

Requested by Representative GRAYBER

**PROPOSED AMENDMENTS TO
HOUSE BILL 4138**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 260.005.

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

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

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

26 “(g)(A) Temporary disability compensation is not due and payable pursu-
27 ant to ORS 656.268 after the worker’s attending physician or nurse practi-
28 tioner authorized to provide compensable medical services under ORS 656.245
29 ceases to authorize temporary disability or for any period of time not au-
30 thorized by the attending physician or nurse practitioner. No authorization

1 of temporary disability compensation by the attending physician or nurse
2 practitioner under ORS 656.268 shall be effective to retroactively authorize
3 the payment of temporary disability more than [14] 45 days prior to its is-
4 suance.

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

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

9 **“(ii) During periods in which there is a dispute over the identity of,**
10 **or treatment by, an attending physician or nurse practitioner that af-**
11 **fects the worker’s ability to obtain authorization of temporary disa-**
12 **bility; or**

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

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

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

29 **“(j)(A) The insurer or self-insured employer may not end temporary**
30 **disability benefits until written notice has been mailed or delivered to**

1 **the worker and the worker’s attorney, if the worker is represented.**
2 **The notice must state the reason that temporary disability benefits**
3 **are no longer due and payable.**

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

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

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

26 **“(b) To establish the maximum amount an employer may pay for medical**
27 **services for nondisabling claims under paragraph (a) of this subsection, the**
28 **director shall use \$1,500 as the base compensation amount and shall adjust**
29 **the base compensation amount annually to reflect changes in the United**
30 **States City Average Consumer Price Index for All Urban Consumers for**

1 Medical Care for July of each year as published by the Bureau of Labor
2 Statistics of the United States Department of Labor. The adjustment shall
3 be rounded to the nearest multiple of \$100.

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

8 “(6)(a) Written notice of acceptance or denial of the claim shall be fur-
9 nished to the claimant by the insurer or self-insured employer within 60 days
10 after the employer has notice or knowledge of the claim. Once the claim is
11 accepted, the insurer or self-insured employer shall not revoke acceptance
12 except as provided in this section. The insurer or self-insured employer may
13 revoke acceptance and issue a denial at any time when the denial is for
14 fraud, misrepresentation or other illegal activity by the worker. If the
15 worker requests a hearing on any revocation of acceptance and denial al-
16 leging fraud, misrepresentation or other illegal activity, the insurer or self-
17 insured employer has the burden of proving, by a preponderance of the
18 evidence, such fraud, misrepresentation or other illegal activity. Upon such
19 proof, the worker then has the burden of proving, by a preponderance of the
20 evidence, the compensability of the claim. If the insurer or self-insured em-
21 ployer accepts a claim in good faith, in a case not involving fraud, misrep-
22 resentation or other illegal activity by the worker, and later obtains evidence
23 that the claim is not compensable or evidence that the insurer or self-insured
24 employer is not responsible for the claim, the insurer or self-insured em-
25 ployer may revoke the claim acceptance and issue a formal notice of claim
26 denial, if such revocation of acceptance and denial is issued no later than
27 two years after the date of the initial acceptance. If the worker requests a
28 hearing on such revocation of acceptance and denial, the insurer or self-
29 insured employer must prove, by a preponderance of the evidence, that the
30 claim is not compensable or that the insurer or self-insured employer is not

1 responsible for the claim. Notwithstanding any other provision of this chap-
2 ter, if a denial of a previously accepted claim is set aside by an Adminis-
3 trative Law Judge, the Workers' Compensation Board or the court,
4 temporary total disability benefits are payable from the date any such bene-
5 fits were terminated under the denial. Except as provided in ORS 656.247,
6 pending acceptance or denial of a claim, compensation payable to a claimant
7 does not include the costs of medical benefits or funeral expenses. The
8 insurer shall also furnish the employer a copy of the notice of acceptance.

9 “(b) The notice of acceptance shall:

10 “(A) Specify what conditions are compensable.

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

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

17 “(D) Inform the claimant of employment reinstatement rights and re-
18 sponsibilities under ORS chapter 659A.

