or**

31 "**(iii) When notice has not been given pursuant to paragraph (j) of this subsection.**

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

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

42 "**(j)(A) The insurer or self-insured employer may not end temporary disability benefits**
43 **until written notice has been mailed or delivered to the worker and the worker's attorney,**
44 **if the worker is represented. The notice must state the reason that temporary disability**
45 **benefits are no longer due and payable.**

1 **“(B) The worker’s attending physician or nurse practitioner may retroactively authorize**
2 **temporary disability for up to 45 days prior to the date of the notice.**

3 **“(C) If the notice required under subparagraph (A) of this paragraph is given more than**
4 **45 days after the worker was no longer eligible for benefits, the attending physician or nurse**
5 **practitioner may retroactively authorize temporary disability back to the date on which**
6 **benefits were no longer due and payable, provided the authorization is made within 30 days**
7 **following the earlier of the date of mailing or delivery of the written notice that the eligibility**
8 **ended to the worker and the worker’s attorney, if the worker is represented.**

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

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

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

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

1 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
2 payable from the date any such benefits were terminated under the denial. Except as provided in
3 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
4 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
5 a copy of the notice of acceptance.

6 “(b) The notice of acceptance shall:

7 “(A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

42 “(c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
43 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
44 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
45 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-

1 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
2 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
3 garding that condition.

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

6 “(9) If an insurer or any other duly authorized agent of the employer for such purpose, on record
7 with the Director of the Department of Consumer and Business Services denies a claim for com-
8 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
9 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the
10 claimant. The insurer shall issue a copy of the notice of denial to the employer. The insurer shall
11 notify the director of the denial in the manner the director prescribes by rule. The worker may re-
12 quest a hearing pursuant to ORS 656.319.

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

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

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

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

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

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

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

17 “(b) If the attorney is not willing or available to participate in an interview at a time reasonably
18 chosen by the insurer or self-insured employer within 14 days of the request for interview and the
19 insurer or self-insured employer has cause to believe that the attorney’s unwillingness or unavail-
20 ability is unreasonable and is preventing the worker from complying within 14 days of the request
21 for interview, the insurer or self-insured employer shall notify the director. If the director deter-
22 mines that the attorney’s unwillingness or unavailability is unreasonable, the director shall assess
23 a civil penalty against the attorney of not more than \$1,000.

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

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

45 “**SECTION 3. (1) The amendments to ORS 656.262 by sections 1 and 2 of this 2022 Act**

1 apply to all claims that exist on, or arise on or after, January 1, 2024, regardless of the date
2 of injury or the date on which the claim is filed.

3 **“(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.262 by**
4 **sections 1 and 2 of this 2022 Act do not apply to disputes in which a final determination is**
5 **made prior to January 1, 2024.**

6 **“SECTION 4.** ORS 656.268 is amended to read:

7 “656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible
8 and as near as possible to a condition of self support and maintenance as an able-bodied worker.
9 The insurer or self-insured employer shall close the worker’s claim, as prescribed by the Director
10 of the Department of Consumer and Business Services, and determine the extent of the worker’s
11 permanent disability, provided the worker is not enrolled and actively engaged in training according
12 to rules adopted by the director pursuant to ORS 656.340 and 656.726, when **one of the following**
13 **conditions is met:**

14 “(a) The worker has become medically stationary and there is sufficient information to deter-
15 mine permanent disability[;]. **Notwithstanding any other provision of this chapter, a physician**
16 **or nurse practitioner may not retroactively determine a worker to be medically stationary**
17 **more than 60 days prior to the date of the determination except in the case of claims that**
18 **are subject to subsection (13) of this section. An insurer or self-insured employer must mail**
19 **or deliver written notice to a worker and to the worker’s attorney, if the worker is repres-**
20 **ented, within seven days following receipt of information that the worker is medically sta-**
21 **tionary.**

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

28 “(c) Without the approval of the attending physician or nurse practitioner authorized to provide
29 compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a
30 period of 30 days or the worker fails to attend a closing examination, unless the worker
31 affirmatively establishes that such failure is attributable to reasons beyond the worker’s control.[;
32 or]

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

36 “(2) If the worker is enrolled and actively engaged in training according to rules adopted pur-
37 suant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately
38 reduced by any sums earned during the training.

