

House Bill 2040

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor Kate Brown for Department of Consumer and Business Services)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

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.

A BILL FOR AN ACT

1
2 Relating to methods for reporting information related to workers' compensation claims; amending
3 ORS 656.262, 656.268 and 656.277; and prescribing an effective date.

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

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

6 656.262. (1) Processing of claims and providing compensation for a worker [*shall be*] **is** the re-
7 sponsibility of the insurer or self-insured employer. All employers shall assist their insurers in pro-
8 cessing claims as required in this chapter.

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

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

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

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

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

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

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

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

25 (4)(a) The first installment of temporary disability compensation [*shall*] **must** be paid no later
26 than the 14th day after the subject employer has notice or knowledge of the claim and of the
27 worker's disability, if the attending physician or nurse practitioner authorized to provide
28 compensable medical services under ORS 656.245 authorizes the payment of temporary disability
29 compensation. Thereafter, temporary disability compensation [*shall*] **must** be paid at least once each
30 two weeks, except where the Director of the Department of Consumer and Business Services deter-

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 mines that payment in installments should be made at some other interval. The director may by rule
2 convert monthly benefit schedules to weekly or other periodic schedules.

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

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

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

18 (e) If a worker fails to appear at an appointment with the worker's attending physician or nurse
19 practitioner authorized to provide compensable medical services under ORS 656.245, the insurer or
20 self-insured employer shall notify the worker by certified mail that temporary disability benefits may
21 be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to
22 appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of
23 temporary disability benefits to the worker until the worker appears at a subsequent rescheduled
24 appointment.

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

30 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
31 worker's attending physician or nurse practitioner authorized to provide compensable medical ser-
32 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
33 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
34 compensation by the attending physician or nurse practitioner under ORS 656.268 *[shall be]* **is** ef-
35 fective to retroactively authorize the payment of temporary disability more than 14 days prior to
36 *[its]* **the issuance of the authorization.**

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

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

1 the mailing of notice by the insurer or self-insured employer.

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

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

17 (c) The adjusted amount established under paragraph (b) of this subsection *[shall be]* **is** effective
18 on January 1 following the establishment of the amount and *[shall apply]* **applies** to claims with a
19 date of injury on or after the effective date of the adjusted amount.

20 (6)(a) **The insurer or self-insured employer shall furnish** written notice of acceptance or
21 denial of the claim *[shall be furnished]* to the claimant *[by the insurer or self-insured employer]* within
22 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the
23 insurer or self-insured employer *[shall]* **may** not revoke acceptance except as provided in this sec-
24 tion. The insurer or self-insured employer may revoke acceptance and issue a denial at any time
25 *[when]* **if** the denial is for fraud, misrepresentation or other illegal activity by the worker. If the
26 worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresen-
27 tation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a
28 preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such
29 proof, the worker then has the burden of proving, by a preponderance of the evidence, the
30 compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in
31 a case not involving fraud, misrepresentation or other illegal activity by the worker, and later ob-
32 tains evidence that the claim is not compensable or evidence that the insurer or self-insured em-
33 ployer is not responsible for the claim, the insurer or self-insured employer may revoke the claim
34 acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is
35 issued no later than two years after the date of the initial acceptance. If the worker requests a
36 hearing on such revocation of acceptance and denial, the insurer or self-insured employer must
37 prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer
38 or self-insured employer is not responsible for the claim. Notwithstanding any other provision of
39 this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge,
40 the Workers' Compensation Board or the court, temporary total disability benefits are payable from
41 the date any such benefits were terminated under the denial. Except as provided in ORS 656.247,
42 pending acceptance or denial of a claim, compensation payable to a claimant does not include the
43 costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of
44 the notice of acceptance.

