

HB 3374-2
(LC 4163)
3/17/25 (ASD/ps)

Requested by Representative PHAM H

**PROPOSED AMENDMENTS TO
HOUSE BILL 3374**

On page 1 of the printed bill, line 2, delete “656.260” and delete line 3 and insert “656.005, 656.214, 656.245, 656.250, 656.252, 656.260, 656.262, 656.268, 656.325, 656.340, 656.726, 656.752, 656.797, 657.170, 659A.043, 659A.046, 659A.049 and 659A.063; and prescribing an effective date.”.

On page 2, delete lines 6 and 7 and insert:

“(b) Enter into contracts to use such managed care services, on such terms as the State Accident Insurance Fund Corporation deems reasonable, with:

“(A) Self-insured employers;

“(B) Other insurers; or

“(C) Cities that provide by ordinance or charter a disability or retirement system for firefighters and police officers that is not subject to this chapter; and”.

On page 9, delete lines 12 and 13 and insert:

“SECTION 6. ORS 656.005, as amended by section 110, chapter 73, Oregon Laws 2024, is amended to read:

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

“(2)(a) ‘Beneficiary’ means an injured worker, and the spouse in a mar-

riage, child or dependent of a worker, who is entitled to receive payments under this chapter.

“(b) ‘Beneficiary’ does not include a person who intentionally causes the compensable injury to or death of an injured worker.

“(3) ‘Board’ means the Workers’ Compensation Board.

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

“(5) ‘Child’ means a child of an injured worker, including:

“(a) A posthumous child;

“(b) A child legally adopted before the injury;

“(c) A child toward whom the worker stands in loco parentis;

“(d) A child born out of wedlock;

“(e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker’s family and substantially dependent upon the worker for support; and

“(f) A child of any age who was incapacitated at the time of the accident and thereafter remains incapacitated and substantially dependent on the worker for support.

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

“(7)(a) A ‘compensable injury’ is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death. An injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

“(A) An injury or disease is not compensable as a consequence of a

1 compensable injury unless the compensable injury is the major contributing
2 cause of the consequential condition.

3 “(B) If an otherwise compensable injury combines at any time with a
4 preexisting condition to cause or prolong disability or a need for treatment,
5 the combined condition is compensable only if, so long as and to the extent
6 that the otherwise compensable injury is the major contributing cause of the
7 disability of the combined condition or the major contributing cause of the
8 need for treatment of the combined condition.

9 “(b) ‘Compensable injury’ does not include:

10 “(A) Injury to any active participant in assaults or combats that are not
11 connected to the job assignment and that amount to a deviation from cus-
12 tomary duties;

13 “(B) Injury incurred while engaging in or performing, or as the result of
14 engaging in or performing, any recreational or social activities primarily for
15 the worker’s personal pleasure; or

16 “(C) Injury the major contributing cause of which is demonstrated to be
17 by a preponderance of the evidence the injured worker’s consumption of al-
18 coholic beverages or cannabis or the unlawful consumption of any controlled
19 substance, unless the employer permitted, encouraged or had actual knowl-
20 edge of such consumption.

21 “(c) A ‘disabling compensable injury’ is an injury that entitles the worker
22 to compensation for disability or death. An injury is not disabling if no
23 temporary benefits are due and payable, unless there is a reasonable expect-
24 tation that permanent disability will result from the injury.

25 “(d) A ‘nondisabling compensable injury’ is any injury that requires
26 medical services only.

27 “(8) ‘Compensation’ includes all benefits, including medical services, pro-
28 vided for a compensable injury to a subject worker or the worker’s benefi-
29 ciaries by an insurer or self-insured employer pursuant to this chapter.

30 “(9) ‘Department’ means the Department of Consumer and Business Ser-

1 vices.

2 “(10) ‘Dependent’ means any of the following individuals who, at the time
3 of an accident, depended in whole or in part for the individual’s support on
4 the earnings of a worker who dies as a result of an injury:

5 “(a) A parent of a worker or the parent’s spouse or domestic partner;

6 “(b) A grandparent of a worker or the grandparent’s spouse or domestic
7 partner;

8 “(c) A grandchild of a worker or the grandchild’s spouse or domestic
9 partner;

10 “(d) A sibling or stepsibling of a worker or the sibling’s or stepsibling’s
11 spouse or domestic partner; and

12 “(e) Any individual related by blood or affinity whose close association
13 with a worker is the equivalent of a family relationship.

14 “(11) ‘Director’ means the Director of the Department of Consumer and
15 Business Services.

16 “(12)(a) [*‘Doctor’ or ‘physician’*] **‘Doctor,’ ‘physician,’ ‘nurse practi-**
17 **tioner’ or ‘physician associate’** means a person duly licensed to practice
18 one or more of the healing arts in any country or in any state, territory or
19 possession of the United States within the limits of the license of the
20 licensee.

21 “(b) Except as otherwise provided for workers subject to a managed care
22 contract, ‘attending physician’ means a doctor, physician, **nurse practi-**
23 **tioner** or physician associate who is primarily responsible for the treatment
24 of a worker’s compensable injury and who is:

25 “(A)(i) A physician licensed under ORS 677.100 to 677.228 by the Oregon
26 Medical Board;[, or]

27 “(ii) A podiatric physician and surgeon licensed under ORS 677.805 to
28 677.840 by the Oregon Medical Board;[,]

29 “(iii) An oral and maxillofacial surgeon licensed by the Oregon Board of
30 Dentistry; [or]

1 “(iv) A nurse practitioner licensed under ORS 678.375 to 678.390 or
2 a similarly licensed nurse practitioner in any country or in any state,
3 territory or possession of the United States;

4 “(v) A physician associate licensed by the Oregon Medical Board in
5 accordance with ORS 677.505 to 677.525 or a similarly licensed physician
6 associate in any country or in any state, territory or possession of the
7 United States; or

8 “(vi) A similarly licensed doctor in any country or in any state, territory
9 or possession of the United States; or

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

13 “(i) Doctor or physician licensed by the State Board of Chiropractic Ex-
14 aminers for the State of Oregon under ORS chapter 684 or a similarly li-
15 censed doctor or physician in any country or in any state, territory or
16 possession of the United States; or

17 “(ii) Doctor of naturopathy or naturopathic physician licensed by the
18 Oregon Board of Naturopathic Medicine under ORS chapter 685 or a simi-
19 larly licensed doctor or physician in any country or in any state, territory
20 or possession of the United States.[: or]

21 “[(C) For a cumulative total of 180 days from the first visit on the initial
22 claim, a physician associate licensed by the Oregon Medical Board in accord-
23 ance with ORS 677.505 to 677.525 or a similarly licensed physician associate
24 in any country or in any state, territory or possession of the United States.]

25 “(c) Except as otherwise provided for workers subject to a managed care
26 contract, ‘attending physician’ does not include a physician who provides
27 care in a hospital emergency room and refers the injured worker to a pri-
28 mary care physician for follow-up care and treatment.

29 “(d) ‘Consulting physician’ means a doctor or physician who examines a
30 worker or the worker’s medical record to advise the attending physician [or

1 *nurse practitioner authorized to provide compensable medical services under*
2 *ORS 656.245]* regarding treatment of a worker's compensable injury.

3 “(13)(a) ‘Employer’ means any person, including receiver, administrator,
4 executor or trustee, and the state, state agencies, counties, municipal corpo-
5 rations, school districts and other public corporations or political subdi-
6 visions, that contracts to pay a remuneration for the services of any worker.

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

10 “(c) As used in paragraph (b) of this subsection, ‘temporary service pro-
11 vider’ has the meaning given that term in ORS 656.850.

12 “(d) For the purposes of this chapter, ‘subject employer’ means an em-
13 ployer that is subject to this chapter as provided in ORS 656.023.

14 “(14) ‘Insurer’ means the State Accident Insurance Fund Corporation or
15 an insurer authorized under ORS chapter 731 to transact workers’ compen-
16 sation insurance in this state or an assigned claims agent selected by the
17 director under ORS 656.054.

18 “(15) ‘Consumer and Business Services Fund’ means the fund created by
19 ORS 705.145.

20 “(16) ‘Incapacitated’ means an individual is physically or mentally unable
21 to earn a livelihood.

22 “(17) ‘Medically stationary’ means that no further material improvement
23 would reasonably be expected from medical treatment or the passage of time.

24 “(18) ‘Noncomplying employer’ means a subject employer that has failed
25 to comply with ORS 656.017.

26 “(19) ‘Objective findings’ in support of medical evidence are verifiable
27 indications of injury or disease that may include, but are not limited to,
28 range of motion, atrophy, muscle strength and palpable muscle spasm. ‘Ob-
29 jective findings’ does not include physical findings or subjective responses
30 to physical examinations that are not reproducible, measurable or observa-

1 ble.

2 “(20) ‘Palliative care’ means medical service rendered to reduce or mod-
3 erate temporarily the intensity of an otherwise stable medical condition, but
4 does not include those medical services rendered to diagnose, heal or per-
5 manently alleviate or eliminate a medical condition.

6 “(21) ‘Party’ means a claimant for compensation, the employer of the in-
7 jured worker at the time of injury and the insurer, if any, of the employer.

8 “(22) ‘Payroll’ means a record of wages payable to workers for their ser-
9 vices and includes commissions, value of exchange labor and the reasonable
10 value of board, rent, housing, lodging or similar advantage received from the
11 employer. However, ‘payroll’ does not include overtime pay, vacation pay,
12 bonus pay, tips, amounts payable under profit-sharing agreements or bonus
13 payments to reward workers for safe working practices. Bonus pay is limited
14 to payments that are not anticipated under the contract of employment and
15 that are paid at the sole discretion of the employer. The exclusion from
16 payroll of bonus payments to reward workers for safe working practices is
17 only for the purpose of calculations based on payroll to determine premium
18 for workers’ compensation insurance, and does not affect any other calcu-
19 lation or determination based on payroll for the purposes of this chapter.

