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D R A F T

SUMMARY

Permits Director of Department of Consumer and Business Services to specify by rule methods for reporting claims, denials of claims and closures of claims related to workers' compensation cases.

Takes effect on 91st day following adjournment sine die.

1 **A BILL FOR AN ACT**

2 Relating to methods for reporting information related to workers' compen-
3 sation claims; amending ORS 656.262, 656.268 and 656.277; and prescribing
4 an effective date.

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

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

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

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

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

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

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

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 claim,
3 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 **must** be paid no later than the 14th day after the subject employer has no-
14 tice or knowledge of the claim and of the worker's disability, if the attending
15 physician or nurse practitioner authorized to provide compensable medical
16 services under ORS 656.245 authorizes the payment of temporary disability
17 compensation. Thereafter, temporary disability compensation [*shall*] **must**
18 be paid at least once each two weeks, except where the Director of the De-
19 partment of Consumer and Business Services determines that payment in
20 installments should be made at some other interval. The director may by rule
21 convert 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
31 payment of temporary disability payments pursuant to ORS 656.210 and

1 656.212 during the time the wage payments are made. As used in this sub-
2 section, "public office" has the meaning for that term provided in ORS
3 260.005.
4 (d) Temporary disability compensation is not due and payable for any
5 period of time for which the insurer or self-insured employer has requested
6 from the worker's attending physician or nurse practitioner authorized to
7 provide compensable medical services under ORS 656.245 verification of the
8 worker's inability to work resulting from the claimed injury or disease and
9 the physician or nurse practitioner cannot verify the worker's inability to
10 work, unless the worker has been unable to receive treatment for reasons
11 beyond the worker's control.
12 (e) If a worker fails to appear at an appointment with the worker's at-
13 tending physician or nurse practitioner authorized to provide compensable
14 medical services under ORS 656.245, the insurer or self-insured employer
15 shall notify the worker by certified mail that temporary disability benefits
16 may be suspended after the worker fails to appear at a rescheduled appoint-
17 ment. If the worker fails to appear at a rescheduled appointment, the insurer
18 or self-insured employer may suspend payment of temporary disability bene-
19 fits to the worker until the worker appears at a subsequent rescheduled ap-
20 pointment.
21 (f) If the insurer or self-insured employer has requested and failed to re-
22 ceive from the worker's attending physician or nurse practitioner authorized
23 to provide compensable medical services under ORS 656.245 verification of
24 the worker's inability to work resulting from the claimed injury or disease,
25 medical services provided by the attending physician or nurse practitioner
26 are not compensable until the attending physician or nurse practitioner
27 submits such verification.
28 (g) Temporary disability compensation is not due and payable pursuant
29 to ORS 656.268 after the worker's attending physician or nurse practitioner
30 authorized to provide compensable medical services under ORS 656.245 ceases
31 to authorize temporary disability or for any period of time not authorized

1 by the attending physician or nurse practitioner. No authorization of tem-
2 porary disability compensation by the attending physician or nurse practi-
3 tioner under ORS 656.268 [*shall be*] **is** effective to retroactively authorize the
4 payment of temporary disability more than 14 days prior to [*its*] **the** issuance
5 **of the authorization**.
6 (h) The worker's disability may be authorized only by a person described
7 in ORS 656.005 (12)(b)(B) or 656.245 for the period of time permitted by those
8 sections. The insurer or self-insured employer may unilaterally suspend pay-
9 ment of temporary disability benefits to the worker at the expiration of the
10 period until temporary disability is reauthorized by an attending physician
11 or nurse practitioner authorized to provide compensable medical services
12 under ORS 656.245.
13 (i) The insurer or self-insured employer may unilaterally suspend payment
14 of all compensation to a worker enrolled in a managed care organization if
15 the worker continues to seek care from an attending physician or nurse
16 practitioner authorized to provide compensable medical services under ORS
17 656.245 that is not authorized by the managed care organization more than
18 seven days after the mailing of notice by the insurer or self-insured employer.
19 (5)(a) Payment of compensation under subsection (4) of this section or
20 payment, in amounts per claim not to exceed the maximum amount estab-
21 lished annually by the Director of the Department of Consumer and Business
22 Services, for medical services for nondisabling claims, may be made by the
23 subject employer if the employer so chooses. The making of such payments
24 does not constitute a waiver or transfer of the insurer's duty to determine
25 entitlement to benefits. If the employer chooses to make such payment, the
26 employer shall report the injury to the insurer in the same manner that
27 other injuries are reported. However, an insurer [*shall*] **may** not modify an
28 employer's experience rating or otherwise make charges against the employer
29 for any medical expenses paid by the employer pursuant to this subsection.
30 (b) To establish the maximum amount an employer may pay for medical
31 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 **must** be rounded to the nearest multiple of $100.