45 (b) The notice of acceptance *[shall]* **must**:

- 1 (A) Specify what conditions are compensable.
- 2 (B) Advise the claimant whether the claim is considered disabling or nondisabling.
- 3 (C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation
4 rights concerning nondisabling injuries, including the right to object to a decision that the injury
5 of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.
- 6 (D) Inform the claimant of employment reinstatement rights and responsibilities under ORS
7 chapter 659A.
- 8 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-
9 ment Assistance Program under ORS 656.622.
- 10 (F) Be modified by the insurer or self-insured employer from time to time as medical or other
11 information changes a previously issued notice of acceptance.
- 12 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition
13 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, *[shall]* **does** not
14 preclude the insurer or self-insured employer from later denying the combined or consequential
15 condition if the otherwise compensable injury ceases to be the major contributing cause of the
16 combined or consequential condition.
- 17 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
18 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the
19 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
20 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
21 revise the notice or to make other written clarification in response. A worker who fails to comply
22 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
23 hearing or other proceeding on the claim a de facto denial of a condition based on information in
24 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
25 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.
- 26 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation
27 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 *[shall]* **must**
28 be furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer
29 or self-insured employer receives written notice of such claims. A worker who fails to comply with
30 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at
31 any hearing or other proceeding on the claim a de facto denial of a condition based on information
32 in the notice of acceptance from the insurer or self-insured employer.
- 33 (b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a
34 written denial to the worker when the accepted injury is no longer the major contributing cause
35 of the worker's combined condition before the claim may be closed.
- 36 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-
37 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
38 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
39 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
40 tions *[shall]* **does** not delay claim closure pursuant to ORS 656.268. If a condition is found
41 compensable after claim closure, the insurer or self-insured employer shall reopen the claim for
42 processing regarding that condition.
- 43 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-
44 ceptance or denial to the noncomplying employer.
- 45 (9) If an insurer or any other duly authorized agent of the employer for such purpose, on record

1 with the Director of the Department of Consumer and Business Services denies a claim for com-
2 pensation, written notice of such denial, stating the reason for the denial, and informing the worker
3 of the Expedited Claim Service and of hearing rights under ORS 656.283, *[shall]* **must** be given to
4 the claimant. **The insurer shall issue** a copy of the notice of denial *[shall be mailed to the director*
5 *and]* to the employer *[by the insurer]*. **The insurer shall notify the director of the denial in the**
6 **manner the director prescribes by rule.** The worker may request a hearing pursuant to ORS
7 656.319.

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

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

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

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

41 (b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney
42 fees authorized under this subsection. The matrix *[shall]* **must** provide for penalties based on a
43 percentage of the settlement proceeds allocated to the claimant and for attorney fees based on a
44 percentage of the settlement proceeds allocated to the claimant's attorney as an attorney fee.

45 (13) The insurer may authorize an employer to pay compensation to injured workers and shall

1 reimburse employers for compensation so paid.

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

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

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

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

40 **SECTION 2.** ORS 656.268 is amended to read:

41 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
 42 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
 43 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
 44 Department of Consumer and Business Services, and determine the extent of the worker's permanent
 45 disability, provided the worker is not enrolled and actively engaged in training according to rules

1 adopted by the director pursuant to ORS 656.340 and 656.726, when:

2 (a) The worker has become medically stationary and there is sufficient information to determine
3 permanent disability;

4 (b) The accepted injury is no longer the major contributing cause of the worker's combined or
5 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
6 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
7 quential condition or conditions, and there is sufficient information to determine permanent disabil-
8 ity, the likely permanent disability that would have been due to the current accepted condition
9 [shall] **must** be estimated;

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

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

17 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
18 ant to ORS 656.340 and 656.726, the temporary disability compensation [shall] **must** be proportion-
19 ately reduced by any sums earned during the training.

20 (3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors
21 [shall] **must** be furnished to the worker, if requested by the worker.

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

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

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

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

33 (A) Requires a commute that is beyond the physical capacity of the worker according to the
34 worker's attending physician or the nurse practitioner who may authorize temporary disability un-
35 der ORS 656.245;

36 (B) Is at a work site more than 50 miles one way from where the worker was injured unless the
37 site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire
38 or as established by the pattern of employment prior to the injury was that the employer had mul-
39 tiple or mobile work sites and the worker could be assigned to any such site;

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

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

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

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

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

3 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician
 4 or nurse practitioner who has authorized temporary disability benefits under ORS 656.245 for a home
 5 care worker or a personal support worker who has been made a subject worker pursuant to ORS
 6 656.039 advises the home care worker or personal support worker and documents in writing that the
 7 home care worker or personal support worker is released to return to modified employment, appro-
 8 priate modified employment is offered in writing by the Home Care Commission or a designee of the
 9 commission to the home care worker or personal support worker for any client of the Department
 10 of Human Services who employs a home care worker or personal support worker and the worker
 11 fails to begin the employment.