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

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

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

30 “(d) An injured worker who believes that a condition has been incorrectly

1 omitted from a notice of acceptance, or that the notice is otherwise deficient,
2 first must communicate in writing to the insurer or self-insured employer the
3 worker's objections to the notice pursuant to ORS 656.267. The insurer or
4 self-insured employer has 60 days from receipt of the communication from the
5 worker to revise the notice or to make other written clarification in re-
6 sponse. A worker who fails to comply with the communication requirements
7 of this paragraph or ORS 656.267 may not allege at any hearing or other
8 proceeding on the claim a de facto denial of a condition based on information
9 in the notice of acceptance from the insurer or self-insured employer. Not-
10 withstanding any other provision of this chapter, the worker may initiate
11 objection to the notice of acceptance at any time.

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

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

25 “(c) When an insurer or self-insured employer determines that the claim
26 qualifies for claim closure, the insurer or self-insured employer shall issue
27 at claim closure an updated notice of acceptance that specifies which condi-
28 tions are compensable. The procedures specified in subsection (6)(d) of this
29 section apply to this notice. Any objection to the updated notice or appeal
30 of denied conditions shall not delay claim closure pursuant to ORS 656.268.

1 If a condition is found compensable after claim closure, the insurer or self-
2 insured employer shall reopen the claim for processing regarding that con-
3 dition.

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

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

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

23 “(11)(a) If the insurer or self-insured employer unreasonably delays or
24 unreasonably refuses to pay compensation, attorney fees or costs, or unrea-
25 sonably delays acceptance or denial of a claim, the insurer or self-insured
26 employer shall be liable for an additional amount up to 25 percent of the
27 amounts then due plus any attorney fees assessed under this section. The fees
28 assessed by the director, an Administrative Law Judge, the board or the
29 court under this section shall be reasonable attorney fees. In assessing fees,
30 the director, an Administrative Law Judge, the board or the court shall

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

14 “(b) When the director does not have exclusive jurisdiction over pro-
15 ceedings regarding the assessment and payment of the additional amount and
16 attorney fees described in this subsection, the provisions of this subsection
17 shall apply in the other proceeding.

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

27 “(b) The director shall adopt by rule a matrix for the assessment of the
28 penalties and attorney fees authorized under this subsection. The matrix
29 shall provide for penalties based on a percentage of the settlement proceeds
30 allocated to the claimant and for attorney fees based on a percentage of the

1 settlement proceeds allocated to the claimant's attorney as an attorney fee.

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

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

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

26 “(15) If the director finds that a worker fails to reasonably cooperate with
27 an investigation involving an initial claim to establish a compensable injury
28 or an aggravation claim to reopen the claim for a worsened condition, the
29 director shall suspend all or part of the payment of compensation after notice
30 to the worker. If the worker does not cooperate for an additional 30 days

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

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

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

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

29 “(2) The compensation due under this chapter shall be paid periodically,
30 promptly and directly to the person entitled thereto upon the employer's re-

1 ceiving notice or knowledge of a claim, except where the right to compen-
2 sation is denied by the insurer or self-insured employer.

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

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

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

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

11 “(D) The name and address of any health insurance provider for the in-
12 jured worker.

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

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

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

29 “(b) Notwithstanding any other provision of this chapter, if a self-insured
30 employer pays to an injured worker who becomes disabled the same wage at

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

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

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

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

29 “(f) If the insurer or self-insured employer has requested and failed to
30 receive from the worker’s attending physician or nurse practitioner author-

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

6 “(g)(A) Temporary disability compensation is not due and payable pursu-
7 ant to ORS 656.268 after the worker's attending physician or nurse practi-
8 tioner authorized to provide compensable medical services under ORS 656.245
9 ceases to authorize temporary disability or for any period of time not au-
10 thorized by the attending physician or nurse practitioner. No authorization
11 of temporary disability compensation by the attending physician or nurse
12 practitioner under ORS 656.268 shall be effective to retroactively authorize
13 the payment of temporary disability more than [14] 45 days prior to its is-
14 suance.

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

16 **“(i) During periods in which there is a denial under the jurisdiction**
17 **of the Workers' Compensation Board that affects the worker's ability**
18 **to obtain authorization of temporary disability;**

19 **“(ii) During periods in which there is a dispute over the identity of,**
20 **or treatment by, an attending physician or nurse practitioner that af-**
21 **fects the worker's ability to obtain authorization of temporary disa-**
22 **bility; or**

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

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

1 under ORS 656.245.