20 “(23) ‘Person’ includes a partnership, joint venture, association, limited
21 liability company and corporation.

22 “(24)(a) ‘Preexisting condition’ means, for all industrial injury claims, any
23 injury, disease, congenital abnormality, personality disorder or similar con-
24 dition that contributes to disability or need for treatment, provided that:

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

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

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

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

5 “(b) ‘Preexisting condition’ means, for all occupational disease claims, any
6 injury, disease, congenital abnormality, personality disorder or similar con-
7 dition that contributes to disability or need for treatment and that precedes
8 the onset of the claimed occupational disease, or precedes a claim for wors-
9 ening in such claims pursuant to ORS 656.273 or 656.278.

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

13 “(25) ‘Self-insured employer’ means an employer or group of employers
14 certified under ORS 656.430 as meeting the qualifications set out by ORS
15 656.407.

16 “(26) ‘State Accident Insurance Fund Corporation’ and ‘corporation’ mean
17 the State Accident Insurance Fund Corporation created under ORS 656.752.

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

29 “(28)(a) ‘Worker’ means any person, other than an independent contractor,
30 who engages to furnish services for a remuneration, including a minor

1 whether lawfully or unlawfully employed and salaried, elected and appointed
2 officials of the state, state agencies, counties, cities, school districts and
3 other public corporations, but does not include any person whose services
4 are performed as an adult in custody or ward of a state institution or as part
5 of the eligibility requirements for a general or public assistance grant.

6 “(b) For the purpose of determining entitlement to temporary disability
7 benefits or permanent total disability benefits under this chapter, ‘worker’
8 does not include a person who has withdrawn from the workforce during the
9 period for which such benefits are sought.

10 “(c) For the purposes of this chapter, ‘subject worker’ means a worker
11 who is subject to this chapter as provided in ORS 656.027.

12 “(29) ‘Independent contractor’ has the meaning given that term in ORS
13 670.600.

14 **“SECTION 7.** ORS 656.214 is amended to read:

15 “656.214. (1) As used in this section:

16 “(a) ‘Impairment’ means the loss of use or function of a body part or
17 system due to the compensable industrial injury or occupational disease de-
18 termined in accordance with the standards provided under ORS 656.726, ex-
19 pressed as a percentage of the whole person.

20 “(b) ‘Loss’ includes permanent and complete or partial loss of use.

21 “(c) ‘Permanent partial disability’ means:

22 “(A) Permanent impairment resulting from the compensable industrial
23 injury or occupational disease; or

24 “(B) Permanent impairment and work disability resulting from the
25 compensable industrial injury or occupational disease.

26 “(d) ‘Regular work’ means the job the worker held at injury.

27 “(e) ‘Work disability’ means impairment modified by age, education and
28 adaptability to perform a given job.

29 “(2) When permanent partial disability results from a compensable injury
30 or occupational disease, benefits shall be awarded as follows:

1 “(a) If the worker has been released to regular work by the attending
2 physician [*or nurse practitioner authorized to provide compensable medical*
3 *services under ORS 656.245*] or has returned to regular work [*at the job held*
4 *at the time of injury*], the award shall be for impairment only. Impairment
5 shall be determined in accordance with the standards provided by the Di-
6 rector of the Department of Consumer and Business Services pursuant to
7 ORS 656.726 (4). Impairment benefits are determined by multiplying the
8 impairment value times 100 times the average weekly wage as defined by
9 ORS 656.005.

10 “(b) If the worker has not been released to regular work by the attending
11 physician [*or nurse practitioner authorized to provide compensable medical*
12 *services under ORS 656.245*] or has not returned to regular work [*at the job*
13 *held at the time of injury*], the award shall be for impairment and work dis-
14 ability. Work disability shall be determined in accordance with the standards
15 provided by the director pursuant to ORS 656.726 (4). Impairment shall be
16 determined as provided in paragraph (a) of this subsection. Work disability
17 benefits shall be determined by multiplying the impairment value, as modi-
18 fied by the factors of age, education and adaptability to perform a given job,
19 times 150 times the worker’s weekly wage for the job at injury as calculated
20 under ORS 656.210 (2). The factor for the worker’s weekly wage used for the
21 determination of the work disability may be no more than 133 percent or no
22 less than 50 percent of the average weekly wage as defined in ORS 656.005.

23 “(3) Impairment benefits awarded under subsection (2)(a) of this section
24 shall be expressed as a percentage of the whole person. Impairment benefits
25 for the following body parts may not exceed:

26 “(a) For the loss of one arm at or above the elbow joint, 60 percent.

27 “(b) For the loss of one forearm at or above the wrist joint, or the loss
28 of one hand, 47 percent.

29 “(c) For the loss of one leg, at or above the knee joint, 47 percent.

30 “(d) For the loss of one foot, 42 percent.

1 “(e) For the loss of a great toe, six percent; for loss of any other toe, one
2 percent.

3 “(f) For partial or complete loss of hearing in one ear, that proportion
4 of 19 percent which the loss bears to normal monaural hearing.

5 “(g) For partial or complete loss of hearing in both ears, that proportion
6 of 60 percent which the combined binaural hearing loss bears to normal
7 combined binaural hearing. For the purpose of this paragraph, combined
8 binaural hearing loss shall be calculated by taking seven times the hearing
9 loss in the less damaged ear plus the hearing loss in the more damaged ear
10 and dividing that amount by eight. In the case of individuals with
11 compensable hearing loss involving both ears, either the method of calcu-
12 lation for monaural hearing loss or that for combined binaural hearing loss
13 shall be used, depending upon which allows the greater award of impairment.

14 “(h) For partial or complete loss of vision of one eye, that proportion of
15 31 percent which the loss of monocular vision bears to normal monocular
16 vision. For the purposes of this paragraph, the term ‘normal monocular vi-
17 sion’ shall be considered as Snellen 20/20 for distance and Snellen 14/14 for
18 near vision with full sensory field.

19 “(i) For partial loss of vision in both eyes, that proportion of 94 percent
20 which the combined binocular visual loss bears to normal combined
21 binocular vision. In all cases of partial loss of sight, the percentage of said
22 loss shall be measured with maximum correction. For the purpose of this
23 paragraph, combined binocular visual loss shall be calculated by taking three
24 times the visual loss in the less damaged eye plus the visual loss in the more
25 damaged eye and dividing that amount by four. In the case of individuals
26 with compensable visual loss involving both eyes, either the method of cal-
27 culation for monocular visual loss or that for combined binocular visual loss
28 shall be used, depending upon which allows the greater award of impairment.

29 “(j) For the loss of a thumb, 15 percent.

30 “(k) For the loss of a first finger, eight percent; of a second finger, seven

1 percent; of a third finger, three percent; of a fourth finger, two percent.

2 “(4) The loss of one phalange of a thumb, including the adjacent
3 epiphyseal region of the proximal phalange, is considered equal to the loss
4 of one-half of a thumb. The loss of one phalange of a finger, including the
5 adjacent epiphyseal region of the middle phalange, is considered equal to the
6 loss of one-half of a finger. The loss of two phalanges of a finger, including
7 the adjacent epiphyseal region of the proximal phalange of a finger, is con-
8 sidered equal to the loss of 75 percent of a finger. The loss of more than one
9 phalange of a thumb, excluding the epiphyseal region of the proximal
10 phalange, is considered equal to the loss of an entire thumb. The loss of more
11 than two phalanges of a finger, excluding the epiphyseal region of the
12 proximal phalange of a finger, is considered equal to the loss of an entire
13 finger. A proportionate loss of use may be allowed for an uninjured finger
14 or thumb where there has been a loss of effective opposition.

15 “(5) A proportionate loss of the hand may be allowed where impairment
16 extends to more than one digit, in lieu of ratings on the individual digits.

17 “(6) All permanent disability contemplates future waxing and waning of
18 symptoms of the condition. The results of waxing and waning of symptoms
19 may include, but are not limited to, loss of earning capacity, periods of
20 temporary total or temporary partial disability, or inpatient hospitalization.

21 **“SECTION 8.** ORS 656.245, as amended by section 111, chapter 73, Oregon
22 Laws 2024, is amended to read:

23 “656.245. (1)(a) For every compensable injury, the insurer or the self-
24 insured employer shall cause to be provided medical services for conditions
25 caused in material part by the injury for such period as the nature of the
26 injury or the process of the recovery requires, subject to the limitations in
27 ORS 656.225, including such medical services as may be required after a de-
28 termination of permanent disability. In addition, for consequential and com-
29 bined conditions described in ORS 656.005 (7), the insurer or the self-insured
30 employer shall cause to be provided only those medical services directed to

1 medical conditions caused in major part by the injury.

2 “(b) Compensable medical services shall include medical, surgical, hospi-
3 tal, nursing, ambulances and other related services, and drugs, medicine,
4 crutches and prosthetic appliances, braces and supports and where necessary,
5 physical restorative services. A pharmacist or dispensing physician shall
6 dispense generic drugs to the worker in accordance with ORS 689.515. The
7 duty to provide such medical services continues for the life of the worker.

8 “(c) Notwithstanding any other provision of this chapter, medical services
9 after the worker’s condition is medically stationary are not compensable ex-
10 cept for the following:

11 “(A) Services provided to a worker who has been determined to be per-
12 manently and totally disabled.