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

41 “(4) Temporary total disability benefits shall continue until whichever of the following events
42 first occurs:

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

44 “(b) The attending physician or nurse practitioner who has authorized temporary disability
45 benefits for the worker under ORS 656.245 advises the worker and documents in writing that the

1 worker is released to return to regular employment;

2 “(c) The attending physician or nurse practitioner who has authorized temporary disability
3 benefits for the worker under ORS 656.245 advises the worker and documents in writing that the
4 worker is released to return to modified employment, such employment is offered in writing to the
5 worker and the worker fails to begin such employment. However, an offer of modified employment
6 may be refused by the worker without the termination of temporary total disability benefits if the
7 offer:

8 “(A) Requires a commute that is beyond the physical capacity of the worker according to the
9 worker’s attending physician or the nurse practitioner who may authorize temporary disability un-
10 der ORS 656.245;

11 “(B) Is at a work site more than 50 miles one way from where the worker was injured unless
12 the site is less than 50 miles from the worker’s residence or the intent of the parties at the time
13 of hire or as established by the pattern of employment prior to the injury was that the employer had
14 multiple or mobile work sites and the worker could be assigned to any such site;

15 “(C) Is not with the employer at injury;

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

17 “(E) Is not consistent with the existing written shift change policy or is not consistent with
18 common practice of the employer at injury or aggravation; or

19 “(F) Is not consistent with an existing shift change provision of an applicable collective bar-
20 gaining agreement;

21 “(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
22 or terminated under ORS 656.262 (4) or other provisions of this chapter; or

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

32 “(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker’s
33 disability in closure of the claim shall be pursuant to the standards prescribed by the director.

34 “(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the
35 worker, to the worker’s attorney if the worker is represented, and to the director. If the worker is
36 deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail
37 the worker’s copy of the notice of closure, addressed to the estate of the worker, to the worker’s last
38 known address and may mail copies of the notice of closure to any known or potential beneficiaries
39 to the estate of the deceased worker.

40 “(c) The notice of closure must inform:

41 “(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dis-
42 satisfied with the terms of the notice of closure;

43 “(B) The worker of:

44 “(i) The amount of any further compensation, including permanent disability compensation to
45 be awarded;

1 “(ii) The duration of temporary total or temporary partial disability compensation;

2 “(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the no-

3 tice of closure under paragraph (b) of this subsection to request reconsideration by the director

4 under this section within 60 days of the date of the notice of closure;

5 “(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under par-

6 agraph (b) of this subsection to request reconsideration by the director under this section within one

7 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)

8 of this subsection;

9 “(v) The right of the insurer or self-insured employer to request reconsideration by the director

10 under this section within seven days of the date of the notice of closure;

11 “(vi) The aggravation rights; and

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

13 “(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204

14 and 656.208.

15 “(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may

16 request closure. Within 10 days of receipt of a written request from the worker, the insurer or

17 self-insured employer shall issue a notice of closure if the requirements of this section have been

18 met or a notice of refusal to close if the requirements of this section have not been met. A notice

19 of refusal to close shall advise the worker of:

20 “(A) The decision not to close;

21 “(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the

22 date of the notice of refusal to close;

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

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

25 “(e) If a worker, a worker’s beneficiary, an insurer or a self-insured employer objects to the

26 notice of closure, the objecting party first must request reconsideration by the director under this

27 section. A worker’s request for reconsideration must be made within 60 days of the date of the no-

28 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for

29 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under

30 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.

31 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not

32 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within

33 one year of the date the notice of closure was mailed to the estate of the worker under paragraph

34 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be

35 based only on disagreement with the findings used to rate impairment and must be made within

36 seven days of the date of the notice of closure.