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

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

1 such revocation of acceptance and denial, the insurer or self-insured em-
2 ployer must prove, by a preponderance of the evidence, that the claim is not
3 compensable or that the insurer or self-insured employer is not responsible
4 for the claim. Notwithstanding any other provision of this chapter, if a de-
5 nial of a previously accepted claim is set aside by an Administrative Law
6 Judge, the Workers' Compensation Board or the court, temporary total dis-
7 ability benefits are payable from the date any such benefits were terminated
8 under the denial. Except as provided in ORS 656.247, pending acceptance or
9 denial of a claim, compensation payable to a claimant does not include the
10 costs of medical benefits or funeral expenses. The insurer shall also furnish
11 the employer a copy of the notice of acceptance.
12 (b) The notice of acceptance [*shall*] **must**:
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 hearing
17 and aggravation rights concerning nondisabling injuries, including the right
18 to object to a decision that the injury of the claimant is nondisabling by
19 requesting reclassification pursuant to ORS 656.277.
20 (D) Inform the claimant of employment reinstatement rights and respon-
21 sibilities 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*] **does** not preclude the insurer or self-
30 insured employer from later denying the combined or consequential condition
31 if the otherwise compensable injury ceases to be the major contributing

1 cause of the combined or consequential condition.
2 (d) An injured worker who believes that a condition has been incorrectly
3 omitted from a notice of acceptance, or that the notice is otherwise deficient,
4 first must communicate in writing to the insurer or self-insured employer the
5 worker's objections to the notice pursuant to ORS 656.267. The insurer or
6 self-insured employer has 60 days from receipt of the communication from the
7 worker to revise the notice or to make other written clarification in re-
8 sponse. A worker who fails to comply with the communication requirements
9 of this paragraph or ORS 656.267 may not allege at any hearing or other
10 proceeding on the claim a de facto denial of a condition based on information
11 in the notice of acceptance from the insurer or self-insured employer. Not-
12 withstanding any other provision of this chapter, the worker may initiate
13 objection to the notice of acceptance at any time.
14 (7)(a) After claim acceptance, written notice of acceptance or denial of
15 claims for aggravation or new medical or omitted condition claims properly
16 initiated pursuant to ORS 656.267 [*shall*] **must** be furnished to the claimant
17 by the insurer or self-insured employer within 60 days after the insurer or
18 self-insured employer receives written notice of such claims. A worker who
19 fails to comply with the communication requirements of subsection (6) of this
20 section or ORS 656.267 may not allege at any hearing or other proceeding
21 on the claim a de facto denial of a condition based on information in the
22 notice of acceptance from the insurer or self-insured employer.
23 (b) Once a worker's claim has been accepted, the insurer or self-insured
24 employer must issue a written denial to the worker when the accepted injury
25 is no longer the major contributing cause of the worker's combined condition
26 before the claim may be closed.
27 (c) When an insurer or self-insured employer determines that the claim
28 qualifies for claim closure, the insurer or self-insured employer shall issue
29 at claim closure an updated notice of acceptance that specifies which condi-
30 tions are compensable. The procedures specified in subsection (6)(d) of this
31 section apply to this notice. Any objection to the updated notice or appeal

1 of denied conditions [*shall*] **does** not delay claim closure pursuant to ORS
2 656.268. If a condition is found compensable after claim closure, the insurer
3 or self-insured employer shall reopen the claim for processing regarding that
4 condition.