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

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

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

17 **“(C) If the notice required under subparagraph (A) of this para-**
18 **graph is given more than 45 days after the worker was no longer eli-**
19 **gible for benefits, the attending physician or nurse practitioner may**
20 **retroactively authorize temporary disability back to the date on which**
21 **benefits were no longer due and payable, provided the authorization**
22 **is made within 30 days following the earlier of the date of mailing or**
23 **delivery of the written notice that the eligibility ended to the worker**
24 **and the worker’s attorney, if the worker is represented.**

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

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

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

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

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

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

19 “(b) The notice of acceptance shall:

20 “(A) Specify what conditions are compensable.

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

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

27 “(D) Inform the claimant of employment reinstatement rights and re-
28 sponsibilities under ORS chapter 659A.

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

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

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

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

22 “(7)(a) After claim acceptance, written notice of acceptance or denial of
23 claims for aggravation or new medical or omitted condition claims properly
24 initiated pursuant to ORS 656.267 shall be furnished to the claimant by the
25 insurer or self-insured employer within 60 days after the insurer or self-
26 insured employer receives written notice of such claims. A worker who fails
27 to comply with the communication requirements of subsection (6) of this
28 section or ORS 656.267 may not allege at any hearing or other proceeding
29 on the claim a de facto denial of a condition based on information in the
30 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
2 employer must issue a written denial to the worker when the accepted injury
3 is no longer the major contributing cause of the worker’s combined condition
4 before the claim may be closed.

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

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

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

25 “(10) Merely paying or providing compensation shall not be considered
26 acceptance of a claim or an admission of liability, nor shall mere acceptance
27 of such compensation be considered a waiver of the right to question the
28 amount thereof. Payment of permanent disability benefits pursuant to a no-
29 tice of closure, reconsideration order or litigation order, or the failure to
30 appeal or seek review of such an order or notice of closure, shall not pre-

1 clude an insurer or self-insured employer from subsequently contesting the
2 compensability of the condition rated therein, unless the condition has been
3 formally accepted.

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

25 “(b) When the director does not have exclusive jurisdiction over pro-
26 ceedings regarding the assessment and payment of the additional amount and
27 attorney fees described in this subsection, the provisions of this subsection
28 shall apply in the other proceeding.

29 “(12)(a) If payment is due on a disputed claim settlement authorized by
30 ORS 656.289 and the insurer or self-insured employer has failed to make the

1 payment in accordance with the requirements specified in the disputed claim
2 settlement, the claimant or the claimant's attorney shall clearly notify the
3 insurer or self-insured employer in writing that the payment is past due. If
4 the required payment is not made within five business days after receipt of
5 the notice by the insurer or self-insured employer, the director may assess
6 a penalty and attorney fee in accordance with a matrix adopted by the di-
7 rector by rule.

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

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

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

28 “(b) If the attorney is not willing or available to participate in an inter-
29 view at a time reasonably chosen by the insurer or self-insured employer
30 within 14 days of the request for interview and the insurer or self-insured

1 employer has cause to believe that the attorney's unwillingness or unavail-
2 ability is unreasonable and is preventing the worker from complying within
3 14 days of the request for interview, the insurer or self-insured employer
4 shall notify the director. If the director determines that the attorney's un-
5 willingness or unavailability is unreasonable, the director shall assess a civil
6 penalty against the attorney of not more than \$1,000.

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

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

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

4 **“SECTION 3. (1) The amendments to ORS 656.262 by sections 1 and**
5 **2 of this 2022 Act apply to all claims that exist on, or arise on or after,**
6 **January 1, 2024, regardless of the date of injury or the date on which**
7 **the claim is filed.**

8 **“(2) Notwithstanding subsection (1) of this section, the amendments**
9 **to ORS 656.262 by sections 1 and 2 of this 2022 Act do not apply to**
10 **disputes in which a final determination is made prior to January 1,**
11 **2024.**

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

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

22 **“(a) The worker has become medically stationary and there is sufficient**
23 **information to determine permanent disability[;]. Notwithstanding any**
24 **other provision of this chapter, a physician or nurse practitioner may**
25 **not retroactively determine a worker to be medically stationary more**
26 **than 60 days prior to the date of the determination except in the case**
27 **of claims that are subject to subsection (13) of this section. An insurer**
28 **or self-insured employer must mail or deliver written notice to a**
29 **worker and to the worker’s attorney, if the worker is represented,**
30 **within seven days following receipt of information that the worker is**