37 “(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant

38 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing

39 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close

40 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid

41 to the worker in an amount equal to 25 percent of all compensation determined to be then due the

42 claimant.

43 “(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the di-

44 rector orders an increase by 25 percent or more of the amount of compensation to be paid to the

45 worker for permanent disability and the worker is found upon reconsideration to be at least 20

1 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured em-
2 ployer and paid to the worker in an amount equal to 25 percent of all compensation determined to
3 be then due the claimant. If the increase in compensation results from information that the insurer
4 or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have
5 known at the time of claim closure, from new information obtained through a medical arbiter ex-
6 amination or from a determination order issued by the director that addresses the extent of the
7 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
8 (4)(f), the penalty shall not be assessed.

9 “(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
10 held on each notice of closure. At the reconsideration proceeding:

11 “(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
12 worker about the worker's condition at the time of claim closure, shall become part of the recon-
13 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
14 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
15 cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the
16 deposition for the Department of Consumer and Business Services and one copy of the transcript
17 of the deposition for each party shall be paid by the insurer or self-insured employer. The recon-
18 sideration proceeding may not be postponed to receive a deposition taken under this subparagraph.
19 A deposition taken in accordance with this subparagraph may be received as evidence at a hearing
20 even if the deposition is not prepared in time for use in the reconsideration proceeding.

21 “(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured em-
22 ployer may correct information in the record that is erroneous and may submit any medical evidence
23 that should have been but was not submitted by the attending physician or nurse practitioner au-
24 thorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

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

27 “(b) If necessary, the director may require additional medical or other information with respect
28 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

29 “(c) In any reconsideration proceeding under this section in which the worker was represented
30 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
31 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
32 pensation awarded to the worker.

33 “(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall
34 be completed within 18 working days from the date the reconsideration proceeding begins, and shall
35 be performed by a special evaluation appellate unit within the department. The deadline of 18
36 working days may be postponed by an additional 60 calendar days if within the 18 working days the
37 department mails notice of review by a medical arbiter. If an order on reconsideration has not been
38 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within
39 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was
40 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-
41 section, or within such additional time as provided in subsection (8) of this section when reconsid-
42 eration is postponed further because the worker has failed to cooperate in the medical arbiter
43 examination, reconsideration shall be deemed denied and any further proceedings shall occur as
44 though an order on reconsideration affirming the notice of closure was mailed on the date the order
45 was due to issue.

1 “(e) The period for completing the reconsideration proceeding described in paragraph (d) of this
2 subsection begins upon receipt by the director of a worker’s or a beneficiary’s request for recon-
3 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
4 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the
5 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
6 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
7 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
8 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
9 ation proceeding, including the right to proceed with the reconsideration if the initiating party
10 withdraws the request for reconsideration.

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

13 “(g) If any party objects to the reconsideration order, the party may request a hearing under
14 ORS 656.283 within 30 days from the date of the reconsideration order.

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

17 “(A) A request for reconsideration of a notice of closure has been made to the director within
18 60 days of the date of the notice of closure;

19 “(B) The parties are actively engaged in settlement negotiations that include issues in dispute
20 at reconsideration;

21 “(C) The parties agree to the delay; and

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

24 “(b) A delay of the reconsideration proceeding granted by the director under this subsection
25 expires:

26 “(A) If a party requests the director to resume the reconsideration proceeding before the expi-
27 ration of the delay period;

28 “(B) If the parties reach a settlement and the director receives a copy of the approved settle-
29 ment documents before the expiration of the delay period; or

30 “(C) On the next calendar day following the expiration of the delay period authorized by the
31 director.

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

34 “(d) Compensation due the worker shall continue to be paid during the period of delay author-
35 ized under this subsection.

36 “(e) The director may authorize only one delay period for each reconsideration proceeding.

37 “(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement
38 with the impairment used in rating of the worker’s disability, the director shall refer the claim to
39 a medical arbiter appointed by the director.

