SB 801-1
(LC 2084)
3/12/21 (TSB/ps)

Requested by Senator GORSEK

PROPOSED AMENDMENTS TO
SENATE BILL 801

On page 1 of the printed bill, line 2, before the period insert "; creating new provisions; amending ORS 656.206, 656.218, 656.245, 656.247, 656.262, 656.264, 656.267, 656.268, 656.273, 656.277, 656.278, 656.283, 656.313, 656.325, 656.327, 656.331, 656.403, 656.407, 656.455, 656.752, 656.780 and 656.802; and prescribing an effective date.".

Delete lines 4 through 30 and delete page 2 and insert:

"**SECTION 1.** ORS 656.206 is amended to read:

"656.206. (1) As used in this section:

"(a) 'Essential functions' means the primary tasks associated with the job.

"(b) 'Materially improved medically' means an actual change for the better in the worker's medical condition that is supported by objective findings.

"(c) 'Materially improved vocationally' means an actual change for the better in the:

"(A) Worker's vocational capability; or

"(B) Likelihood that the worker can return to work in a gainful and suitable occupation.

"(d) 'Permanent total disability' means, notwithstanding ORS 656.225, the loss, including preexisting disability, of use or function of any portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation.

"(e) 'Regularly performing work' means the ability of the worker to dis-

charge the essential functions of the job.

"(f) 'Suitable occupation' means one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation.

"(g) 'Wages' means wages as determined under ORS 656.210.

"(2) If permanent total disability results from a worker's injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages, no more than 133 percent of the average weekly wage or no less than 33 percent of the average weekly wage.

"(3) A worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment.

"(4) When requested by the Director of the Department of Consumer and Business Services, a worker who receives permanent total disability benefits shall file on a form provided by the director, a sworn statement of the worker's gross annual income for the preceding year along with such other information as the director considers necessary to determine whether the worker regularly performs work at a gainful and suitable occupation.

"(5) Each insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker has materially improved, either medically or vocationally, and is no longer permanently incapacitated from regularly performing work at a gainful and suitable occupation. Reexamination must be conducted every two years or at such other more frequent interval as the director may prescribe. Reexamination must include such medical examinations, vocational evaluations, reports and other records as the insurer considers necessary or the director may require.

"(6)(a) If a worker receiving permanent total disability benefits is found to be materially improved and capable of regularly performing work at a

gainful and suitable occupation, the insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** shall issue a notice of closure pursuant to ORS 656.268. Permanent total disability benefits shall be paid through the date of the notice of closure. Notwithstanding ORS 656.268 (5), if a worker objects to a notice of closure issued under this subsection, the worker shall request a hearing. If the worker requests a hearing on the notice of closure before the Hearings Division of the Workers' Compensation Board within 30 days of the date of the notice of closure, the insurer or self-insured employer shall continue payment of permanent total disability benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the worker requests a hearing on the notice of closure more than 30 days from the date of the notice of closure but before the 60-day period for requesting a hearing expires, the insurer or self-insured employer shall resume paying permanent total disability benefits from the date the hearing is requested and shall continue payment of benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the notice of closure is upheld by the Hearings Division, the insurer or self-insured employer must be reimbursed from the Workers' Benefit Fund for the amount of permanent total disability benefits paid after the date of the notice of closure issued under this subsection.

"(b) An insurer or self-insured employer must establish that the condition of a worker who is receiving permanent total disability benefits has materially improved by a preponderance of the evidence presented at hearing.

"(c) Medical examinations or vocational evaluations used to support the issuance of a notice of closure under this subsection must include at least one report in which the author personally observed the worker.

"(d) Notwithstanding section 54 (3), chapter 2, Oregon Laws 1990, the Hearings Division of the Workers' Compensation Board may request the di-

rector to order a medical arbiter examination of an injured worker who has requested a hearing under this subsection.

"(7) A worker who has had permanent total disability benefits terminated under this section by an order that has become final is eligible for vocational assistance pursuant to ORS 656.340. Notwithstanding ORS 656.268 (10), if a worker has enrolled in and is actively engaged in a training program, when vocational assistance provided under this section ends or the worker ceases to be enrolled and actively engaged in the training program, the insurer or the **corporation, on behalf of the** self-insured employer**,** shall determine the extent of disability pursuant to ORS 656.214.