1 **medically stationary.**

2 “(b) The accepted injury is no longer the major contributing cause of the
3 worker’s combined or consequential condition or conditions pursuant to ORS
4 656.005 (7). When the claim is closed because the accepted injury is no longer
5 the major contributing cause of the worker’s combined or consequential
6 condition or conditions, and there is sufficient information to determine
7 permanent disability, the likely permanent disability that would have been
8 due to the current accepted condition shall be estimated;

9 “(c) Without the approval of the attending physician or nurse practitioner
10 authorized to provide compensable medical services under ORS 656.245, the
11 worker fails to seek medical treatment for a period of 30 days or the worker
12 fails to attend a closing examination, unless the worker affirmatively estab-
13 lishes that such failure is attributable to reasons beyond the worker’s con-
14 trol; or

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

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

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

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

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

28 “(b) The attending physician or nurse practitioner who has authorized
29 temporary disability benefits for the worker under ORS 656.245 advises the
30 worker and documents in writing that the worker is released to return to

1 regular employment;

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

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

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

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

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

19 “(E) Is not consistent with the existing written shift change policy or is
20 not consistent with common practice of the employer at injury or aggra-
21 vation; or

22 “(F) Is not consistent with an existing shift change provision of an ap-
23 plicable collective bargaining agreement;

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

27 “(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection,
28 the attending physician or nurse practitioner who has authorized temporary
29 disability benefits under ORS 656.245 for a home care worker or a personal
30 support worker who has been made a subject worker pursuant to ORS 656.039

1 advises the home care worker or personal support worker and documents in
2 writing that the home care worker or personal support worker is released
3 to return to modified employment, appropriate modified employment is of-
4 fered in writing by the Home Care Commission or a designee of the com-
5 mission to the home care worker or personal support worker for any client
6 of the Department of Human Services who employs a home care worker or
7 personal support worker and the worker fails to begin the employment.

8 “(5)(a) Findings by the insurer or self-insured employer regarding the ex-
9 tent of the worker’s disability in closure of the claim shall be pursuant to
10 the standards prescribed by the director.

11 “(b) The insurer or self-insured employer shall issue a notice of closure
12 of the claim to the worker, to the worker’s attorney if the worker is repres-
13 ented, and to the director. If the worker is deceased at the time the notice
14 of closure is issued, the insurer or self-insured employer shall mail the
15 worker’s copy of the notice of closure, addressed to the estate of the worker,
16 to the worker’s last known address and may mail copies of the notice of
17 closure to any known or potential beneficiaries to the estate of the deceased
18 worker.

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

20 “(A) The parties, in boldfaced type, of the proper manner in which to
21 proceed if they are dissatisfied with the terms of the notice of closure;

22 “(B) The worker of:

23 “(i) The amount of any further compensation, including permanent disa-
24 bility compensation to be awarded;

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

27 “(iii) The right of the worker or beneficiaries of the worker who were
28 mailed a copy of the notice of closure under paragraph (b) of this subsection
29 to request reconsideration by the director under this section within 60 days
30 of the date of the notice of closure;

1 “(iv) The right of beneficiaries who were not mailed a copy of the notice
2 of closure under paragraph (b) of this subsection to request reconsideration
3 by the director under this section within one year of the date the notice of
4 closure was mailed to the estate of the worker under paragraph (b) of this
5 subsection;

6 “(v) The right of the insurer or self-insured employer to request recon-
7 sideration by the director under this section within seven days of the date
8 of the notice of closure;

9 “(vi) The aggravation rights; and

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

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

13 “(d) If the insurer or self-insured employer has not issued a notice of
14 closure, the worker may request closure. Within 10 days of receipt of a
15 written request from the worker, the insurer or self-insured employer shall
16 issue a notice of closure if the requirements of this section have been met
17 or a notice of refusal to close if the requirements of this section have not
18 been met. A notice of refusal to close shall advise the worker of:

19 “(A) The decision not to close;

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

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

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

24 “(e) If a worker, a worker’s beneficiary, an insurer or a self-insured em-
25 ployer objects to the notice of closure, the objecting party first must request
26 reconsideration by the director under this section. A worker’s request for
27 reconsideration must be made within 60 days of the date of the notice of
28 closure. If the worker is deceased at the time the notice of closure is issued,
29 a request for reconsideration by a beneficiary of the worker who was mailed
30 a copy of the notice of closure under paragraph (b) of this subsection must

1 be made within 60 days of the date of the notice of closure. A request for
2 reconsideration by a beneficiary to the estate of a deceased worker who was
3 not mailed a copy of the notice of closure under paragraph (b) of this sub-
4 section must be made within one year of the date the notice of closure was
5 mailed to the estate of the worker under paragraph (b) of this subsection.
6 A request for reconsideration by an insurer or self-insured employer may be
7 based only on disagreement with the findings used to rate impairment and
8 must be made within seven days of the date of the notice of closure.