13 “(B) Prescription medications.

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

16 “(D) Prosthetic devices, braces and supports.

17 “(E) Services necessary to monitor the status, replacement or repair of
18 prosthetic devices, braces and supports.

19 “(F) Services provided pursuant to an accepted claim for aggravation un-
20 der ORS 656.273.

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

22 “(H) Services that are necessary to diagnose the worker’s condition.

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

25 “(J) With the approval of the insurer or self-insured employer, palliative
26 care that the worker’s attending physician referred to in ORS 656.005
27 (12)(b)(A) prescribes and that is necessary to enable the worker to continue
28 current employment or a vocational training program. If the insurer or self-
29 insured employer does not approve, the attending physician or the worker
30 may request approval from the Director of the Department of Consumer and

1 Business Services for such treatment. The director may order a medical re-
2 view by a physician or panel of physicians pursuant to ORS 656.327 (3) to
3 aid in the review of such treatment. The decision of the director is subject
4 to review under ORS 656.704.

5 “(K) With the approval of the director, curative care arising from a gen-
6 erally recognized, nonexperimental advance in medical science since the
7 worker’s claim was closed that is highly likely to improve the worker’s
8 condition and that is otherwise justified by the circumstances of the claim.
9 The decision of the director is subject to review under ORS 656.704.

10 “(L) Curative care provided to a worker to stabilize a temporary and
11 acute waxing and waning of symptoms of the worker’s condition.

12 “(d) When the medically stationary date in a disabling claim is estab-
13 lished by the insurer or self-insured employer and is not based on the
14 findings of the attending physician, the insurer or self-insured employer is
15 responsible for reimbursement to affected medical service providers for oth-
16 erwise compensable services rendered until the insurer or self-insured em-
17 ployer provides written notice to the attending physician of the worker’s
18 medically stationary status.

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

28 “(2)(a) The worker may choose an attending [*doctor, physician or nurse*
29 *practitioner*] **physician** within the State of Oregon. The worker may choose
30 the initial attending physician [*or nurse practitioner*] and may subsequently

1 change attending physician [*or nurse practitioner*] two times without ap-
2 proval from the director. If the worker thereafter selects another attending
3 physician [*or nurse practitioner*], the insurer or self-insured employer may
4 require the director's approval of the selection. The decision of the director
5 is subject to review under ORS 656.704. The worker also may choose an at-
6 tending doctor or physician in another country or in any state or territory
7 or possession of the United States with the prior approval of the insurer or
8 self-insured employer.

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

11 “(A) A medical service provider who is not qualified to be an attending
12 physician may provide compensable medical service to an injured worker for
13 a period of 30 days from the date of the first visit on the initial claim or for
14 12 visits, whichever first occurs, without the authorization of an attending
15 physician. Thereafter, medical service provided to an injured worker without
16 the written authorization of an attending physician is not compensable.

17 “(B) A medical service provider who is not an attending physician cannot
18 authorize the payment of temporary disability compensation. However, an
19 emergency room physician who is not authorized to serve as an attending
20 physician under ORS 656.005 (12)(c) may authorize temporary disability ben-
21 efits for a maximum of 14 days. A medical service provider qualified to serve
22 as an attending physician under ORS 656.005 (12)(b)(B) may authorize the
23 payment of temporary disability compensation for a period not to exceed 30
24 days from the date of the first visit on the initial claim.

25 “(C) Except as otherwise provided in this chapter, only a physician qual-
26 ified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i)
27 who is serving as the attending physician at the time of claim closure may
28 make findings regarding the worker's impairment for the purpose of evalu-
29 ating the worker's disability.

30 “[*(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a*

1 nurse practitioner licensed under ORS 678.375 to 678.390 or a physician asso-
2 ciate licensed by the Oregon Medical Board in accordance with ORS 677.505
3 to 677.525 or a similarly licensed physician associate in any country or in any
4 state, territory or possession of the United States:]

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

7 “[(ii) May authorize the payment of temporary disability benefits for a pe-
8 riod not to exceed 180 days from the date of the first visit on the initial claim;
9 and]

10 “[(iii) When an injured worker treating with a nurse practitioner or phy-
11 sician associate authorized to provide compensable services under this section
12 becomes medically stationary within the 180-day period in which the nurse
13 practitioner or physician associate is authorized to treat the injured worker,
14 shall refer the injured worker to a physician qualified to be an attending
15 physician as defined in ORS 656.005 for the purpose of making findings re-
16 garding the worker’s impairment for the purpose of evaluating the worker’s
17 disability. If a worker returns to the nurse practitioner or physician associate
18 after initial claim closure for evaluation of a possible worsening of the
19 worker’s condition, the nurse practitioner or physician associate shall refer the
20 worker to an attending physician and the insurer shall compensate the nurse
21 practitioner or physician associate for the examination performed.]

22 “(3) Notwithstanding any other provision of this chapter, the director, by
23 rule, upon the advice of the committee created by ORS 656.794 and upon the
24 advice of the professional licensing boards of practitioners affected by the
25 rule, may exclude from compensability any medical treatment the director
26 finds to be unscientific, unproven, outmoded or experimental. The decision
27 of the director is subject to review under ORS 656.704.

28 “(4) Notwithstanding subsection (2)(a) of this section, when a self-insured
29 employer or the insurer of an employer contracts with a managed care or-
30 ganization certified pursuant to ORS 656.260 for medical services required

1 by this chapter to be provided to injured workers:

2 “(a) Those workers who are subject to the contract shall receive medical
3 services in the manner prescribed in the contract. Workers subject to the
4 contract include those who are receiving medical treatment for an accepted
5 compensable injury or occupational disease, regardless of the date of injury
6 or medically stationary status, on or after the effective date of the contract.
7 If the managed care organization determines that the change in provider
8 would be medically detrimental to the worker, the worker shall not become
9 subject to the contract until the worker is found to be medically stationary,
10 the worker changes physicians [*or nurse practitioners*], or the managed care
11 organization determines that the change in provider is no longer medically
12 detrimental, whichever event first occurs. A worker becomes subject to the
13 contract upon the worker’s receipt of actual notice of the worker’s enroll-
14 ment in the managed care organization, or upon the third day after the no-
15 tice was sent by regular mail by the insurer or self-insured employer,
16 whichever event first occurs. A worker shall not be subject to a contract
17 after it expires or terminates without renewal. A worker may continue to
18 treat with the attending physician [*or nurse practitioner*] authorized to pro-
19 vide compensable medical services under this section under an expired or
20 terminated managed care organization contract if the **attending** physician
21 [*or nurse practitioner*] agrees to comply with the rules, terms and conditions
22 regarding services performed under any subsequent managed care organiza-
23 tion contract to which the worker is subject. A worker shall not be subject
24 to a contract if the worker’s primary residence is more than 100 miles out-
25 side the managed care organization’s certified geographical area. Each such
26 contract must comply with the certification standards provided in ORS
27 656.260. However, a worker may receive immediate emergency medical treat-
28 ment that is compensable from a medical service provider who is not a
29 member of the managed care organization. Insurers or self-insured employers
30 who contract with a managed care organization for medical services shall

1 give notice to the workers of eligible medical service providers and such
2 other information regarding the contract and manner of receiving medical
3 services as the director may prescribe. Notwithstanding any provision of law
4 or rule to the contrary, a worker of a noncomplying employer is considered
5 to be subject to a contract between the State Accident Insurance Fund Cor-
6 poration as a processing agent or the assigned claims agent and a managed
7 care organization.

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

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

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

28 “(D) If the claim is denied, the worker may receive medical services after
29 the date of denial from sources other than the managed care organization
30 until the denial is reversed. Reasonable and necessary medical services re-

ceived from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

“(5)(a) A nurse practitioner[,] or a physician associate described in ORS 656.005 [(12)(b)(C),] **(12)(b)(A)(iv) or (v)** who is not a member of the managed care organization is authorized to provide the same level of services as a primary care physician as established by ORS 656.260 (4) if the nurse practitioner or physician associate:

“(A) Maintains the worker’s medical records;

“(B) Has a documented history of treatment with the worker;

“(C) Agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require; and

“(D) Agrees to comply with all the rules, terms and conditions regarding services performed by the managed care organization.

“(b)[(A)] A nurse practitioner or physician associate authorized to provide medical services to a worker enrolled in the managed care organization may:

“[(i)] **(A)** Provide medical treatment to the worker if the treatment is determined to be medically appropriate according to the service utilization review process of the managed care organization; and

“[(ii)] **(B)** Authorize temporary disability payments [*as provided in subsection (2)(b)(D) of this section*].

“[(B) *The managed care organization may also authorize the nurse practitioner or physician associate to provide medical services and authorize temporary disability payments beyond the periods established in subsection (2)(b)(D) of this section.*]

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

1 **“SECTION 9.** ORS 656.250 is amended to read:

2 “656.250. A physical therapist [*shall*] **may** not provide compensable ser-
3 vices to injured workers governed by this chapter except as allowed by a
4 governing managed care organization contract or as authorized by the
5 worker’s attending physician [*or nurse practitioner authorized to provide*
6 *compensable medical services under ORS 656.245*].

7 **“SECTION 10.** ORS 656.252 is amended to read:

8 “656.252. (1) In order to ensure the prompt and correct reporting and
9 payment of compensation in compensable injuries, the Director of the De-
10 partment of Consumer and Business Services shall make rules governing
11 audits of medical service bills and reports by attending and consulting phy-
12 sicians and other personnel of all medical information relevant to the de-
13 termination of a claim to the injured worker’s representative, the worker’s
14 employer, the employer’s insurer and the Department of Consumer and
15 Business Services. Such rules shall include, but not necessarily be limited
16 to:

17 “(a) Requiring attending physicians [*and nurse practitioners authorized to*
18 *provide compensable medical services under ORS 656.245*] to make the insurer
19 or self-insured employer a first report of injury within 72 hours after the first
20 service rendered.