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

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

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

26 (11)(a) If the insurer or self-insured employer unreasonably delays or un-
27 reasonably refuses to pay compensation, attorney fees or costs, or unreason-
28 ably delays acceptance or denial of a claim, the insurer or self-insured
29 employer [*shall be*] **is** liable for an additional amount up to 25 percent of the
30 amounts then due plus any attorney fees assessed under this section. The fees
31 assessed by the director, an Administrative Law Judge, the board or the

court under this section [*shall*] **must** be reasonable attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court shall consider the proportionate benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph [*shall*] **must** be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this chapter, the director [*shall have*] **has** exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. The action of the director and the review of the action taken by the director [*shall be*] **is** subject to review under ORS 656.704.

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

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

(b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney fees authorized under this subsection. The matrix [*shall*] **must** provide for penalties based on a percentage of the settlement

1 proceeds allocated to the claimant and for attorney fees based on a percent-
2 age of the settlement proceeds allocated to the claimant's attorney as an
3 attorney fee.
4 (13) The insurer may authorize an employer to pay compensation to in-
5 jured workers and shall reimburse employers for compensation so paid.
6 (14)(a) Injured workers have the duty to cooperate and assist the insurer
7 or self-insured employer in the investigation of claims for compensation. In-
8 jured workers shall submit to and shall fully cooperate with personal and
9 telephonic interviews and other formal or informal information gathering
10 techniques. Injured workers who are represented by an attorney [*shall*] have
11 the right to have the attorney present during any personal or telephonic
12 interview or deposition. If the injured worker is represented by an attorney,
13 the insurer or self-insured employer shall pay the attorney a reasonable at-
14 torney fee based upon an hourly rate for actual time spent during the per-
15 sonal or telephonic interview or deposition. After consultation with the
16 Board of Governors of the Oregon State Bar, the Workers' Compensation
17 Board shall adopt rules for the establishment, assessment and enforcement
18 of an hourly attorney fee rate specified in this subsection.
19 (b) If the attorney is not willing or available to participate in an inter-
20 view at a time reasonably chosen by the insurer or self-insured employer
21 within 14 days of the request for interview and the insurer or self-insured
22 employer has cause to believe that the attorney's unwillingness or unavail-
23 ability is unreasonable and is preventing the worker from complying within
24 14 days of the request for interview, the insurer or self-insured employer
25 shall notify the director. If the director determines that the attorney's un-
26 willingness or unavailability is unreasonable, the director shall assess a civil
27 penalty against the attorney of not more than $1,000.
28 (15) If the director finds that a worker fails to reasonably cooperate with
29 an investigation involving an initial claim to establish a compensable injury
30 or an aggravation claim to reopen the claim for a worsened condition, the
31 director shall suspend all or part of the payment of compensation after notice