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

16 “(g) If, upon reconsideration of a claim closed by an insurer or self-
17 insured employer, the director orders an increase by 25 percent or more of
18 the amount of compensation to be paid to the worker for permanent disabili-
19 ty and the worker is found upon reconsideration to be at least 20 percent
20 permanently disabled, a penalty shall be assessed against the insurer or
21 self-insured employer and paid to the worker in an amount equal to 25 per-
22 cent of all compensation determined to be then due the claimant. If the in-
23 crease in compensation results from information that the insurer or
24 self-insured employer demonstrates the insurer or self-insured employer could
25 not reasonably have known at the time of claim closure, from new informa-
26 tion obtained through a medical arbiter examination or from a determination
27 order issued by the director that addresses the extent of the worker’s per-
28 manent disability that is not based on the standards adopted pursuant to
29 ORS 656.726 (4)(f), the penalty shall not be assessed.

30 “(6)(a) Notwithstanding any other provision of law, only one reconsider-

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

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

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

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

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

28 “(c) In any reconsideration proceeding under this section in which the
29 worker was represented by an attorney, the director shall order the insurer
30 or self-insured employer to pay to the attorney, out of the additional com-

1 pensation awarded, an amount equal to 10 percent of any additional com-
2 pensation awarded to the worker.

3 “(d) Except as provided in subsection (7) of this section, the reconsider-
4 ation proceeding shall be completed within 18 working days from the date
5 the reconsideration proceeding begins, and shall be performed by a special
6 evaluation appellate unit within the department. The deadline of 18 working
7 days may be postponed by an additional 60 calendar days if within the 18
8 working days the department mails notice of review by a medical arbiter. If
9 an order on reconsideration has not been mailed on or before 18 working
10 days from the date the reconsideration proceeding begins, or within 18
11 working days plus the additional 60 calendar days where a notice for medical
12 arbiter review was timely mailed or the director postponed the reconsider-
13 ation pursuant to paragraph (b) of this subsection, or within such additional
14 time as provided in subsection (8) of this section when reconsideration is
15 postponed further because the worker has failed to cooperate in the medical
16 arbiter examination, reconsideration shall be deemed denied and any further
17 proceedings shall occur as though an order on reconsideration affirming the
18 notice of closure was mailed on the date the order was due to issue.

19 “(e) The period for completing the reconsideration proceeding described
20 in paragraph (d) of this subsection begins upon receipt by the director of a
21 worker’s or a beneficiary’s request for reconsideration pursuant to subsection
22 (5)(e) of this section. If the insurer or self-insured employer requests recon-
23 sideration, the period for reconsideration begins upon the earlier of the date
24 of the request for reconsideration by the worker or beneficiary, the date of
25 receipt of a waiver from the worker or beneficiary of the right to request
26 reconsideration or the date of expiration of the right of the worker or ben-
27 eficiary to request reconsideration. If a party elects not to file a separate
28 request for reconsideration, the party does not waive the right to fully par-
29 ticipate in the reconsideration proceeding, including the right to proceed
30 with the reconsideration if the initiating party withdraws the request for

1 reconsideration.

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

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

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

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

13 “(B) The parties are actively engaged in settlement negotiations that in-
14 clude issues in dispute at reconsideration;

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

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

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

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

23 “(B) If the parties reach a settlement and the director receives a copy of
24 the approved settlement documents before the expiration of the delay period;
25 or

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

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

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

3 “(e) The director may authorize only one delay period for each reconsid-
4 eration proceeding.

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

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

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

15 “(d) The arbiter, or panel of medical arbiters, must be chosen from among
16 a list of physicians qualified to be attending physicians referred to in ORS
17 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon
18 Medical Board and the committee referred to in ORS 656.790.

19 “(e)(A) The medical arbiter or panel of medical arbiters may examine the
20 worker and perform such tests as may be reasonable and necessary to es-
21 tablish the worker’s impairment.