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

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

44 “(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians
45 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected

1 in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

2 “(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform
3 such tests as may be reasonable and necessary to establish the worker’s impairment.

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

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

15 “(D) All disability benefits suspended under this subsection, including all disability benefits
16 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers’ Com-
17 pensation Board or upon court review, are not due and payable to the worker.

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

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

22 “(h) After reconsideration, no subsequent medical evidence of the worker’s impairment is ad-
23 missible before the director, the Workers’ Compensation Board or the courts for purposes of making
24 findings of impairment on the claim closure.

25 “(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement
26 with the impairment used in rating the worker’s disability, and the director determines that the
27 worker is not medically stationary at the time of the reconsideration or that the closure was not
28 made pursuant to this section, the director is not required to appoint a medical arbiter before
29 completing the reconsideration proceeding.

30 “(B) If the worker’s condition has substantially changed since the notice of closure, upon the
31 consent of all the parties to the claim, the director shall postpone the proceeding until the worker’s
32 condition is appropriate for claim closure under subsection (1) of this section.

33 “(9) No hearing shall be held on any issue that was not raised and preserved before the director
34 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
35 resolved at hearing.

36 “(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
37 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
38 any permanent disability payments due for work disability under the closure shall be suspended, and
39 the worker shall receive temporary disability compensation and any permanent disability payments
40 due for impairment while the worker is enrolled and actively engaged in the training. When the
41 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
42 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
43 if the worker’s accepted injury is no longer the major contributing cause of the worker’s combined
44 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
45 duration of temporary total or temporary partial disability compensation. Permanent disability

1 compensation shall be redetermined for work disability only. If the worker has returned to work or
2 the worker's attending physician has released the worker to return to regular or modified employ-
3 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
4 be appealed only in the same manner as are other notices of closure under this section.

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

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

14 “(13) An insurer or self-insured employer may take a credit or offset of previously paid workers'
15 compensation benefits or payments against any further workers' compensation benefits or payments
16 due a worker from that insurer or self-insured employer when the worker admits to having obtained
17 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
18 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
19 fits or payments obtained 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 insurer, a rating organiza-
21 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the
22 director.

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

28 “(b) An insurer or self-insured employer may suspend and offset any compensation payable to
29 the beneficiary of the worker, and recover an overpayment of permanent total disability benefits
30 caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer
31 about the death of the worker.

32 “(15) Conditions that are direct medical sequelae to the original accepted condition shall be in-
33 cluded in rating permanent disability of the claim unless they have been specifically denied.

34 “(16)(a) **Except as provided under subsection (13) of this section, an insurer or self-**
35 **insured employer may not recover an overpayment from a worker's permanent partial disa-**
36 **bility compensation for overpayments, offsets or credits of wage loss in an amount that**
37 **exceeds 50 percent of the total compensation awarded to the worker.**

38 “(b) **An insurer or self-insured employer may not declare an overpayment of any com-**
39 **ensation that was paid more than two years prior to the date of the declaration.**

40 “**SECTION 5.** ORS 656.268, as amended by section 2, chapter 47, Oregon Laws 2021, is amended
41 to read:

42 “656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible
43 and as near as possible to a condition of self support and maintenance as an able-bodied worker.
44 The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director
45 of the Department of Consumer and Business Services, and determine the extent of the worker's

1 permanent disability, provided the worker is not enrolled and actively engaged in training according
2 to rules adopted by the director pursuant to ORS 656.340 and 656.726, when **one of the following**
3 **conditions is met:**

4 “(a) The worker has become medically stationary and there is sufficient information to deter-
5 mine permanent disability[;]. **Notwithstanding any other provision of this chapter, a physician**
6 **or nurse practitioner may not retroactively determine a worker to be medically stationary**
7 **more than 60 days prior to the date of the determination except in the case of claims that**
8 **are subject to subsection (13) of this section. An insurer or self-insured employer must mail**
9 **or deliver written notice to a worker and to the worker’s attorney, if the worker is repres-**
10 **ented, within seven days following receipt of information that the worker is medically sta-**
11 **tionary.**