1 to the worker. If the worker does not cooperate for an additional 30 days
2 after the notice, the insurer or self-insured employer may deny the claim
3 because of the worker's failure to cooperate. The obligation of the insurer
4 or self-insured employer to accept or deny the claim within 60 days is sus-
5 pended during the time of the worker's noncooperation. After such a denial,
6 the worker [*shall*] **may** not be granted a hearing or other proceeding under
7 this chapter on the merits of the claim unless the worker first requests and
8 establishes at an expedited hearing under ORS 656.291 that the worker fully
9 and completely cooperated with the investigation, that the worker failed to
10 cooperate for reasons beyond the worker's control or that the investigative
11 demands were unreasonable. If the Administrative Law Judge finds that the
12 worker has not fully cooperated, the Administrative Law Judge shall affirm
13 the denial, and the worker's claim for injury shall remain denied. If the
14 Administrative Law Judge finds that the worker has cooperated, or that the
15 investigative demands were unreasonable, the Administrative Law Judge
16 shall set aside the denial, order the reinstatement of interim compensation
17 if appropriate and remand the claim to the insurer or self-insured employer
18 to accept or deny the claim.
19 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge
20 assigned a request for hearing for a claim for compensation involving more
21 than one potentially responsible employer or insurer may specify what is
22 required of an injured worker to reasonably cooperate with the investigation
23 of the claim as required by subsection (14) of this section.
24 **SECTION 2.** ORS 656.268 is amended to read:
25 656.268. (1) One purpose of this chapter is to restore the injured worker
26 as soon as possible and as near as possible to a condition of self support and
27 maintenance as an able-bodied worker. The insurer or self-insured employer
28 shall close the worker's claim, as prescribed by the Director of the Depart-
29 ment of Consumer and Business Services, and determine the extent of the
30 worker's permanent disability, provided the worker is not enrolled and ac-
31 tively engaged in training according to rules adopted by the director pursu-

1 ant to ORS 656.340 and 656.726, when:
2 (a) The worker has become medically stationary and there is sufficient
3 information to determine permanent disability;
4 (b) The accepted injury is no longer the major contributing cause of the
5 worker's combined or consequential condition or conditions pursuant to ORS
6 656.005 (7). When the claim is closed because the accepted injury is no longer
7 the major contributing cause of the worker's combined or consequential
8 condition or conditions, and there is sufficient information to determine
9 permanent disability, the likely permanent disability that would have been
10 due to the current accepted condition [*shall*] **must** be estimated;
11 (c) Without the approval of the attending physician or nurse practitioner
12 authorized to provide compensable medical services under ORS 656.245, the
13 worker fails to seek medical treatment for a period of 30 days or the worker
14 fails to attend a closing examination, unless the worker affirmatively estab-
15 lishes that such failure is attributable to reasons beyond the worker's con-
16 trol; or
17 (d) An insurer or self-insured employer finds that a worker who has been
18 receiving permanent total disability benefits has materially improved and is
19 capable of regularly performing work at a gainful and suitable occupation.
20 (2) If the worker is enrolled and actively engaged in training according
21 to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disa-
22 bility compensation [*shall*] **must** be proportionately reduced by any sums
23 earned during the training.
24 (3) A copy of all medical reports and reports of vocational rehabilitation
25 agencies or counselors [*shall*] **must** be furnished to the worker, if requested
26 by the worker.
27 (4) Temporary total disability benefits shall continue until whichever of
28 the following events first occurs:
29 (a) The worker returns to regular or modified employment;
30 (b) The attending physician or nurse practitioner who has authorized
31 temporary disability benefits for the worker under ORS 656.245 advises the

1 worker and documents in writing that the worker is released to return to
2 regular employment;
3 (c) The attending physician or nurse practitioner who has authorized
4 temporary disability benefits for the worker under ORS 656.245 advises the
5 worker and documents in writing that the worker is released to return to
6 modified employment, such employment is offered in writing to the worker
7 and the worker fails to begin such employment. However, an offer of modi-
8 fied employment may be refused by the worker without the termination of
9 temporary total disability benefits if the offer:
10 (A) Requires a commute that is beyond the physical capacity of the
11 worker according to the worker's attending physician or the nurse practi-
12 tioner who may authorize temporary disability under ORS 656.245;
13 (B) Is at a work site more than 50 miles one way from where the worker
14 was injured unless the site is less than 50 miles from the worker's residence
15 or the intent of the parties at the time of hire or as established by the pat-
16 tern of employment prior to the injury was that the employer had multiple
17 or mobile work sites and the worker could be assigned to any such site;
18 (C) Is not with the employer at injury;
19 (D) Is not at a work site of the employer at injury;
20 (E) Is not consistent with the existing written shift change policy or is
21 not consistent with common practice of the employer at injury or aggra-
22 vation; or
23 (F) Is not consistent with an existing shift change provision of an appli-
24 cable collective bargaining agreement;
25 (d) Any other event that causes temporary disability benefits to be law-
26 fully suspended, withheld or terminated under ORS 656.262 (4) or other pro-
27 visions of this chapter; or
28 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection,
29 the attending physician or nurse practitioner who has authorized temporary
30 disability benefits under ORS 656.245 for a home care worker or a personal
31 support worker who has been made a subject worker pursuant to ORS 656.039