21 “(b) Requiring attending physicians [*and nurse practitioners authorized to*
22 *provide compensable medical services under ORS 656.245*] to submit follow-up
23 reports within specified time limits or upon the request of an interested
24 party.

25 “(c) Requiring examining physicians [*and nurse practitioners authorized*
26 *to provide compensable medical services under ORS 656.245*] to submit their
27 reports, and to whom, within a specified time.

28 “(d) Such other reporting requirements as the director may deem neces-
29 sary to insure that payments of compensation be prompt and that all inter-
30 ested parties be given information necessary to the prompt determination of

1 claims.

2 “(e) Requiring insurers and self-insured employers to audit billings for all
3 medical services, including hospital services.

4 “(2) The attending physician [*or nurse practitioner authorized to provide*
5 *compensable medical services under ORS 656.245*] shall do the following:

6 “(a) Cooperate with the insurer or self-insured employer to expedite di-
7 agnostic and treatment procedures and with efforts to return injured workers
8 to appropriate work.

9 “(b) Advise the insurer or self-insured employer of the anticipated date
10 for release of the injured worker to return to employment, the anticipated
11 date that the worker will be medically stationary, and the next appointment
12 date. Except when the attending physician [*or nurse practitioner authorized*
13 *to provide compensable medical services under ORS 656.245*] has previously
14 indicated that temporary disability will not exceed 14 days, the insurer or
15 self-insured employer may request a medical report every 15 days, and the
16 attending physician [*or nurse practitioner*] shall forward such reports.

17 “(c) Advise the insurer or self-insured employer within five days of the
18 date the injured worker is released to return to work. Under no circum-
19 stances shall the physician [*or nurse practitioner authorized to provide*
20 *compensable medical services under ORS 656.245*] notify the insurer or em-
21 ployer of the worker’s release to return to work without notifying the worker
22 at the same time.

23 “(d) After a claim has been closed, advise the insurer or self-insured em-
24 ployer within five days after the treatment is resumed or the reopening of
25 a claim is recommended. The attending physician under this paragraph need
26 not be the same attending physician who released the worker when the claim
27 was closed.

28 “(3) In promulgating the rules regarding medical reporting the director
29 may consult and confer with physicians and members of medical associations
30 and societies.

1 “(4) No person who reports medical information to a person referred to
2 in subsection (1) of this section, in accordance with department rules, shall
3 incur any legal liability for the disclosure of such information.

4 “(5) Whenever an injured worker changes attending [*physicians or nurse*
5 *practitioners authorized to provide compensable medical services under ORS*
6 *656.245*] **physician**, the newly selected attending physician [*or nurse practi-*
7 *tioner*] shall so notify the responsible insurer or self-insured employer not
8 later than five days after the date of the change or the date of first treat-
9 ment. Every attending physician [*or nurse practitioner authorized to provide*
10 *compensable medical services under ORS 656.245*] who refers a worker to a
11 consulting physician promptly shall notify the responsible insurer or self-
12 insured employer of the referral.

13 “(6) A provider of medical services, including hospital services, that sub-
14 mits a billing to the insurer or self-insured employer shall also submit a copy
15 of the billing to the worker for whom the service was performed after receipt
16 from the injured worker of a written request for such a copy.

17 **“SECTION 11.** ORS 656.262 is amended to read:

18 “656.262. (1) Processing of claims and providing compensation for a
19 worker shall be the responsibility of the insurer or self-insured employer.
20 All employers shall assist their insurers in processing claims as required in
21 this chapter.

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

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

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

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

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

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

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

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

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

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

28 “(c) Notwithstanding any other provision of this chapter, when the holder
29 of a public office is injured in the course and scope of that public office, full
30 official salary paid to the holder of that public office shall be deemed timely

1 payment of temporary disability payments pursuant to ORS 656.210 and
2 656.212 during the time the wage payments are made. As used in this sub-
3 section, 'public office' has the meaning for that term provided in ORS
4 260.005.

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

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

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

29 “(g)(A) Temporary disability compensation is not due and payable pursu-
30 ant to ORS 656.268 after the worker’s attending physician [*or nurse practi-*

tioner *authorized to provide compensable medical services under ORS 656.245*] ceases to authorize temporary disability or for any period of time not authorized by the attending physician [*or nurse practitioner*]. No authorization of temporary disability compensation by the attending physician [*or nurse practitioner*] under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 45 days prior to its issuance.

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

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

“(ii) During periods in which there is a dispute over the identity of, or treatment by, an attending physician [*or nurse practitioner*] that affects the worker’s ability to obtain authorization of temporary disability; or

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

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

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

1 employer.

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

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

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

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

29 “(b) To establish the maximum amount an employer may pay for medical
30 services for nondisabling claims under paragraph (a) of this subsection, the

1 director shall use \$1,500 as the base compensation amount and shall adjust
2 the base compensation amount annually to reflect changes in the United
3 States City Average Consumer Price Index for All Urban Consumers for
4 Medical Care for July of each year as published by the Bureau of Labor
5 Statistics of the United States Department of Labor. The adjustment shall
6 be rounded to the nearest multiple of \$100.

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

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

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

12 “(b) The notice of acceptance shall:

13 “(A) Specify what conditions are compensable.

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

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

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

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

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

27 “(c) An insurer's or self-insured employer's acceptance of a combined or
28 consequential condition under ORS 656.005 (7), whether voluntary or as a
29 result of a judgment or order, shall not preclude the insurer or self-insured
30 employer from later denying the combined or consequential condition if the

1 otherwise compensable injury ceases to be the major contributing cause of
2 the combined or consequential condition.

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

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

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

28 “(c) When an insurer or self-insured employer determines that the claim
29 qualifies for claim closure, the insurer or self-insured employer shall issue
30 at claim closure an updated notice of acceptance that specifies which condi-

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

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

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

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

27 “(11)(a) If the insurer or self-insured employer unreasonably delays or
28 unreasonably refuses to pay compensation, attorney fees or costs, or unrea-
29 sonably delays acceptance or denial of a claim, the insurer or self-insured
30 employer shall be liable for an additional amount up to 25 percent of the

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

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

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

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

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

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

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

30 “(15) If the director finds that a worker fails to reasonably cooperate with

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

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

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

28 “656.268. (1) One purpose of this chapter is to restore the injured worker
29 as soon as possible and as near as possible to a condition of self support and
30 maintenance as an able-bodied worker. The insurer or self-insured employer

1 shall close the worker's claim, as prescribed by the Director of the Depart-
2 ment of Consumer and Business Services, and determine the extent of the
3 worker's permanent disability, provided the worker is not enrolled and ac-
4 tively engaged in training according to rules adopted by the director pursu-
5 ant to ORS 656.340 and 656.726, when one of the following conditions is met:

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

15 “(b) The accepted injury is no longer the major contributing cause of the
16 worker's combined or consequential condition or conditions pursuant to ORS
17 656.005 (7). When the claim is closed because the accepted injury is no longer
18 the major contributing cause of the worker's combined or consequential
19 condition or conditions, and there is sufficient information to determine
20 permanent disability, the likely permanent disability that would have been
21 due to the current accepted condition shall be estimated.

22 “(c) Without the approval of the attending physician [*or nurse practitioner*
23 *authorized to provide compensable medical services under ORS 656.245*], the
24 worker fails to seek medical treatment for a period of 30 days or the worker
25 fails to attend a closing examination, unless the worker affirmatively estab-
26 lishes that such failure is attributable to reasons beyond the worker's con-
27 trol.

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

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

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

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

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

11 “(b) The attending physician [*or nurse practitioner who has authorized*
12 *temporary disability benefits for the worker under ORS 656.245*] advises the
13 worker and documents in writing that the worker is released to return to
14 regular employment;

15 “(c) The attending physician [*or nurse practitioner who has authorized*
16 *temporary disability benefits for the worker under ORS 656.245*] advises the
17 worker and documents in writing that the worker is released to return to
18 modified employment, such employment is offered in writing to the worker
19 and the worker fails to begin such employment. However, an offer of modi-
20 fied employment may be refused by the worker without the termination of
21 temporary total disability benefits if the offer:

22 “(A) Requires a commute that is beyond the physical capacity of the
23 worker according to the worker’s attending physician [*or the nurse practi-*
24 *tioner who may authorize temporary disability under ORS 656.245*];

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

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

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

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

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

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

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

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

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

1 may mail copies of the notice of closure to any known or potential benefi-
2 ciaries to the estate of the deceased worker.

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

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

6 “(B) The worker of:

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

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

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

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

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

23 “(vi) The aggravation rights; and

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

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

27 “(d) If the insurer or self-insured employer has not issued a notice of
28 closure, the worker may request closure. Within 10 days of receipt of a
29 written request from the worker, the insurer or self-insured employer shall
30 issue a notice of closure if the requirements of this section have been met

1 or a notice of refusal to close if the requirements of this section have not
2 been met. A notice of refusal to close shall advise the worker of:

3 “(A) The decision not to close;

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

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

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

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

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

30 “(g) If, upon reconsideration of a claim closed by an insurer or self-

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

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

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

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

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

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

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

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

proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

“(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker’s or a beneficiary’s request for reconsideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

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

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

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

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

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

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

“(D) Both parties notify the director before the 18th working day after the

1 reconsideration proceeding has begun that they request a delay under this
2 subsection.