"(8) A worker receiving permanent total disability benefits is required, if requested by the director, the insurer or the **corporation, on behalf of the** self-insured employer, to submit to a vocational evaluation at a time reasonably convenient to the worker as may be provided by the rules of the director. No more than three evaluations may be requested except after notification to and authorization by the director. If the worker refuses to submit to or obstructs a vocational evaluation, the rights of the worker to compensation must be suspended with the consent of the director until the evaluation has taken place, and no compensation is payable for the period during which the worker refused to submit to or obstructed the evaluation. The insurer or self-insured employer shall pay the costs of the evaluation and related services that are reasonably necessary to allow the worker to attend the evaluation requested under this subsection. As used in this subsection, 'related services' includes, but is not limited to, wages, child care, travel, meals and lodging.

"(9) Notwithstanding any other provisions of this chapter, if a worker receiving permanent total disability incurs a new compensable injury, the worker's entitlement to compensation for the new injury shall be limited to medical benefits pursuant to ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS

656.214 (2).

"(10) When a worker eligible for benefits under this section returns to work, if the combined total of the worker's post-injury wages plus permanent total disability benefit exceeds the worker's wage at the time of injury, the worker's permanent total disability benefit must be reduced by the amount the worker's wages plus statutory permanent total disability benefit exceeds the worker's wage at injury.

"(11) For purposes of this section:

"(a) A gainful occupation for workers with a date of injury prior to January 1, 2006, who were:

"(A) Employed continuously for 52 weeks prior to the injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wages from all employment for the 52 weeks prior to the date of injury.

"(B) Not employed continuously for the 52 weeks prior to the date of injury, but who were employed for at least four weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wage from all employment for the 52 weeks prior to the date of injury based on weeks of actual employment, excluding any extended periods of unemployment.

"(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon

residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire.

"(b) A gainful occupation for workers with a date of injury on or after January 1, 2006, who were:

"(A) Employed continuously for 52 weeks prior to the injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wages from all employment for the 52 weeks prior to the date of injury adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

"(B) Not employed continuously for the 52 weeks prior to the date of injury, but who were employed for at least four weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wage from all employment for the 52 weeks prior to the date of injury based on weeks of actual employment, excluding any extended periods of unemployment and as adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

"(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent

federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

"SECTION 2. ORS 656.218 is amended to read:

"656.218. (1) In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof has been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.

"(2) If the worker's death occurs prior to issuance of a notice of closure under ORS 656.268, the insurer or the **State Accident Insurance Fund Corporation, on behalf of the** self-insured employer**,** shall determine compensation for permanent partial disability, if any.

"(3) If the worker has filed a request for hearing pursuant to ORS 656.283 or a request for reconsideration pursuant to ORS 656.268 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request.

"(4) If the worker dies before filing a request for hearing or a request for reconsideration, the persons described in subsection (5) of this section shall be entitled to file a request for hearing or a request for reconsideration and to pursue the matter to final determination as to all issues presented by the request.

"(5) The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, the unpaid balance of the award shall be paid to the worker's estate.

"(6) This section does not entitle any person to double payments on account of the death of a worker and a continuation of payments for permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

"SECTION 3. ORS 656.245 is amended to read:

"656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

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

"(c) Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:

"(A) Services provided to a worker who has been determined to be permanently and totally disabled.

"(B) Prescription medications.

"(C) Services necessary to administer prescription medication or monitor the administration of prescription medication.

"(D) Prosthetic devices, braces and supports.

"(E) Services necessary to monitor the status, replacement or repair of

prosthetic devices, braces and supports.

"(F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.

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

"(H) Services that are necessary to diagnose the worker's condition.

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

"(J) With the approval of the insurer or **the State Accident Insurance Fund Corporation, on behalf of the** self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable the worker to continue current employment or a vocational training program. If the insurer or **the corporation, on behalf of the** self-insured employer**,** does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such treatment. The decision of the director is subject to review under ORS 656.704.

"(K) With the approval of the director, curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. The decision of the director is subject to review under ORS 656.704.

"(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning of symptoms of the worker's condition.

"(d) When the medically stationary date in a disabling claim is established by the insurer or **the corporation, on behalf of the** self-insured employer**,** and is not based on the findings of the attending physician, the insurer or self-insured employer is responsible for reimbursement to affected medical service providers for otherwise compensable services rendered until

the insurer or self-insured employer provides written notice to the attending physician of the worker's medically stationary status.