22 “(B) If the director determines that the worker failed to attend the ex-
23 amination without good cause or failed to cooperate with the medical arbi-
24 ter, or panel of medical arbiters, the director shall postpone the
25 reconsideration proceedings for up to 60 days from the date of the determi-
26 nation that the worker failed to attend or cooperate, and shall suspend all
27 disability benefits resulting from this or any prior opening of the claim until
28 such time as the worker attends and cooperates with the examination or the
29 request for reconsideration is withdrawn. Any additional evidence regarding
30 good cause must be submitted prior to the conclusion of the 60-day

1 postponement period.

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

8 “(D) All disability benefits suspended under this subsection, including all
9 disability benefits awarded in the order on reconsideration, or by an Ad-
10 ministrative Law Judge, the Workers’ Compensation Board or upon court
11 review, are not due and payable to the worker.

12 “(f) The insurer or self-insured employer shall pay the costs of examina-
13 tion and review by the medical arbiter or panel of medical arbiters.

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

16 “(h) After reconsideration, no subsequent medical evidence of the
17 worker’s impairment is admissible before the director, the Workers’ Com-
18 pensation Board or the courts for purposes of making findings of impairment
19 on the claim closure.

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

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

30 “(9) No hearing shall be held on any issue that was not raised and pre-

1 served before the director at reconsideration. However, issues arising out
2 of the reconsideration order may be addressed and resolved at hearing.

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

22 “(11) If the attending physician or nurse practitioner authorized to pro-
23 vide compensable medical services under ORS 656.245 has approved the
24 worker’s return to work and there is a labor dispute in progress at the place
25 of employment, the worker may refuse to return to that employment without
26 loss of reemployment rights or any vocational assistance provided by this
27 chapter.

28 “(12) Any notice of closure made under this section may include necessary
29 adjustments in compensation paid or payable prior to the notice of closure,
30 including disallowance of permanent disability payments prematurely made,

1 crediting temporary disability payments against current or future permanent
2 or temporary disability awards or payments and requiring the payment of
3 temporary disability payments which were payable but not paid.

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

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

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

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

29 “(16)(a) **Except as provided under subsection (13) of this section, an**
30 **insurer or self-insured employer may not recover an overpayment**

1 **from a worker’s permanent partial disability compensation for over-**
2 **payments, offsets or credits of wage loss in an amount that exceeds**
3 **50 percent of the total compensation awarded to the worker.**

4 **“(b) An insurer or self-insured employer may not declare an over-**
5 **payment of any compensation that was paid more than two years prior**
6 **to the date of the declaration.**

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

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

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

28 **“(b) The accepted injury is no longer the major contributing cause of the**
29 **worker’s combined or consequential condition or conditions pursuant to ORS**
30 **656.005 (7). When the claim is closed because the accepted injury is no longer**

1 the major contributing cause of the worker's combined or consequential
2 condition or conditions, and there is sufficient information to determine
3 permanent disability, the likely permanent disability that would have been
4 due to the current accepted condition shall be estimated.[;]

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

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

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

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

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

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

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

28 “(c) The attending physician or nurse practitioner who has authorized
29 temporary disability benefits for the worker under ORS 656.245 advises the
30 worker and documents in writing that the worker is released to return to

1 modified employment, such employment is offered in writing to the worker
2 and the worker fails to begin such employment. However, an offer of modi-
3 fied employment may be refused by the worker without the termination of
4 temporary total disability benefits if the offer:

5 “(A) Requires a commute that is beyond the physical capacity of the
6 worker according to the worker’s attending physician or the nurse practi-
7 tioner who may authorize temporary disability under ORS 656.245;

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

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

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

15 “(E) Is not consistent with the existing written shift change policy or is
16 not consistent with common practice of the employer at injury or aggra-
17 vation; or

18 “(F) Is not consistent with an existing shift change provision of an ap-
19 plicable collective bargaining agreement;

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

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

1 mission to the home care worker or personal support worker for any client
2 of the Department of Human Services who employs a home care worker or
3 personal support worker and the worker fails to begin the employment.