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

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

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

9 or

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

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

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

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

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

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

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

29 “(d) The arbiter, or panel of medical arbiters, must be chosen from among
30 a list of physicians qualified to be attending physicians referred to in ORS

1 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon
2 Medical Board and the committee referred to in ORS 656.790.

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

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

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

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

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

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

30 “(h) After reconsideration, no subsequent medical evidence of the

1 worker's impairment is admissible before the director, the Workers' Com-
2 pensation Board or the courts for purposes of making findings of impairment
3 on the claim closure.

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

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

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

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

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

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

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

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

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

1 insurer or self-insured employer. When overpayments are recovered from
2 temporary disability or permanent total disability benefits, the amount re-
3 covered from each payment shall not exceed 25 percent of the payment,
4 without prior authorization from the worker.

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

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

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

18 “(b) An insurer or self-insured employer may not declare an overpayment
19 of any compensation that was paid more than two years prior to the date
20 of the declaration.

21 **“SECTION 13.** ORS 656.325 is amended to read:

22 “656.325. (1)(a) Any worker entitled to receive compensation under this
23 chapter is required, if requested by the Director of the Department of Con-
24 sumer and Business Services, the insurer or self-insured employer, to submit
25 to a medical examination at a time reasonably convenient for the worker as
26 may be provided by the rules of the director. No more than three independent
27 medical examinations may be requested except after notification to and au-
28 thorization by the director. If the worker refuses to submit to any such ex-
29 amination, or obstructs the same, the rights of the worker to compensation
30 shall be suspended with the consent of the director until the examination

1 has taken place, and no compensation shall be payable during or for account
2 of such period. The provisions of this paragraph are subject to the limita-
3 tions on medical examinations provided in ORS 656.268.

4 “(b) When a worker is requested by the director, the insurer or self-
5 insured employer to attend an independent medical examination, the exam-
6 ination must be conducted by a physician selected from a list of qualified
7 physicians established by the director under ORS 656.328.

8 “(c) The director shall adopt rules applicable to independent medical ex-
9 aminations conducted pursuant to paragraph (a) of this subsection that:

10 “(A) Provide a worker the opportunity to request review by the director
11 of the reasonableness of the location selected for an independent medical
12 examination. Upon receipt of the request for review, the director shall con-
13 duct an expedited review of the location selected for the independent medical
14 examination and issue an order on the reasonableness of the location of the
15 examination. The director shall determine if there is substantial evidence for
16 the objection to the location for the independent medical examination based
17 on a conclusion that the required travel is medically contraindicated or
18 other good cause establishing that the required travel is unreasonable. The
19 determinations of the director about the location of independent medical
20 examinations are not subject to review.

21 “(B) Impose a monetary penalty against a worker who fails to attend an
22 independent medical examination without prior notification or without jus-
23 tification for not attending the examination. A penalty imposed under this
24 subparagraph may be imposed only on a worker who is not receiving tem-
25 porary disability benefits under ORS 656.210 or 656.212. An insurer or self-
26 insured employer may offset any future compensation payable to the worker
27 to recover any penalty imposed under this subparagraph from a claim with
28 the same insurer or self-insured employer. When a penalty is recovered from
29 temporary disability or permanent total disability benefits, the amount re-
30 covered from each payment may not exceed 25 percent of the benefit payment

1 without prior authorization from the worker.

2 “(C) Impose a sanction against a medical service provider that unreason-
3 ably fails to provide in a timely manner diagnostic records required for an
4 independent medical examination.

5 “(d) Notwithstanding ORS 656.262 (6), if the director determines that the
6 location selected for an independent medical examination is unreasonable,
7 the insurer or self-insured employer shall accept or deny the claim within
8 90 days after the employer has notice or knowledge of the claim.

9 “(e) If the worker has made a timely request for a hearing on a denial
10 of compensability as required by ORS 656.319 (1)(a) that is based on one or
11 more reports of examinations conducted pursuant to paragraph (a) of this
12 subsection and the worker’s attending physician [*or nurse practitioner au-*
13 *thorized to provide compensable medical services under ORS 656.245*] does not
14 concur with the report or reports, the worker may request an examination
15 to be conducted by a physician selected by the director from the list de-
16 scribed in ORS 656.328. The cost of the examination and the examination
17 report shall be paid by the insurer or self-insured employer.

18 “(f) The insurer or self-insured employer shall pay the costs of the medical
19 examination and related services which are reasonably necessary to allow
20 the worker to submit to any examination requested under this section. As
21 used in this paragraph, ‘related services’ includes, but is not limited to, child
22 care, travel, meals, lodging and an amount equivalent to the worker’s net
23 lost wages for the period during which the worker is absent if the worker
24 does not receive benefits pursuant to ORS 656.210 (4) during the period of
25 absence. A claim for ‘related services’ described in this paragraph shall be
26 made in the manner prescribed by the director.

27 “(g) A worker who objects to the location of an independent medical ex-
28 amination must request review by the director under paragraph (c)(A) of this
29 subsection within six business days of the date the notice of the independent
30 medical examination was mailed.

1 “(2) For any period of time during which any worker commits insanitary
2 or injurious practices which tend to either imperil or retard recovery of the
3 worker, or refuses to submit to such medical or surgical treatment as is
4 reasonably essential to promote recovery, or fails to participate in a program
5 of physical rehabilitation, the right of the worker to compensation shall be
6 suspended with the consent of the director and no payment shall be made for
7 such period. The period during which such worker would otherwise be enti-
8 tled to compensation may be reduced with the consent of the director to such
9 an extent as the disability has been increased by such refusal.

10 “(3) A worker who has received an award for permanent total or perma-
11 nent partial disability should be encouraged to make a reasonable effort to
12 reduce the disability; and the award shall be subject to periodic examination
13 and adjustment in conformity with ORS 656.268.

14 “(4) When the employer of an injured worker, or the employer’s insurer
15 determines that the injured worker has failed to follow medical advice from
16 the attending physician [*or nurse practitioner authorized to provide*
17 *compensable medical services under ORS 656.245*] or has failed to participate
18 in or complete physical restoration or vocational rehabilitation programs
19 prescribed for the worker pursuant to this chapter, the employer or insurer
20 may petition the director for reduction of any benefits awarded the worker.
21 Notwithstanding any other provision of this chapter, if the director finds
22 that the worker has failed to accept treatment as provided in this subsection,
23 the director may reduce any benefits awarded the worker by such amount
24 as the director considers appropriate.

25 “(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or
26 self-insured employer shall cease making payments pursuant to ORS 656.210
27 and shall commence making payment of such amounts as are due pursuant
28 to ORS 656.212 when an injured worker refuses wage earning employment
29 prior to claim determination and the worker’s attending physician [*or nurse*
30 *practitioner authorized to provide compensable medical services under ORS*

1 656.245], after being notified by the employer of the specific duties to be
2 performed by the injured worker, agrees that the injured worker is capable
3 of performing the employment offered.

4 “(b) If the worker has been terminated for violation of work rules or other
5 disciplinary reasons, the insurer or self-insured employer shall cease pay-
6 ments pursuant to ORS 656.210 and commence payments pursuant to ORS
7 656.212 when the attending physician [*or nurse practitioner authorized to*
8 *provide compensable medical services under ORS 656.245*] approves employ-
9 ment in a modified job that would have been offered to the worker if the
10 worker had remained employed, provided that the employer has a written
11 policy of offering modified work to injured workers.

12 “(c) If the worker is a person present in the United States in violation
13 of federal immigration laws, the insurer or self-insured employer shall cease
14 payments pursuant to ORS 656.210 and commence payments pursuant to ORS
15 656.212 when the attending physician [*or nurse practitioner authorized to*
16 *provide compensable medical services under ORS 656.245*] approves employ-
17 ment in a modified job whether or not such a job is available.

18 “(6) Any party may request a hearing on any dispute under this section
19 pursuant to ORS 656.283.

20 **“SECTION 14.** ORS 656.340 is amended to read:

21 “656.340. (1)(a) The insurer or self-insured employer shall cause vocational
22 assistance to be provided to an injured worker who is eligible for assistance
23 in returning to work.

24 “(b) For this purpose the insurer or self-insured employer shall contact a
25 worker with a claim for a disabling compensable injury or claim for aggra-
26 vation for evaluation of the worker’s eligibility for vocational assistance
27 within five days of:

28 “(A) Having knowledge of the worker’s likely eligibility for vocational
29 assistance, from a medical or investigation report, notification from the
30 worker, or otherwise; or

1 “(B) The time the worker is medically stationary, if the worker has not
2 returned to or been released for the worker’s regular employment or has not
3 returned to other suitable employment with the employer at the time of in-
4 jury or aggravation and the worker is not receiving vocational assistance.

5 “(c) Eligibility may be redetermined by the insurer or self-insured em-
6 ployer upon receipt of new information that would change the eligibility
7 determination.

8 “(2) Contact under subsection (1) of this section shall include informing
9 the worker about reemployment rights, the responsibility of the worker to
10 request reemployment, and wage subsidy and job site modification assistance
11 and the provisions of the preferred worker program pursuant to rules adopted
12 by the Director of the Department of Consumer and Business Services.

13 “(3) Within five days after notification that the attending physician [*or*
14 *nurse practitioner authorized to provide compensable medical services under*
15 *ORS 656.245*] has released a worker to return to work, the insurer or self-
16 insured employer shall inform the worker about the opportunity to seek re-
17 employment or reinstatement under ORS 659A.043 and 659A.046. The insurer
18 shall inform the employer of the worker’s reemployment rights, wage subsidy
19 and the job site modification assistance and the provisions of the preferred
20 worker program.