1 advises the home care worker or personal support worker and documents in
2 writing that the home care worker or personal support worker is released
3 to return to modified employment, appropriate modified employment is of-
4 fered in writing by the Home Care Commission or a designee of the com-
5 mission to the home care worker or personal support worker for any client
6 of the Department of Human Services who employs a home care worker or
7 personal support worker and the worker fails to begin the employment.
8 (5)(a) Findings by the insurer or self-insured employer regarding the ex-
9 tent of the worker's disability in closure of the claim [*shall*] **must** be pur-
10 suant to the standards prescribed by the director.
11 (b) The insurer or self-insured employer shall issue a notice of closure of
12 the claim to the worker[*,*] **and** to the worker's attorney if the worker is
13 represented[*, and to the director*]. **The insurer or self-insured employer**
14 **shall notify the director of the closure in the manner the director**
15 **prescribes by rule.** If the worker is deceased at the time the notice of clo-
16 sure is issued, the insurer or self-insured employer shall mail the worker's
17 copy of the notice of closure, addressed to the estate of the worker, to the
18 worker's last known address and may mail copies of the notice of closure to
19 any known or potential beneficiaries to the estate of the deceased worker.
20 (c) The notice of closure must inform:
21 (A) The parties, in boldfaced type, of the proper manner in which to pro-
22 ceed if they are dissatisfied with the terms of the notice of closure;
23 (B) The worker of:
24 (i) The amount of any further compensation, including permanent disa-
25 bility compensation to be awarded;
26 (ii) The duration of temporary total or temporary partial disability com-
27 pensation;
28 (iii) The right of the worker or beneficiaries of the worker who were
29 mailed a copy of the notice of closure under paragraph (b) of this subsection
30 to request reconsideration by the director under this section within 60 days
31 of the date of the notice of closure;

1 (iv) The right of beneficiaries who were not mailed a copy of the notice
2 of closure under paragraph (b) of this subsection to request reconsideration
3 by the director under this section within one year of the date the notice of
4 closure was mailed to the estate of the worker under paragraph (b) of this
5 subsection;
6 (v) The right of the insurer or self-insured employer to request reconsid-
7 eration by the director under this section within seven days of the date of
8 the notice of closure;
9 (vi) The aggravation rights; and
10 (vii) Any other information as the director may require; and
11 (C) Any beneficiaries of death benefits to which they may be entitled
12 pursuant to ORS 656.204 and 656.208.
13 (d) If the insurer or self-insured employer has not issued a notice of clo-
14 sure, the worker may request closure. Within 10 days of receipt of a written
15 request from the worker, the insurer or self-insured employer shall issue a
16 notice of closure if the requirements of this section have been met or a no-
17 tice of refusal to close if the requirements of this section have not been met.
18 A notice of refusal to close [*shall*] **must** advise the worker of:
19 (A) The decision not to close;
20 (B) The right of the worker to request a hearing pursuant to ORS 656.283
21 within 60 days of the date of the notice of refusal to close;
22 (C) The right to be represented by an attorney; and
23 (D) Any other information as the director may require.
24 (e) If a worker, a worker's beneficiary, an insurer or a self-insured em-
25 ployer objects to the notice of closure, the objecting party first must request
26 reconsideration by the director under this section. A worker's request for
27 reconsideration must be made within 60 days of the date of the notice of
28 closure. If the worker is deceased at the time the notice of closure is issued,
29 a request for reconsideration by a beneficiary of the worker who was mailed
30 a copy of the notice of closure under paragraph (b) of this subsection must
31 be made within 60 days of the date of the notice of closure. A request for