12 “(b) The accepted injury is no longer the major contributing cause of the worker’s combined or
13 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
14 the accepted injury is no longer the major contributing cause of the worker’s combined or conse-
15 quential condition or conditions, and there is sufficient information to determine permanent disabil-
16 ity, the likely permanent disability that would have been due to the current accepted condition shall
17 be estimated.[;]

18 “(c) Without the approval of the attending physician or nurse practitioner authorized to provide
19 compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a
20 period of 30 days or the worker fails to attend a closing examination, unless the worker
21 affirmatively establishes that such failure is attributable to reasons beyond the worker’s control.[;
22 or]

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

26 “(2) If the worker is enrolled and actively engaged in training according to rules adopted pur-
27 suant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately
28 reduced by any sums earned during the training.

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

31 “(4) Temporary total disability benefits shall continue until whichever of the following events
32 first occurs:

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

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

37 “(c) The attending physician or nurse practitioner who has authorized temporary disability
38 benefits for the worker under ORS 656.245 advises the worker and documents in writing that the
39 worker is released to return to modified employment, such employment is offered in writing to the
40 worker and the worker fails to begin such employment. However, an offer of modified employment
41 may be refused by the worker without the termination of temporary total disability benefits if the
42 offer:

43 “(A) Requires a commute that is beyond the physical capacity of the worker according to the
44 worker’s attending physician or the nurse practitioner who may authorize temporary disability un-
45 der ORS 656.245;

1 “(B) Is at a work site more than 50 miles one way from where the worker was injured unless
2 the site is less than 50 miles from the worker’s residence or the intent of the parties at the time
3 of hire or as established by the pattern of employment prior to the injury was that the employer had
4 multiple 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 not consistent with
8 common practice of the employer at injury or aggravation; or

9 “(F) Is not consistent with an existing shift change provision of an applicable collective bar-
10 gaining agreement;

11 “(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
12 or terminated under ORS 656.262 (4) or other provisions of this chapter; or

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

22 “(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker’s
23 disability in closure of the claim shall be pursuant to the standards prescribed by the director.

24 “(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the
25 worker and to the worker’s attorney if the worker is represented. The insurer or self-insured em-
26 ployer shall notify the director of the closure in the manner the director prescribes by rule. If the
27 worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer
28 shall mail the worker’s copy of the notice of closure, addressed to the estate of the worker, to the
29 worker’s last known address and may mail copies of the notice of closure to any known or potential
30 beneficiaries to the estate of the deceased worker.

31 “(c) The notice of closure must inform:

32 “(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dis-
33 satisfied with the terms of the notice of closure;

34 “(B) The worker of:

35 “(i) The amount of any further compensation, including permanent disability compensation to
36 be awarded;

37 “(ii) The duration of temporary total or temporary partial disability compensation;

38 “(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the no-
39 tice of closure under paragraph (b) of this subsection to request reconsideration by the director
40 under this section within 60 days of the date of the notice of closure;

41 “(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under par-
42 agraph (b) of this subsection to request reconsideration by the director under this section within one
43 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
44 of this subsection;

45 “(v) The right of the insurer or self-insured employer to request reconsideration by the director

1 under this section within seven days of the date of the notice of closure;

2 “(vi) The aggravation rights; and

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

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

6 “(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may
7 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
8 self-insured employer shall issue a notice of closure if the requirements of this section have been
9 met or a notice of refusal to close if the requirements of this section have not been met. A notice
10 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 within 60 days of the
13 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 employer objects to the
17 notice of closure, the objecting party first must request reconsideration by the director under this
18 section. A worker’s request for reconsideration must be made within 60 days of the date of the no-
19 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for
20 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under
21 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.
22 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not
23 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within
24 one year of the date the notice of closure was mailed to the estate of the worker under paragraph
25 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be
26 based only on disagreement with the findings used to rate impairment and must be made within
27 seven days of the date of the notice of closure.