"(e) Except for services provided under a managed care contract, out-of-pocket expense reimbursement to receive care from the attending physician or nurse practitioner authorized to provide compensable medical services under this section shall not exceed the amount required to seek care from an appropriate nurse practitioner or attending physician of the same specialty who is in a medical community geographically closer to the worker's home. For the purposes of this paragraph, all physicians and nurse practitioners within a metropolitan area are considered to be part of the same medical community.

"(2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon. The worker may choose the initial attending physician or nurse practitioner and may subsequently change attending physician or nurse practitioner two times without approval from the director. If the worker thereafter selects another attending physician or nurse practitioner, the insurer or self-insured employer may require the director's approval of the selection. The decision of the director is subject to review under ORS 656.704. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

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

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

"(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. However, an emergency room physician who is not authorized to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim.

"(C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

"(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed under ORS 678.375 to 678.390:

"(i) May provide compensable medical services for 180 days from the date of the first visit on the initial claim;

"(ii) May authorize the payment of temporary disability benefits for a period not to exceed 180 days from the date of the first visit on the initial claim; and

"(iii) When an injured worker treating with a nurse practitioner authorized to provide compensable services under this section becomes medically stationary within the 180-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse

practitioner for the examination performed.

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

"(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provided to injured workers:

"(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the physician or nurse

practitioner agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

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

"(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician or nurse practitioner authorized to provide compensable medical services under this section who agrees to the

conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.

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

"(D) If the claim is denied, the worker may receive medical services after the date of denial from sources other than the managed care organization until the denial is reversed. Reasonable and necessary medical services received from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

"(5)(a) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the managed care organization is authorized to provide the same level of services as a primary care physician as established by ORS 656.260 (4) if the nurse practitioner maintains the worker's medical records and with whom the worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require and if that nurse practitioner agrees to comply with all the rules, terms and conditions regarding services performed by the managed care organization.

"(b) A nurse practitioner authorized to provide medical services to a worker enrolled in the managed care organization may provide medical treatment to the worker if the treatment is determined to be medically appropriate according to the service utilization review process of the managed care organization and may authorize temporary disability payments as provided in subsection (2)(b)(D) of this section. However, the managed care organization may authorize the nurse practitioner to provide medical services and authorize temporary disability payments beyond the periods established

in subsection (2)(b)(D) of this section.

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

"SECTION 4. ORS 656.247 is amended to read:

"656.247. (1) Except for medical services provided to workers subject to ORS 656.245 (4)(b)(B), payment for medical services provided to a subject worker in response to an initial claim for a work-related injury or occupational disease from the date of the employer's notice or knowledge of the claim until the date the claim is accepted or denied shall be payable in accordance with subsection (4) of this section.

"(2) Notwithstanding subsection (1) of this section, no payment shall be due from the insurer or self-insured employer if the insurer or **the State Accident Insurance Fund Corporation, on behalf of the** self-insured employer**,** denies the claim within 14 days of the date of the employer's notice or knowledge of the claim.

"(3)(a) Disputes about whether the medical services provided to treat the claimed work-related injury or occupational disease under subsection (1) of this section are excessive, inappropriate or ineffectual or are consistent with the criteria in subsection (1) of this section shall be resolved by the Director of the Department of Consumer and Business Services. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such services. If a party is dissatisfied with the order of the director, the dissatisfied party may request review under ORS 656.704 within 60 days of the date of the director's order. The order of the director may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law.

"(b) Disputes about the amount of the fee or nonpayment of bills for medical treatment and services pursuant to this section shall be resolved

pursuant to ORS 656.248.

"(c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS 656.289 (4), all medical services payable under subsection (1) of this section that are provided on or before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer or self-insured employer shall notify each affected service provider of the results of the settlement.

"(4)(a) If the claim in which medical services are provided under subsection (1) of this section has not been accepted or denied and a health benefit plan provides benefits to the worker, the health benefit plan shall expedite preauthorizations and guarantee payment of expenses for medical services provided prior to acceptance or denial of the claim according to the terms, conditions and benefits of the plan.