21 “(4) As soon as possible, and not more than 30 days after the contact re-
22 quired by subsection (1) of this section, the insurer or self-insured employer
23 shall cause an individual certified by the director to provide vocational as-
24 sistance to determine whether the worker is eligible for vocational assist-
25 ance. The insurer or self-insured employer shall notify the worker of the
26 decision regarding the worker’s eligibility for vocational assistance. If the
27 insurer or self-insured employer decides that the worker is not eligible, the
28 worker may apply to the director for review of the decision as provided in
29 subsection (16) of this section. A worker determined ineligible upon evalu-
30 ation under subsection (1)(b)(B) of this section, or because the worker’s el-

1 eligibility has fully and finally expired under standards prescribed by the
2 director, may not be found eligible thereafter unless that eligibility deter-
3 mination is rejected by the director under subsection (16) of this section or
4 the worker's condition worsens so as to constitute an aggravation claim un-
5 der ORS 656.273. A worker is not entitled to vocational assistance benefits
6 when possible eligibility for such benefits arises from a worsening of the
7 worker's condition that occurs after the expiration of the worker's aggra-
8 vation rights under ORS 656.273.

9 “(5) The objectives of vocational assistance are to return the worker to
10 employment which is as close as possible to the worker's regular employment
11 at a wage as close as possible to the weekly wage currently being paid for
12 employment which was the worker's regular employment even though the
13 wage available following employment may be less than the wage prescribed
14 by subsection (6) of this section. As used in this subsection and subsection
15 (6) of this section, ‘regular employment’ means the employment the worker
16 held at the time of the injury or the claim for aggravation under ORS
17 656.273, whichever gave rise to the potential eligibility for vocational as-
18 sistance; or, for a worker not employed at the time of the aggravation, the
19 employment the worker held on the last day of work prior to the aggra-
20 vation.

21 “(6)(a) A worker is eligible for vocational assistance if the worker will
22 not be able to return to the previous employment or to any other available
23 and suitable employment with the employer at the time of injury or aggra-
24 vation, and the worker has a substantial handicap to employment.

25 “(b) As used in this subsection:

26 “(A) A ‘substantial handicap to employment’ exists when the worker, be-
27 cause of the injury or aggravation, lacks the necessary physical capacities,
28 knowledge, skills and abilities to be employed in suitable employment.

29 “(B) ‘Suitable employment’ means:

30 “(i) Employment of the kind for which the worker has the necessary

1 physical capacity, knowledge, skills and abilities;

2 “(ii) Employment that is located where the worker customarily worked
3 or is within reasonable commuting distance of the worker’s residence; and

4 “(iii) Employment that produces a weekly wage within 20 percent of that
5 currently being paid for employment that was the worker’s regular employ-
6 ment as defined in subsection (5) of this section. The director shall adopt
7 rules providing methods of calculating the weekly wage currently being paid
8 for the worker’s regular employment for use in determining eligibility and
9 for providing assistance to eligible workers. If the worker’s regular employ-
10 ment was seasonal or temporary, the worker’s wage shall be averaged based
11 on a combination of the worker’s earned income and any unemployment in-
12 surance payments. Only earned income evidenced by verifiable documenta-
13 tion such as federal or state tax returns shall be used in the calculation.
14 Earned income does not include fringe benefits or reimbursement of the
15 worker’s employment expenses.

16 “(7) Vocational evaluation, help in directly obtaining employment and
17 training shall be available under conditions prescribed by the director. The
18 director may establish other conditions for providing vocational assistance,
19 including those relating to the worker’s availability for assistance, partic-
20 ipation in previous assistance programs connected with the same claim and
21 the nature and extent of assistance that may be provided. Such conditions
22 shall give preference to direct employment assistance over training.

23 “(8) An insurer or self-insured employer may utilize its own staff or may
24 engage any other individual certified by the director to perform the voca-
25 tional evaluation required by subsection (4) of this section.

26 “(9) The director shall adopt rules providing:

27 “(a) Standards for and methods of certifying individuals qualified by ed-
28 ucation, training and experience to provide vocational assistance to injured
29 workers;

30 “(b) Standards for registration of vocational assistance providers;

1 “(c) Conditions and procedures under which the certification of an indi-
2 vidual to provide vocational assistance services or the registration of a vo-
3 cational assistance provider may be suspended or revoked for failure to
4 maintain compliance with the certification or registration standards;

5 “(d) Standards for the nature and extent of services a worker may receive,
6 for plans for return to work and for determining when the worker has re-
7 turned to work; and

8 “(e) Procedures, schedules and conditions relating to the payment for
9 services performed by a vocational assistance provider, that are based on
10 payment for specific services performed and not fees for services performed
11 on an hourly basis. Fee schedules shall reflect a reasonable rate for direct
12 worker purchases and for all vocational assistance providers and shall be the
13 same within suitable geographic areas.

14 “(10) Insurers and self-insured employers shall maintain records and make
15 reports to the director of vocational assistance actions at times and in the
16 manner as the director may prescribe. The requirements prescribed shall be
17 for the purpose of assisting the Department of Consumer and Business Ser-
18 vices in monitoring compliance with this section to insure that workers re-
19 ceive timely and appropriate vocational assistance. The director shall
20 minimize to the greatest extent possible the number, extent and kinds of re-
21 ports required. The director shall compile a list of organizations or agencies
22 registered to provide vocational assistance. A current list shall be distributed
23 by the director to all insurers and self-insured employers. The insurer shall
24 send the list to each worker with the notice of eligibility.

25 “(11) When a worker is eligible to receive vocational assistance, the
26 worker and the insurer or self-insured employer shall attempt to agree on the
27 choice of a vocational assistance provider. If the worker agrees, the insurer
28 or self-insured employer may utilize its own staff to provide vocational as-
29 sistance. If they are unable to agree on a vocational assistance provider, the
30 insurer or self-insured employer shall notify the director and the director

1 shall select a provider. Any change in the choice of vocational assistance
2 provider is subject to the approval of the director.

3 “(12) Notwithstanding ORS 656.268, a worker actively engaged in training
4 may receive temporary disability compensation for a maximum of 16 months.
5 The insurer or self-insured employer may voluntarily extend the payment of
6 temporary disability compensation to a maximum of 21 months. The director
7 may order the payment of temporary disability compensation for up to 21
8 months upon good cause shown by the injured worker. The costs related to
9 vocational assistance training programs may be paid for periods longer than
10 21 months, but in no event may temporary disability benefits be paid for a
11 period longer than 21 months.

12 “(13) As used in this section, ‘vocational assistance provider’ means a
13 public or private organization or agency that provides vocational assistance
14 to injured workers.

15 “(14)(a) Determination of eligibility for vocational assistance does not
16 entitle all workers to the same type or extent of assistance.

17 “(b) Training shall not be provided to an eligible worker solely because
18 the worker cannot obtain employment, otherwise suitable, that will produce
19 the wage prescribed in subsection (6) of this section unless such training will
20 enable the worker to find employment which will produce a wage signif-
21 icantly closer to that prescribed in subsection (6) of this section.

22 “(c) Nothing in this section shall be interpreted to expand the availability
23 of training under this section.

24 “(15) A physical capacities evaluation shall be performed in conjunction
25 with vocational assistance or determination of eligibility for such assistance
26 at the request of the insurer or self-insured employer or worker. The request
27 shall be made to the attending physician [*or nurse practitioner authorized to*
28 *provide compensable medical services under ORS 656.245*]. [*The attending*
29 *physician or nurse practitioner,*] Within 20 days of the request, **the attending**
30 **physician** shall perform a physical capacities evaluation or refer the worker

1 for such evaluation or advise the insurer or self-insured employer and the
2 worker in writing that the injured worker is incapable of participating in a
3 physical capacities evaluation.

4 “(16)(a) The Legislative Assembly finds that vocational rehabilitation of
5 injured workers requires a high degree of cooperation between all of the
6 participants in the vocational assistance process. Based on this finding, the
7 Legislative Assembly concludes that disputes regarding eligibility for and
8 extent of vocational assistance services should be resolved through nonad-
9 versarial procedures to the greatest extent possible consistent with consti-
10 tutional principles. The director shall adopt by rule a procedure for resolving
11 vocational assistance disputes in the manner provided in this subsection.

12 “(b) If a worker is dissatisfied with an action of the insurer or self-insured
13 employer regarding vocational assistance, the worker must apply to the di-
14 rector for administrative review of the matter. Application for review must
15 be made not later than the 60th day after the date the worker was notified
16 of the action. The director shall complete the review within a reasonable
17 time.

18 “(c) If the worker’s dissatisfaction is resolved by agreement of the parties,
19 the agreement shall be reduced to writing, and the director and the parties
20 shall review the agreement and either approve or disapprove it. The agree-
21 ment is subject to reconsideration by the director under limitations pre-
22 scribed by the director, but is not subject to review by any other forum.

23 “(d) If the worker’s dissatisfaction is not resolved by agreement of the
24 parties, the director shall resolve the matter in a written order based on a
25 record sufficient to permit review. The order is subject to review under ORS
26 656.704. The request for a hearing must be filed within 60 days of the date
27 the order was issued. At the hearing, the order of the director shall be
28 modified only if it:

29 “(A) Violates a statute or rule;

30 “(B) Exceeds the statutory authority of the agency;

1 “(C) Was made upon unlawful procedure; or

2 “(D) Was characterized by abuse of discretion or clearly unwarranted
3 exercise of discretion.

4 “(e) For purposes of this subsection, the term ‘parties’ does not include
5 a noncomplying employer.