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

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

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

17 “(A) The parties, in boldfaced type, of the proper manner in which to
18 proceed if they are dissatisfied with the terms of the notice of closure;

19 “(B) The worker of:

20 “(i) The amount of any further compensation, including permanent disa-
21 bility compensation to be awarded;

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

24 “(iii) The right of the worker or beneficiaries of the worker who were
25 mailed a copy of the notice of closure under paragraph (b) of this subsection
26 to request reconsideration by the director under this section within 60 days
27 of the date of the notice of closure;

28 “(iv) The right of beneficiaries who were not mailed a copy of the notice
29 of closure under paragraph (b) of this subsection to request reconsideration
30 by the director under this section within one year of the date the notice of

1 closure was mailed to the estate of the worker under paragraph (b) of this
2 subsection;

3 “(v) The right of the insurer or self-insured employer to request recon-
4 sideration by the director under this section within seven days of the date
5 of the notice of closure;

6 “(vi) The aggravation rights; and

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

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

10 “(d) If the insurer or self-insured employer has not issued a notice of
11 closure, the worker may request closure. Within 10 days of receipt of a
12 written request from the worker, the insurer or self-insured employer shall
13 issue a notice of closure if the requirements of this section have been met
14 or a notice of refusal to close if the requirements of this section have not
15 been met. A notice of refusal to close shall advise the worker of:

16 “(A) The decision not to close;

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

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

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

21 “(e) If a worker, a worker’s beneficiary, an insurer or a self-insured em-
22 ployer objects to the notice of closure, the objecting party first must request
23 reconsideration by the director under this section. A worker’s request for
24 reconsideration must be made within 60 days of the date of the notice of
25 closure. If the worker is deceased at the time the notice of closure is issued,
26 a request for reconsideration by a beneficiary of the worker who was mailed
27 a copy of the notice of closure under paragraph (b) of this subsection must
28 be made within 60 days of the date of the notice of closure. A request for
29 reconsideration by a beneficiary to the estate of a deceased worker who was
30 not mailed a copy of the notice of closure under paragraph (b) of this sub-

1 section must be made within one year of the date the notice of closure was
2 mailed to the estate of the worker under paragraph (b) of this subsection.
3 A request for reconsideration by an insurer or self-insured employer may be
4 based only on disagreement with the findings used to rate impairment and
5 must be made within seven days of the date of the notice of closure.

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

13 “(g) If, upon reconsideration of a claim closed by an insurer or self-
14 insured employer, the director orders an increase by 25 percent or more of
15 the amount of compensation to be paid to the worker for permanent disabili-
16 ty and the worker is found upon reconsideration to be at least 20 percent
17 permanently disabled, a penalty shall be assessed against the insurer or
18 self-insured employer and paid to the worker in an amount equal to 25 per-
19 cent of all compensation determined to be then due the claimant. If the in-
20 crease in compensation results from information that the insurer or
21 self-insured employer demonstrates the insurer or self-insured employer could
22 not reasonably have known at the time of claim closure, from new informa-
23 tion obtained through a medical arbiter examination or from a determination
24 order issued by the director that addresses the extent of the worker’s per-
25 manent disability that is not based on the standards adopted pursuant to
26 ORS 656.726 (4)(f), the penalty shall not be assessed.

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

30 “(A) A deposition arranged by the worker, limited to the testimony and

1 cross-examination of the worker about the worker's condition at the time of
2 claim closure, shall become part of the reconsideration record. The deposi-
3 tion must be conducted subject to the opportunity for cross-examination by
4 the insurer or self-insured employer and in accordance with rules adopted
5 by the director. The cost of the court reporter, interpreter services, if nec-
6 essary, and one original of the transcript of the deposition for the Depart-
7 ment of Consumer and Business Services and one copy of the transcript of
8 the deposition for each party shall be paid by the insurer or self-insured
9 employer. The reconsideration proceeding may not be postponed to receive
10 a deposition taken under this subparagraph. A deposition taken in accord-
11 ance with this subparagraph may be received as evidence at a hearing even
12 if the deposition is not prepared in time for use in the reconsideration pro-
13 ceeding.

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

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

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

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

30 “(d) Except as provided in subsection (7) of this section, the reconsider-

1 ation proceeding shall be completed within 18 working days from the date
2 the reconsideration proceeding begins, and shall be performed by a special
3 evaluation appellate unit within the department. The deadline of 18 working
4 days may be postponed by an additional 60 calendar days if within the 18
5 working days the department mails notice of review by a medical arbiter. If
6 an order on reconsideration has not been mailed on or before 18 working
7 days from the date the reconsideration proceeding begins, or within 18
8 working days plus the additional 60 calendar days where a notice for medical
9 arbiter review was timely mailed or the director postponed the reconsider-
10 ation pursuant to paragraph (b) of this subsection, or within such additional
11 time as provided in subsection (8) of this section when reconsideration is
12 postponed further because the worker has failed to cooperate in the medical
13 arbiter examination, reconsideration shall be deemed denied and any further
14 proceedings shall occur as though an order on reconsideration affirming the
15 notice of closure was mailed on the date the order was due to issue.