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

34 “(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the di-
35 rector orders an increase by 25 percent or more of the amount of compensation to be paid to the
36 worker for permanent disability and the worker is found upon reconsideration to be at least 20
37 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured em-
38 ployer and paid to the worker in an amount equal to 25 percent of all compensation determined to
39 be then due the claimant. If the increase in compensation results from information that the insurer
40 or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have
41 known at the time of claim closure, from new information obtained through a medical arbiter ex-
42 amination or from a determination order issued by the director that addresses the extent of the
43 worker’s permanent disability that is not based on the standards adopted pursuant to ORS 656.726
44 (4)(f), the penalty shall not be assessed.

45 “(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be

1 held on each notice of closure. At the reconsideration proceeding:

2 “(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
3 worker about the worker’s condition at the time of claim closure, shall become part of the recon-
4 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
5 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
6 cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the
7 deposition for the Department of Consumer and Business Services and one copy of the transcript
8 of the deposition for each party shall be paid by the insurer or self-insured employer. The recon-
9 sideration proceeding may not be postponed to receive a deposition taken under this subparagraph.
10 A deposition taken in accordance with this subparagraph may be received as evidence at a hearing
11 even if the deposition is not prepared in time for use in the reconsideration proceeding.

12 “(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured em-
13 ployer may correct information in the record that is erroneous and may submit any medical evidence
14 that should have been but was not submitted by the attending physician or nurse practitioner au-
15 thorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

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

18 “(b) If necessary, the director may require additional medical or other information with respect
19 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

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

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

37 “(e) The period for completing the reconsideration proceeding described in paragraph (d) of this
38 subsection begins upon receipt by the director of a worker’s or a beneficiary’s request for recon-
39 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
40 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the
41 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
42 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
43 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
44 quest for reconsideration, the party does not waive the right to fully participate in the reconsid-
45 eration proceeding, including the right to proceed with the reconsideration if the initiating party

1 withdraws the request for reconsideration.

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

4 “(g) If any party objects to the reconsideration order, the party may request a hearing under
5 ORS 656.283 within 30 days from the date of the reconsideration order.

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

8 “(A) A request for reconsideration of a notice of closure has been made to the director within
9 60 days of the date of the notice of closure;

10 “(B) The parties are actively engaged in settlement negotiations that include issues in dispute
11 at reconsideration;

12 “(C) The parties agree to the delay; and

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

15 “(b) A delay of the reconsideration proceeding granted by the director under this subsection
16 expires:

17 “(A) If a party requests the director to resume the reconsideration proceeding before the expi-
18 ration of the delay period;

19 “(B) If the parties reach a settlement and the director receives a copy of the approved settle-
20 ment documents before the expiration of the delay period; or

21 “(C) On the next calendar day following the expiration of the delay period authorized by the
22 director.

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

25 “(d) Compensation due the worker shall continue to be paid during the period of delay author-
26 ized under this subsection.

27 “(e) The director may authorize only one delay period for each reconsideration proceeding.

28 “(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement
29 with the impairment used in rating of the worker’s disability, the director shall refer the claim to
30 a medical arbiter appointed by the director.

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

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

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

38 “(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform
39 such tests as may be reasonable and necessary to establish the worker’s impairment.

40 “(B) If the director determines that the worker failed to attend the examination without good
41 cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall
42 postpone the reconsideration proceedings for up to 60 days from the date of the determination that
43 the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this
44 or any prior opening of the claim until such time as the worker attends and cooperates with the
45 examination or the request for reconsideration is withdrawn. Any additional evidence regarding

1 good cause must be submitted prior to the conclusion of the 60-day postponement period.

2 “(C) At the conclusion of the 60-day postponement period, if the worker has not attended and
3 cooperated with a medical arbiter examination or established good cause, the worker may not attend
4 a medical arbiter examination for this claim closure. The reconsideration record must be closed, and
5 the director shall issue an order on reconsideration based upon the existing record.