6 **“SECTION 15.** ORS 656.726 is amended to read:

7 “656.726. (1) The Workers’ Compensation Board in its name and the Di-
8 rector of the Department of Consumer and Business Services in the director’s
9 name as director may sue and be sued, and each shall have a seal.

10 “(2) The board hereby is charged with reviewing appealed orders of Ad-
11 ministrative Law Judges in controversies concerning a claim arising under
12 this chapter, exercising own motion jurisdiction under this chapter and pro-
13 viding such policy advice as the director may request, and providing such
14 other review functions as may be prescribed by law. To that end any of its
15 members or assistants authorized thereto by the members shall have power
16 to:

17 “(a) Hold sessions at any place within the state.

18 “(b) Administer oaths.

19 “(c) Issue and serve by the board’s representatives, or by any sheriff,
20 subpoenas for the attendance of witnesses and the production of papers,
21 contracts, books, accounts, documents and testimony before any hearing un-
22 der ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this
23 chapter.

24 “(d) Generally provide for the taking of testimony and for the recording
25 of proceedings.

26 “(3) The board chairperson is hereby charged with the administration of
27 and responsibility for the Hearings Division.

28 “(4) The director hereby is charged with duties of administration, regu-
29 lation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750
30 to 654.780 and this chapter. To that end the director may:

1 “(a) Make and declare all rules and issue orders which are reasonably
2 required in the performance of the director’s duties. Unless otherwise spec-
3 ified by law, all reports, claims or other documents shall be deemed timely
4 provided to the director or board if mailed by regular mail or delivered
5 within the time required by law. Notwithstanding any other provision of this
6 chapter, the director may adopt rules to allow for the electronic transmission
7 and filing of reports, claims or other documents required to be filed under
8 this chapter and to require the electronic transmission and filing of proof
9 of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding
10 ORS 183.310 to 183.410, if a matter comes before the director that is not ad-
11 dressed by rule and the director finds that adoption of a rule to accommodate
12 the matter would be inefficient, unreasonable or unnecessarily burdensome
13 to the public, the director may resolve the matter by issuing an order, sub-
14 ject to review under ORS 656.704. Such order shall not have precedential
15 effect as to any other situation.

16 “(b) Hold sessions at any place within the state.

17 “(c) Administer oaths.

18 “(d) Issue and serve by representatives of the director, or by any sheriff,
19 subpoenas for the attendance of witnesses and the production of papers,
20 contracts, books, accounts, documents and testimony in any inquiry, inves-
21 tigation, proceeding or rulemaking hearing conducted by the director or the
22 director’s representatives. The director may require the attendance and tes-
23 timony of employers, their officers and representatives in any inquiry under
24 this chapter, and the production by employers of books, records, papers and
25 documents without the payment or tender of witness fees on account of such
26 attendance.

27 “(e) Generally provide for the taking of testimony and for the recording
28 of such proceedings.

29 “(f) Provide standards for the evaluation of disabilities. The following
30 provisions apply to the standards:

1 “(A) The criterion for evaluation of permanent impairment under ORS
2 656.214 is the loss of use or function of a body part or system due to the
3 compensable industrial injury or occupational disease. Permanent impair-
4 ment is expressed as a percentage of the whole person. The impairment value
5 may not exceed 100 percent of the whole person.

6 “(B) Impairment is established by a preponderance of medical evidence
7 based upon objective findings.

8 “(C) The criterion for evaluation of work disability under ORS 656.214 is
9 permanent impairment as modified by the factors of age, education and
10 adaptability to perform a given job.

11 “(D) When, upon reconsideration of a notice of closure pursuant to ORS
12 656.268, it is found that the worker’s disability is not addressed by the stan-
13 dards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the
14 director shall, in the order on reconsideration, determine the extent of per-
15 manent disability that addresses the worker’s impairment.

16 “(E) Notwithstanding any other provision of this section, only impairment
17 benefits shall be awarded under ORS 656.214 if the worker has been released
18 to regular work by the attending physician [*or nurse practitioner authorized*
19 *to provide compensable medical services under ORS 656.245*] or has returned
20 to regular work at the job held at the time of injury.

21 “(g) Prescribe procedural rules for and conduct hearings, investigations
22 and other proceedings pursuant to ORS 654.001 to 654.295, 654.412 to 654.423,
23 654.750 to 654.780 and this chapter regarding all matters other than those
24 specifically allocated to the board or the Hearings Division.

25 “(h) Participate fully in any proceeding before the Hearings Division,
26 board or Court of Appeals in which the director determines that the pro-
27 ceeding involves a matter that affects or could affect the discharge of the
28 director’s duties of administration, regulation and enforcement of ORS
29 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

30 “(5)(a) The board may make and declare all rules which are reasonably

1 required in the performance of its duties, including but not limited to rules
2 of practice and procedure in connection with hearing and review proceedings
3 and exercising its authority under ORS 656.278. The board shall adopt stan-
4 dards governing the format and timing of the evidence. The standards shall
5 be uniformly followed by all Administrative Law Judges and practitioners.
6 The rules may provide for informal prehearing conferences in order to expe-
7 dite claim adjudication, amicably dispose of controversies, if possible, narrow
8 issues and simplify the method of proof at hearings. The rules shall specify
9 who may appear with parties at prehearing conferences and hearings.

10 “(b) Notwithstanding any other provision of this chapter, the board may
11 adopt rules to allow for the electronic transmission of filings, reports, no-
12 tices and other documents required to be filed under the board’s authority.

13 “(6) The director and the board chairperson may incur such expenses as
14 they respectively determine are reasonably necessary to perform their au-
15 thorized functions.

16 “(7) The director, the board chairperson and the State Accident Insurance
17 Fund Corporation shall have the right, not subject to review, to contract for
18 the exchange of, or payment for, such services between them as will reduce
19 the overall cost of administering this chapter.

20 “(8) The director shall have lien and enforcement powers regarding as-
21 sessments to be paid by subject employers in the same manner and to the
22 same extent as is provided for lien and enforcement of collection of premiums
23 and assessments by the corporation under ORS 656.552 to 656.566.

24 “(9) The director shall have the same powers regarding inspection of
25 books, records and payrolls of employers as are granted the corporation un-
26 der ORS 656.758. The director may disclose information obtained from such
27 inspections to the Director of the Department of Revenue to the extent the
28 Director of the Department of Revenue requires such information to deter-
29 mine that a person complies with the revenue and tax laws of this state and
30 to the Director of the Employment Department to the extent the Director

1 of the Employment Department requires such information to determine that
2 a person complies with ORS chapter 657.

3 “(10) The director shall collect hours-worked data information in addition
4 to total payroll for workers engaged in various jobs in the construction in-
5 dustry classifications described in the job classification portion of the
6 Workers’ Compensation and Employers Liability Manual and the Oregon
7 Special Rules Section published by the National Council on Compensation
8 Insurance. The information shall be collected in the form and format neces-
9 sary for the National Council on Compensation Insurance to analyze pre-
10 mium equity.

11 **“SECTION 16.** ORS 656.797 is amended to read:

12 “656.797. On or after October 1, 2004, **prior to providing compensable**
13 **medical services or authorizing temporary disability benefits**, a nurse
14 practitioner licensed under ORS 678.375 to 678.390[, *prior to providing*
15 *compensable medical services or authorizing temporary disability benefits un-*
16 *der ORS 656.245,*] must certify in a form acceptable to the Director of the
17 Department of Consumer and Business Services that the nurse practitioner
18 has reviewed the materials developed under ORS 656.795.

19 **“SECTION 17.** ORS 659A.043 is amended to read:

20 “659A.043. (1) A worker who has sustained a compensable injury shall be
21 reinstated by the worker’s employer to the worker’s former position of em-
22 ployment upon demand for such reinstatement, if the position exists and is
23 available and the worker is not disabled from performing the duties of such
24 position. A worker’s former position is available even if that position has
25 been filled by a replacement while the injured worker was absent. If the
26 former position is not available, the worker shall be reinstated in any other
27 existing position that is vacant and suitable. A certificate by the attending
28 physician, **as defined in ORS 656.005 (12)**, [*or a nurse practitioner author-*
29 *ized to provide compensable medical services under ORS 656.245*] that the
30 **attending** physician [*or nurse practitioner*] approves the worker’s return to

1 the worker's regular employment or other suitable employment shall be
2 prima facie evidence that the worker is able to perform such duties.

3 “(2) Such right of reemployment shall be subject to the provisions for
4 seniority rights and other employment restrictions contained in a valid col-
5 lective bargaining agreement between the employer and a representative of
6 the employer's employees.

7 “(3) Notwithstanding subsection (1) of this section:

8 “(a) The right to reinstatement to the worker's former position under this
9 section terminates when whichever of the following events first occurs:

10 “(A) A medical determination by the attending physician or, after an ap-
11 peal of such determination to a medical arbiter or panel of medical arbiters
12 pursuant to ORS chapter 656, has been made that the worker cannot return
13 to the former position of employment.

14 “(B) The worker is eligible and participates in vocational assistance un-
15 der ORS 656.340.

16 “(C) The worker accepts suitable employment with another employer after
17 becoming medically stationary.

18 “(D) The worker refuses a bona fide offer from the employer of light duty
19 or modified employment that is suitable prior to becoming medically sta-
20 tionary.

21 “(E) Seven days elapse from the date that the worker is notified by the
22 insurer or self-insured employer by certified mail that the worker's attending
23 physician [*or a nurse practitioner authorized to provide compensable medical*
24 *services under ORS 656.245*] has released the worker for employment unless
25 the worker requests reinstatement within that time period.

26 “(F) Three years elapse from the date of injury.