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

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

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

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

1 (A) A deposition arranged by the worker, limited to the testimony and
2 cross-examination of the worker about the worker's condition at the time of
3 claim closure, [*shall*] **must** become part of the reconsideration record. The
4 deposition must be conducted subject to the opportunity for cross-
5 examination by the insurer or self-insured employer and in accordance with
6 rules adopted by the director. The cost of the court reporter, interpreter
7 services, if necessary, and one original of the transcript of the deposition for
8 the Department of Consumer and Business Services and one copy of the
9 transcript of the deposition for each party [*shall*] **must** be paid by the
10 insurer or self-insured employer. The reconsideration proceeding may not be
11 postponed to receive a deposition taken under this subparagraph. A deposi-
12 tion taken in accordance with this subparagraph may be received as evidence
13 at a hearing even if the deposition is not prepared in time for use in the
14 reconsideration proceeding.
15 (B) Pursuant to rules adopted by the director, the worker or the insurer
16 or self-insured employer may correct information in the record that is erro-
17 neous and may submit any medical evidence that should have been but was
18 not submitted by the attending physician or nurse practitioner authorized to
19 provide compensable medical services under ORS 656.245 at the time of claim
20 closure.
21 (C) If the director determines that a claim was not closed in accordance
22 with subsection (1) of this section, the director may rescind the closure.
23 (b) If necessary, the director may require additional medical or other in-
24 formation with respect to the claims and may postpone the reconsideration
25 for not more than 60 additional calendar days.
26 (c) In any reconsideration proceeding under this section in which the
27 worker was represented by an attorney, the director shall order the insurer
28 or self-insured employer to pay to the attorney, out of the additional com-
29 pensation awarded, an amount equal to 10 percent of any additional com-
30 pensation awarded to the worker.
31 (d) Except as provided in subsection (7) of this section, the reconsider-

1 ation proceeding [*shall*] **must** be completed within 18 working days from the
2 date the reconsideration proceeding begins, and [*shall*] **must** be performed
3 by a special evaluation appellate unit within the department. The deadline
4 of 18 working days may be postponed by an additional 60 calendar days if
5 within the 18 working days the department mails notice of review by a
6 medical arbiter. If an order on reconsideration has not been mailed on or
7 before 18 working days from the date the reconsideration proceeding begins,
8 or within 18 working days plus the additional 60 calendar days where a no-
9 tice for medical arbiter review was timely mailed or the director postponed
10 the reconsideration pursuant to paragraph (b) of this subsection, or within
11 such additional time as provided in subsection (8) of this section when re-
12 consideration is postponed further because the worker has failed to cooperate
13 in the medical arbiter examination, reconsideration [*shall*] **must** be deemed
14 denied and any further proceedings [*shall*] **must** occur as though an order
15 on reconsideration affirming the notice of closure was mailed on the date the
16 order was due to issue.

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

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

1 proceeding.
2 (g) If any party objects to the reconsideration order, the party may re-
3 quest a hearing under ORS 656.283 within 30 days from the date of the re-
4 consideration order.
5 (7)(a) The director may delay the reconsideration proceeding and toll the
6 reconsideration timeline established under subsection (6) of this section for
7 up to 45 calendar days if:
8 (A) A request for reconsideration of a notice of closure has been made to
9 the director within 60 days of the date of the notice of closure;
10 (B) The parties are actively engaged in settlement negotiations that in-
11 clude issues in dispute at reconsideration;
12 (C) The parties agree to the delay; and
13 (D) Both parties notify the director before the 18th working day after the
14 reconsideration proceeding has begun that they request a delay under this
15 subsection.
16 (b) A delay of the reconsideration proceeding granted by the director un-
17 der this subsection expires:
18 (A) If a party requests the director to resume the reconsideration pro-
19 ceeding before the expiration of the delay period;
20 (B) If the parties reach a settlement and the director receives a copy of
21 the approved settlement documents before the expiration of the delay period;
22 or
23 (C) On the next calendar day following the expiration of the delay period
24 authorized by the director.
25 (c) Upon expiration of a delay granted under this subsection, the timeline
26 for the completion of the reconsideration proceeding [*shall*] **must** resume as
27 if the delay had never been granted.
28 (d) Compensation due the worker [*shall*] **must** continue to be paid during
29 the period of delay authorized under this subsection.
30 (e) The director may authorize only one delay period for each reconsid-
31 eration proceeding.