12 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
 13 ability in closure of the claim [*shall*] **must** be pursuant to the standards prescribed by the director.

14 (b) The insurer or self-insured employer shall issue a notice of closure of the claim to the
 15 worker[,] **and** to the worker's attorney if the worker is represented[, *and to the director*]. **The**
 16 **insurer or self-insured employer shall notify the director of the closure in the manner the**
 17 **director prescribes by rule.** If the worker is deceased at the time the notice of closure is issued,
 18 the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed
 19 to the estate of the worker, to the worker's last known address and may mail copies of the notice
 20 of closure to any known or potential beneficiaries to the estate of the deceased worker.

21 (c) The notice of closure must inform:

22 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
 23 isfied with the terms of the notice of closure;

24 (B) The worker of:

25 (i) The amount of any further compensation, including permanent disability compensation to be
 26 awarded;

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

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

31 (iv) The right of beneficiaries who were not mailed a copy of the notice of closure under para-
 32 graph (b) of this subsection to request reconsideration by the director under this section within one
 33 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
 34 of this subsection;

35 (v) The right of the insurer or self-insured employer to request reconsideration by the director
 36 under this section within seven days of the date of the notice of closure;

37 (vi) The aggravation rights; and

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

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

41 (d) If the insurer or self-insured employer has not issued a notice of closure, the worker may
 42 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
 43 self-insured employer shall issue a notice of closure if the requirements of this section have been
 44 met or a notice of refusal to close if the requirements of this section have not been met. A notice
 45 of refusal to close [*shall*] **must** advise the worker of:

1 (A) The decision not to close;

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

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

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

6 (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the no-
7 tice of closure, the objecting party first must request reconsideration by the director under this
8 section. A worker's request for reconsideration must be made within 60 days of the date of the no-
9 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for
10 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under
11 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.
12 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not
13 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within
14 one year of the date the notice of closure was mailed to the estate of the worker under paragraph
15 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be
16 based only on disagreement with the findings used to rate impairment and must be made within
17 seven days of the date of the notice of closure.

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

24 (g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
25 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
26 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
27 permanently disabled, a penalty [*shall*] **must** be assessed against the insurer or self-insured employer
28 and paid to the worker in an amount equal to 25 percent of all compensation determined to be then
29 due the claimant. If the increase in compensation results from information that the insurer or self-
30 insured employer demonstrates the insurer or self-insured employer could not reasonably have
31 known at the time of claim closure, from new information obtained through a medical arbiter ex-
32 amination or from a determination order issued by the director that addresses the extent of the
33 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
34 (4)(f), the penalty [*shall*] **may** not be assessed.

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

37 (A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
38 worker about the worker's condition at the time of claim closure, [*shall*] **must** become part of the
39 reconsideration record. The deposition must be conducted subject to the opportunity for cross-
40 examination by the insurer or self-insured employer and in accordance with rules adopted by the
41 director. The cost of the court reporter, interpreter services, if necessary, and one original of the
42 transcript of the deposition for the Department of Consumer and Business Services and one copy
43 of the transcript of the deposition for each party [*shall*] **must** be paid by the insurer or self-insured
44 employer. The reconsideration proceeding may not be postponed to receive a deposition taken under
45 this subparagraph. A deposition taken in accordance with this subparagraph may be received as

1 evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration
2 proceeding.

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

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

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

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

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

28 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
29 subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-
30 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-
31 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the
32 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the
33 worker or beneficiary of the right to request reconsideration or the date of expiration of the right
34 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
35 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
36 ation proceeding, including the right to proceed with the reconsideration if the initiating party
37 withdraws the request for reconsideration.

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

40 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
41 656.283 within 30 days from the date of the reconsideration order.

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

44 (A) A request for reconsideration of a notice of closure has been made to the director within
45 60 days of the date of the notice of closure;

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

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

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

6 (b) A delay of the reconsideration proceeding granted by the director under this subsection ex-
 7 pires:

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

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

12 (C) On the next calendar day following the expiration of the delay period authorized by the di-
 13 rector.