27 “(b) The right to reinstatement under this section does not apply to:

28 “(A) A worker hired on a temporary basis as a replacement for an injured
29 worker.

30 “(B) A seasonal worker employed to perform less than six months' work

1 in a calendar year.

2 “(C) A worker whose employment at the time of injury resulted from re-
3 ferral from a hiring hall operating pursuant to a collective bargaining
4 agreement.

5 “(D) A worker whose employer employs 20 or fewer workers at the time
6 of the worker’s injury and at the time of the worker’s demand for rein-
7 statement.

8 “(4) Notwithstanding ORS 659A.165, a worker who refuses an offer of
9 employment under subsection (3)(a)(D) of this section and who otherwise is
10 entitled to family leave under ORS 659A.150 to 659A.186:

11 “(a) Automatically commences a period of family leave under ORS
12 659A.150 to 659A.186 upon refusing the offer of employment; and

13 “(b) Need not give additional written or oral notice to the employer that
14 the employee is commencing a period of family leave.

15 “(5) Any violation of this section is an unlawful employment practice.

16 **“SECTION 18.** ORS 659A.046 is amended to read:

17 “659A.046. (1) A worker who has sustained a compensable injury and is
18 disabled from performing the duties of the worker’s former regular employ-
19 ment shall, upon demand, be reemployed by the worker’s employer at em-
20 ployment which is available and suitable.

21 “(2) A certificate of the worker’s attending physician, **as defined in ORS**
22 **656.005 (12)**, [*or a nurse practitioner authorized to provide compensable med-*
23 *ical services under ORS 656.245*] that the worker is able to perform described
24 types of work shall be prima facie evidence of such ability.

25 “(3) Notwithstanding subsection (1) of this section, the right to reem-
26 ployment under this section terminates when whichever of the following
27 events first occurs:

28 “(a) The worker cannot return to reemployment at any position with the
29 employer either by determination of the attending physician [*or a nurse*
30 *practitioner authorized to provide compensable medical services under ORS*

1 656.245] or upon appeal of that determination, by determination of a medical
2 arbiter or panel of medical arbiters pursuant to ORS chapter 656.

3 “(b) The worker is eligible and participates in vocational assistance under
4 ORS 656.340.

5 “(c) The worker accepts suitable employment with another employer after
6 becoming medically stationary.

7 “(d) The worker refuses a bona fide offer from the employer of light duty
8 or modified employment that is suitable prior to becoming medically sta-
9 tionary.

10 “(e) Seven days elapse from the date that the worker is notified by the
11 insurer or self-insured employer by certified mail that the worker’s attending
12 physician [*or a nurse practitioner authorized to provide compensable medical*
13 *services under ORS 656.245]* has released the worker for reemployment unless
14 the worker requests reemployment within that time period.

15 “(f) Three years elapse from the date of injury.

16 “(4) Such right of reemployment shall be subject to the provisions for
17 seniority rights and other employment restrictions contained in a valid col-
18 lective bargaining agreement between the employer and a representative of
19 the employer’s employees.

20 “(5) Notwithstanding ORS 659A.165, a worker who refuses an offer of
21 employment under subsection (3)(d) of this section and who otherwise is en-
22 titled to family leave under ORS 659A.150 to 659A.186:

23 “(a) Automatically commences a period of family leave under ORS
24 659A.150 to 659A.186 upon refusing the offer of employment; and

25 “(b) Need not give additional written or oral notice to the employer that
26 the employee is commencing a period of family leave.

27 “(6) Any violation of this section is an unlawful employment practice.

28 “(7) This section applies only to employers who employ six or more per-
29 sons.

30 “**SECTION 19.** ORS 659A.049 is amended to read:

1 “659A.049. The rights of reinstatement afforded by ORS 659A.043 and
2 659A.046 shall not be forfeited if the worker refuses to return to the worker’s
3 regular or other offered employment without release to such employment by
4 the worker’s attending physician, **as defined in ORS 656.005 (12)**, [*or a*
5 *nurse practitioner authorized to provide compensable medical services under*
6 *ORS 656.245*].

7 **“SECTION 20.** ORS 659A.063 is amended to read:

8 “659A.063. (1) The State of Oregon shall cause group health benefits to
9 continue in effect with respect to that worker and any covered dependents
10 or family members by timely payment of the premium that includes the con-
11 tribution due from the state under the applicable benefit plan, subject to any
12 premium contribution due from the worker that the worker paid before the
13 occurrence of the injury or illness. If the premium increases or decreases, the
14 State of Oregon and worker contributions shall be adjusted to remain con-
15 sistent with similarly situated active employees. The State of Oregon shall
16 continue the worker’s health benefits in effect until whichever of the fol-
17 lowing events occurs first:

18 “(a) The worker’s attending physician, **as defined in ORS 656.005 (12)**,
19 [*or a nurse practitioner authorized to provide compensable medical services*
20 *under ORS 656.245*] has determined the worker to be medically stationary
21 and a notice of closure has been entered;

22 “(b) The worker returns to work for the State of Oregon, after a period
23 of continued coverage under this section, and satisfies any probationary or
24 minimum work requirement to be eligible for group health benefits;

25 “(c) The worker takes full- or part-time employment with another em-
26 ployer that is comparable in terms of the number of hours per week the
27 worker was employed with the State of Oregon or the worker retires;

28 “(d) Twelve months have elapsed since the date the State of Oregon re-
29 ceived notice that the worker filed a workers’ compensation claim pursuant
30 to ORS chapter 656;

1 “(e) The claim is denied and the claimant fails to appeal within the time
2 provided by ORS 656.319 or the Workers’ Compensation Board or a workers’
3 compensation hearings referee or a court issues an order finding the claim
4 is not compensable;

5 “(f) The worker does not pay the required premium or portion thereof in
6 a timely manner in accordance with the terms and conditions under this
7 section;

8 “(g) The worker elects to discontinue coverage under this section and
9 notifies the State of Oregon in writing of this election;

10 “(h) The worker’s attending physician [*or a nurse practitioner authorized*
11 *to provide compensable medical services under ORS 656.245*] has released the
12 worker to modified or regular work, the work has been offered to the worker
13 and the worker refuses to return to work; or

14 “(i) The worker has been terminated from employment for reasons unre-
15 lated to the workers’ compensation claim.

16 “(2) If the workers’ compensation claim of a worker for whom health
17 benefits are provided pursuant to subsection (1) of this section is denied and
18 the worker does not appeal or the worker appeals and does not prevail, the
19 State of Oregon may recover from the worker the amount of the premiums
20 plus interest at the rate authorized by ORS 82.010. The State of Oregon may
21 recover the payments through a payroll deduction not to exceed 10 percent
22 of gross pay for each pay period.

23 “(3) The State of Oregon shall notify the worker of the provisions of ORS
24 659A.060 to 659A.069, and of the remedies available for breaches of ORS
25 659A.060 to 659A.069, within a reasonable time after the State of Oregon re-
26 ceives notice that the worker will be absent from work as a result of an in-
27 jury or illness for which a workers’ compensation claim has been filed
28 pursuant to ORS chapter 656. The notice from the State of Oregon shall in-
29 clude the terms and conditions of the continuation of health benefits and
30 what events will terminate the coverage.

1 “(4) If the worker fails to make timely payment of any premium contri-
2 bution owing, the State of Oregon shall notify the worker of impending
3 cancellation of the health benefits and provide the worker with 30 days to
4 pay the required premium prior to canceling the policy.

5 “(5) It is an unlawful employment practice for the State of Oregon to
6 discriminate against a worker, as defined in ORS 659A.060, by terminating
7 the worker’s group health benefits while that worker is absent from the place
8 of employment as a result of an injury or illness for which a workers’ com-
9 pensation claim has been filed pursuant to ORS chapter 656, except as pro-
10 vided for in this section.

11 **“SECTION 21.** ORS 657.170 is amended to read:

12 “657.170. (1) If the Director of the Employment Department finds that
13 during the base year of the individual any individual has been incapable of
14 work during the greater part of any calendar quarter, such base year shall
15 be extended a calendar quarter. Except as provided in subsection (2) of this
16 section, no such extension of an individual’s base year shall exceed four
17 calendar quarters.

18 “(2) If the director finds that during and prior to the individual’s base
19 year the individual has had a period of temporary total disability caused by
20 illness or injury and has received compensation under ORS chapter 656 for
21 a period of temporary total disability during the greater part of any calendar
22 quarter, the individual’s base year shall be extended as many calendar
23 quarters as necessary to establish a valid claim, up to a maximum of four
24 calendar quarters prior to the quarter in which the illness or injury oc-
25 curred, if the individual:

26 “(a) Files a claim for benefits not later than the fourth calendar week of
27 unemployment following whichever is the latest of the following dates:

28 “(A) The date the individual is released to return to work by the attend-
29 ing physician[,] as defined in ORS **656.005 (12)** [*chapter 656, or a nurse prac-*
30 *titioner authorized to provide compensable medical services under ORS*

1 656.245]; or

2 “(B) The date of mailing of a notice of claim closure pursuant to ORS
3 chapter 656; and

4 “(b) Files such a claim within the three-year period immediately following
5 the commencement of such period of illness or injury.

6 “(3) Notwithstanding the provisions of this section, benefits payable as a
7 result of the use of wages paid in a calendar quarter prior to the individual’s
8 current base year shall not exceed one-third of such wages less benefits paid
9 previously as a result of the use of such wages in computing a previous
10 benefit determination.

11 **“SECTION 22. This 2025 Act takes effect on the 91st day after the**
12 **date on which the 2025 regular session of the Eighty-third Legislative**
13 **Assembly adjourns sine die.”.**

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