16 “(e) The period for completing the reconsideration proceeding described
17 in paragraph (d) of this subsection begins upon receipt by the director of a
18 worker’s or a beneficiary’s request for reconsideration pursuant to subsection
19 (5)(e) of this section. If the insurer or self-insured employer requests recon-
20 sideration, the period for reconsideration begins upon the earlier of the date
21 of the request for reconsideration by the worker or beneficiary, the date of
22 receipt of a waiver from the worker or beneficiary of the right to request
23 reconsideration or the date of expiration of the right of the worker or ben-
24 eficiary to request reconsideration. If a party elects not to file a separate
25 request for reconsideration, the party does not waive the right to fully par-
26 ticipate in the reconsideration proceeding, including the right to proceed
27 with the reconsideration if the initiating party withdraws the request for
28 reconsideration.

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

1 proceeding.

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

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

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

10 “(B) The parties are actively engaged in settlement negotiations that in-
11 clude issues in dispute 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
14 reconsideration proceeding has begun that they request a delay under this
15 subsection.

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

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

20 “(B) If the parties reach a settlement and the director receives a copy of
21 the approved settlement documents before the expiration of the delay period;

22 or

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

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

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

30 “(e) The director may authorize only one delay period for each reconsid-

1 eration proceeding.

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

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

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

12 “(d) The arbiter, or panel of medical arbiters, must be chosen from among
13 a list of physicians qualified to be attending physicians referred to in ORS
14 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon
15 Medical Board and the committee referred to in ORS 656.790.

16 “(e)(A) The medical arbiter or panel of medical arbiters may examine the
17 worker and perform such tests as may be reasonable and necessary to es-
18 tablish the worker’s impairment.

19 “(B) If the director determines that the worker failed to attend the ex-
20 amination without good cause or failed to cooperate with the medical arbi-
21 ter, or panel of medical arbiters, the director shall postpone the
22 reconsideration proceedings for up to 60 days from the date of the determi-
23 nation that the worker failed to attend or cooperate, and shall suspend all
24 disability benefits resulting from this or any prior opening of the claim until
25 such time as the worker attends and cooperates with the examination or the
26 request for reconsideration is withdrawn. Any additional evidence regarding
27 good cause must be submitted prior to the conclusion of the 60-day
28 postponement period.

29 “(C) At the conclusion of the 60-day postponement period, if the worker
30 has not attended and cooperated with a medical arbiter examination or es-

1 tablished good cause, the worker may not attend a medical arbiter examina-
2 tion for this claim closure. The reconsideration record must be closed, and
3 the director shall issue an order on reconsideration based upon the existing
4 record.

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

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

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

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

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

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

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

30 “(10) If, after the notice of closure issued pursuant to this section, the

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

19 “(11) If the attending physician or nurse practitioner authorized to pro-
20 vide compensable medical services under ORS 656.245 has approved the
21 worker's return to work and there is a labor dispute in progress at the place
22 of employment, the worker may refuse to return to that employment without
23 loss of reemployment rights or any vocational assistance provided by this
24 chapter.

25 “(12) Any notice of closure made under this section may include necessary
26 adjustments in compensation paid or payable prior to the notice of closure,
27 including disallowance of permanent disability payments prematurely made,
28 crediting temporary disability payments against current or future permanent
29 or temporary disability awards or payments and requiring the payment of
30 temporary disability payments which were payable but not paid.

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

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

18 “(b) An insurer or self-insured employer may suspend and offset any
19 compensation payable to the beneficiary of the worker, and recover an
20 overpayment of permanent total disability benefits caused by the failure of
21 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
24 condition shall be included in rating permanent disability of the claim unless
25 they have been specifically denied.

26 **“(16)(a) Except as provided under subsection (13) of this section, an**
27 **insurer or self-insured employer may not recover an overpayment**
28 **from a worker’s permanent partial disability compensation for over-**
29 **payments, offsets or credits of wage loss in an amount that exceeds**
30 **50 percent of the total compensation awarded to the worker.**