14 (c) Upon expiration of a delay granted under this subsection, the timeline for the completion of
 15 the reconsideration proceeding [*shall*] **must** resume as if the delay had never been granted.

16 (d) Compensation due the worker [*shall*] **must** continue to be paid during the period of delay
 17 authorized under this subsection.

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

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

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

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

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

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

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

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

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

45 (f) The insurer or self-insured employer shall pay the costs of examination and review by the

1 medical arbiter or panel of medical arbiters.

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

4 (h) After reconsideration, no subsequent medical evidence of the worker's impairment is admis-
5 sible before the director, the Workers' Compensation Board or the courts for purposes of making
6 findings of impairment on the claim closure.

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

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

15 (9) [No] A hearing [shall] **may not** be held on any issue that was not raised and preserved be-
16 fore the director at reconsideration. However, issues arising out of the reconsideration order may
17 be addressed and resolved at hearing.

18 (10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
19 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
20 any permanent disability payments due for work disability under the closure [shall] **must** be sus-
21 pended, and the worker [shall] **must** receive temporary disability compensation and any permanent
22 disability payments due for impairment while the worker is enrolled and actively engaged in the
23 training. When the worker ceases to be enrolled and actively engaged in the training, the insurer
24 or self-insured employer shall again close the claim pursuant to this section if the worker is med-
25 ically stationary or if the worker's accepted injury is no longer the major contributing cause of the
26 worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure
27 [shall] **must** include the duration of temporary total or temporary partial disability compensation.
28 Permanent disability compensation [shall] **must** be redetermined for work disability only. If the
29 worker has returned to work or the worker's attending physician has released the worker to return
30 to regular or modified employment, the insurer or self-insured employer shall again close the claim.
31 This notice of closure may be appealed only in the same manner as are other notices of closure
32 under this section.

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

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

42 (13) An insurer or self-insured employer may take a credit or offset of previously paid workers'
43 compensation benefits or payments against any further workers' compensation benefits or payments
44 due a worker from that insurer or self-insured employer [when] **if** the worker admits to having ob-
45 tained the previously paid benefits or payments through fraud, or a civil judgment or criminal con-

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

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

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

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

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

18 656.277. (1)(a) A request for reclassification by the worker of an accepted nondisabling injury
 19 that the worker believes was or has become disabling must be submitted to the insurer or self-
 20 insured employer. The insurer or self-insured employer shall classify the claim as disabling or
 21 nondisabling within 14 days of the request. A notice of such classification *[shall]* **must** be mailed
 22 to the worker and the worker's attorney if the worker is represented. The worker may ask the Di-
 23 rector of the Department of Consumer and Business Services to review the classification by the
 24 insurer or self-insured employer by submitting a request for review within 60 days of the mailing
 25 of the classification notice by the insurer or self-insured employer. If any party objects to the clas-
 26 sification of the director, the party may request a hearing under ORS 656.283 within 30 days from
 27 the date of the director's order.

28 (b) If the worker is represented by an attorney and the attorney is instrumental in obtaining an
 29 order from the director that reclassifies the claim from nondisabling to disabling, the director may
 30 award the attorney a reasonable assessed attorney fee.

31 (2) A request by the worker that an accepted nondisabling injury was or has become disabling
 32 *[shall]* **must** be made pursuant to ORS 656.273 as a claim for aggravation, provided the claim has
 33 been classified as nondisabling for at least one year after the date of acceptance.

34 (3) *[A claim for a nondisabling injury shall not be reported to the director by the insurer or self-*
 35 *insured employer except:]*

36 *[(a) When a notice of claim denial is filed;]*

37 *[(b) When the status of the claim is as described in subsection (1) or (2) of this section; or]*

38 *[(c) When otherwise required by the director.]* **An insurer and a self-insured employer shall**
 39 **report a claim for a nondisabling injury to the director in the manner the director prescribes**
 40 **by rule.**

41 **SECTION 4.** This 2021 Act takes effect on the 91st day after the date on which the 2021
 42 regular session of the Eighty-first Legislative Assembly adjourns sine die.