1 (8)(a) If the basis for objection to a notice of closure issued under this
2 section is disagreement with the impairment used in rating of the worker's
3 disability, the director shall refer the claim to a medical arbiter appointed
4 by the director.
5 (b) If the director determines that insufficient medical information is
6 available to determine disability, the director may appoint, and refer the
7 claim to, a medical arbiter.
8 (c) At the request of either of the parties, the director shall appoint a
9 panel of as many as three medical arbiters in accordance with criteria that
10 the director sets by rule.
11 (d) The arbiter, or panel of medical arbiters, must be chosen from among
12 a list of physicians qualified to be attending physicians referred to in ORS
13 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon
14 Medical Board and the committee referred to in ORS 656.790.
15 (e)(A) The medical arbiter or panel of medical arbiters may examine the
16 worker and perform such tests as may be reasonable and necessary to es-
17 tablish the worker's impairment.
18 (B) If the director determines that the worker failed to attend the exam-
19 ination without good cause or failed to cooperate with the medical arbiter,
20 or panel of medical arbiters, the director shall postpone the reconsideration
21 proceedings for up to 60 days from the date of the determination that the
22 worker failed to attend or cooperate, and shall suspend all disability benefits
23 resulting from this or any prior opening of the claim until such time as the
24 worker attends and cooperates with the examination or the request for re-
25 consideration is withdrawn. Any additional evidence regarding good cause
26 must be submitted prior to the conclusion of the 60-day postponement period.
27 (C) At the conclusion of the 60-day postponement period, if the worker
28 has not attended and cooperated with a medical arbiter examination or es-
29 tablished good cause, the worker may not attend a medical arbiter examina-
30 tion for this claim closure. The reconsideration record must be closed, and
31 the director shall issue an order on reconsideration based upon the existing

1 record.
2 (D) All disability benefits suspended under this subsection, including all
3 disability benefits awarded in the order on reconsideration, or by an Ad-
4 ministrative Law Judge, the Workers' Compensation Board or upon court
5 review, are not due and payable to the worker.
6 (f) The insurer or self-insured employer shall pay the costs of examination
7 and review by the medical arbiter or panel of medical arbiters.
8 (g) The findings of the medical arbiter or panel of medical arbiters must
9 be submitted to the director for reconsideration of the notice of closure.
10 (h) After reconsideration, no subsequent medical evidence of the worker's
11 impairment is admissible before the director, the Workers' Compensation
12 Board or the courts for purposes of making findings of impairment on the
13 claim closure.
14 (i)(A) If the basis for objection to a notice of closure issued under this
15 section is a disagreement with the impairment used in rating the worker's
16 disability, and the director determines that the worker is not medically sta-
17 tionary at the time of the reconsideration or that the closure was not made
18 pursuant to this section, the director is not required to appoint a medical
19 arbiter before completing the reconsideration proceeding.
20 (B) If the worker's condition has substantially changed since the notice
21 of closure, upon the consent of all the parties to the claim, the director shall
22 postpone the proceeding until the worker's condition is appropriate for claim
23 closure under subsection (1) of this section.
24 (9) [*No*] **A** hearing [*shall*] **may not** be held on any issue that was not
25 raised and preserved before the director at reconsideration. However, issues
26 arising out of the reconsideration order may be addressed and resolved at
27 hearing.
28 (10) If, after the notice of closure issued pursuant to this section, the
29 worker becomes enrolled and actively engaged in training according to rules
30 adopted pursuant to ORS 656.340 and 656.726, any permanent disability pay-
31 ments due for work disability under the closure [*shall*] **must** be suspended,