6 “(D) All disability benefits suspended under this subsection, including all disability benefits
7 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers’ Com-
8 pensation Board or upon court review, are not due and payable to the worker.

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

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

13 “(h) After reconsideration, no subsequent medical evidence of the worker’s impairment is ad-
14 missible before the director, the Workers’ Compensation Board or the courts for purposes of making
15 findings of impairment on the claim closure.

16 “(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement
17 with the impairment used in rating the worker’s disability, and the director determines that the
18 worker is not medically stationary at the time of the reconsideration or that the closure was not
19 made pursuant to this section, the director is not required to appoint a medical arbiter before
20 completing the reconsideration proceeding.

21 “(B) If the worker’s condition has substantially changed since the notice of closure, upon the
22 consent of all the parties to the claim, the director shall postpone the proceeding until the worker’s
23 condition is appropriate for claim closure under subsection (1) of this section.

24 “(9) No hearing shall be held on any issue that was not raised and preserved before the director
25 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
26 resolved at hearing.

27 “(10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
28 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
29 any permanent disability payments due for work disability under the closure shall be suspended, and
30 the worker shall receive temporary disability compensation and any permanent disability payments
31 due for impairment while the worker is enrolled and actively engaged in the training. When the
32 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
33 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
34 if the worker’s accepted injury is no longer the major contributing cause of the worker’s combined
35 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
36 duration of temporary total or temporary partial disability compensation. Permanent disability
37 compensation shall be redetermined for work disability only. If the worker has returned to work or
38 the worker’s attending physician has released the worker to return to regular or modified employ-
39 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
40 be appealed only in the same manner as are other notices of closure under this section.

41 “(11) If the attending physician or nurse practitioner authorized to provide compensable medical
42 services under ORS 656.245 has approved the worker’s return to work and there is a labor dispute
43 in progress at the place of employment, the worker may refuse to return to that employment without
44 loss of reemployment rights or any vocational assistance provided by this chapter.

45 “(12) Any notice of closure made under this section may include necessary adjustments in com-

1 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
2 bility payments prematurely made, crediting temporary disability payments against current or future
3 permanent or temporary disability awards or payments and requiring the payment of temporary
4 disability payments which were payable but not paid.

5 “(13) An insurer or self-insured employer may take a credit or offset of previously paid workers’
6 compensation benefits or payments against any further workers’ compensation benefits or payments
7 due a worker from that insurer or self-insured employer when the worker admits to having obtained
8 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
9 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
10 fits or payments obtained through fraud by a worker may not be included in any data used for
11 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-
12 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the
13 director.

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

19 “(b) An insurer or self-insured employer may suspend and offset any compensation payable to
20 the beneficiary of the worker, and recover an overpayment of permanent total disability benefits
21 caused by the failure of the worker’s beneficiaries to notify the insurer or self-insured employer
22 about the death of the worker.

23 “(15) Conditions that are direct medical sequelae to the original accepted condition shall be in-
24 cluded in rating permanent disability of the claim unless they have been specifically denied.

25 **“(16)(a) Except as provided under subsection (13) of this section, an insurer or self-**
26 **insured employer may not recover an overpayment from a worker’s permanent partial disa-**
27 **bility compensation for overpayments, offsets or credits of wage loss in an amount that**
28 **exceeds 50 percent of the total compensation awarded to the worker.**

29 **“(b) An insurer or self-insured employer may not declare an overpayment of any com-**
30 **penensation that was paid more than two years prior to the date of the declaration.**

31 **“SECTION 6. (1) The amendments to ORS 656.268 by sections 4 and 5 of this 2022 Act**
32 **apply to all claims that exist on, or arise on or after, January 1, 2024, regardless of the date**
33 **of injury or the date on which the claim is filed.**

34 **“(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.268 by**
35 **sections 4 and 5 of this 2022 Act do not apply to disputes in which a final determination is**
36 **made prior to January 1, 2024.”.**

37