1 and the worker [*shall*] **must** receive temporary disability compensation and
2 any permanent disability payments due for impairment while the worker is
3 enrolled and actively engaged in the training. When the worker ceases to
4 be enrolled and actively engaged in the training, the insurer or self-insured
5 employer shall again close the claim pursuant to this section if the worker
6 is medically stationary or if the worker's accepted injury is no longer the
7 major contributing cause of the worker's combined or consequential condi-
8 tion or conditions pursuant to ORS 656.005 (7). The closure [*shall*] **must** in-
9 clude the duration of temporary total or temporary partial disability
10 compensation. Permanent disability compensation [*shall*] **must** be redeter-
11 mined for work disability only. If the worker has returned to work or the
12 worker's attending physician has released the worker to return to regular
13 or modified employment, the insurer or self-insured employer shall again
14 close the claim. This notice of closure may be appealed only in the same
15 manner as are other notices of closure under this section.

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

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

28 (13) An insurer or self-insured employer may take a credit or offset of
29 previously paid workers' compensation benefits or payments against any
30 further workers' compensation benefits or payments due a worker from that
31 insurer or self-insured employer [*when*] **if** the worker admits to having ob-

1 tained the previously paid benefits or payments through fraud, or a civil
2 judgment or criminal conviction is entered against the worker for having
3 obtained the previously paid benefits through fraud. Benefits or payments
4 obtained through fraud by a worker may not be included in any data used
5 for ratemaking or individual employer rating or dividend calculations by an
6 insurer, a rating organization licensed pursuant to ORS chapter 737, the
7 State Accident Insurance Fund Corporation or the director.

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

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

19 (15) Conditions that are direct medical sequelae to the original accepted
20 condition [*shall*] **must** be included in rating permanent disability of the
21 claim unless they have been specifically denied.

22 **SECTION 3.** ORS 656.277 is amended to read:

23 656.277. (1)(a) A request for reclassification by the worker of an accepted
24 nondisabling injury that the worker believes was or has become disabling
25 must be submitted to the insurer or self-insured employer. The insurer or
26 self-insured employer shall classify the claim as disabling or nondisabling
27 within 14 days of the request. A notice of such classification [*shall*] **must**
28 be mailed to the worker and the worker's attorney if the worker is repres-
29 ented. The worker may ask the Director of the Department of Consumer and
30 Business Services to review the classification by the insurer or self-insured
31 employer by submitting a request for review within 60 days of the mailing

1 of the classification notice by the insurer or self-insured employer. If any
2 party objects to the classification of the director, the party may request a
3 hearing under ORS 656.283 within 30 days from the date of the director's
4 order.
5 (b) If the worker is represented by an attorney and the attorney is in-
6 strumental in obtaining an order from the director that reclassifies the claim
7 from nondisabling to disabling, the director may award the attorney a rea-
8 sonable assessed attorney fee.
9 (2) A request by the worker that an accepted nondisabling injury was or
10 has become disabling [*shall*] **must** be made pursuant to ORS 656.273 as a
11 claim for aggravation, provided the claim has been classified as nondisabling
12 for at least one year after the date of acceptance.
13 (3) [*A claim for a nondisabling injury shall not be reported to the director*
14 *by the insurer or self-insured employer except:*]
15 [*(a) When a notice of claim denial is filed;*]
16 [*(b) When the status of the claim is as described in subsection (1) or (2)*
17 *of this section; or*]
18 [*(c) When otherwise required by the director.*] **An insurer and a self-**
19 **insured employer shall report a claim for a nondisabling injury to the**
20 **director in the manner the director prescribes by rule.**
21 **SECTION 4. This 2021 Act takes effect on the 91st day after the date**
22 **on which the 2021 regular session of the Eighty-first Legislative As-**
23 **sembly adjourns sine die.**
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