"(b) If the claim for which medical services are provided under subsection (1) of this section is accepted, after the claim has been accepted the insurer or self-insured employer shall pay for the medical services provided for accepted conditions, including reimbursements for medical expenses, copayments and deductibles paid by the injured worker or the health benefit plan. Payments made under this subsection are subject to the fee schedules, limitations and conditions of this chapter.

"(c) If the claim for which medical services are provided under subsection (1) of this section is denied and a health benefit plan provides benefits to the worker, after the claim is denied the health benefit plan shall pay for medical services provided according to the terms, conditions and benefits of the plan.

"(d) As used in this subsection, 'health benefit plan' has the meaning given that term in ORS 743B.005 and also means self-insured benefit plans and health benefit plans offered by the Oregon Educators Benefit Board and the Public Employees' Benefit Board.

"SECTION 5. ORS 656.262 is amended to read:

"656.262. (1)**(a) Except as provided in paragraph (b) of this subsection,** processing of claims and providing compensation for a worker shall be the responsibility of the insurer [*or self-insured employer*]. All employers shall assist their insurers in processing claims as required in this chapter.

"**(b) A self-insured employer that receives a claim for a compensable injury or occupational disease from a subject worker shall immediately forward the claim to the State Accident Insurance Fund Corporation for processing and acceptance or denial. Claim processing under this paragraph must occur in accordance with the following conditions:**

"(A) The corporation shall process the claim in the same manner that the corporation processes claims from employers for which the corporation is the insurer, except that the time within which the self-insured employer must pay the first installment of compensation does not begin until after the corporation has received the claim from the self-insured employer.

"(B) The corporation is not and does not act as the self-insured employer's insurer and is not responsible for paying compensation to a worker on behalf of the self-insured employer.

"(C) The self-insured employer shall pay compensation in accordance with the terms of any decision of the corporation to accept the claim and as otherwise provided in this chapter. The corporation shall accept or deny a claim in accordance with the provisions of this chapter and in the same manner in which the corporation accepts or denies claims from employers for which the corporation is the insurer.

"(D) The corporation may charge and receive from the self-insured employer compensation for the corporation's expenses in providing claim processing services. Unless the corporation and the self-insured employer have agreed to other terms, the corporation may not charge the self-insured employer more to process a claim than the equivalent expenses the corporation would incur in processing a claim from an

employer for which the corporation is an insurer.

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

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

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

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

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

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

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

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

"(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim and of the worker's disability, if the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where the Director of the Department of Consumer and Business Services determines that payment in installments

should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

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

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

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

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

fits to the worker until the worker appears at a subsequent rescheduled appointment.

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

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

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

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

employer.

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

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

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

"(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or [*self-insured employer*] **the corporation** within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or **the corporation, on behalf of a** self-insured employer**,** shall not revoke acceptance except as provided in this section. The insurer or **the corporation, on behalf of a**

self-insured employer**,** may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or **the corporation, on behalf of a** self-insured employer**,** accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or **the corporation, on behalf of the** self-insured employer**,** may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or funeral expenses. The insurer **or the corporation, as appropriate,** shall also furnish the employer a copy of the notice of acceptance.

"(b) The notice of acceptance shall:

"(A) Specify what conditions are compensable.

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

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

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

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

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

"(c) An insurer's [*or self-insured employer's*] acceptance**, or the corporation's acceptance on behalf of a self-insured employer,** of a combined or consequential condition under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or **the corporation, on behalf of a** self-insured employer**,** from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition.

"(d) An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or [*self-insured employer*] **the corporation, as appropriate,** the worker's objections to the notice pursuant to ORS 656.267. The insurer or **the corporation, on behalf of the** self-insured employer**,** has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other

proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or **from the corporation, on behalf of the** self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

"(7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be furnished to the claimant by the insurer or**, by the corporation on behalf of the** self-insured employer**,** within 60 days after the insurer or self-insured employer receives written notice of such claims**, except that the time limit begins on the date that the corporation receives notice of the claim from the self-insured employer**. A worker who fails to comply with the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or **the corporation on behalf of the** self-insured employer.

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

"(c) When an insurer or **the corporation, on behalf of a** self-insured employer**,** determines that the claim qualifies for claim closure, the insurer or [*self-insured employer*] **the corporation** shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or **the corporation, on behalf of the** self-insured employer**,** shall reopen the claim for

processing regarding that condition.

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

"(9) If an insurer**, the corporation** or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer **or the corporation, on behalf of a self-insured employer, as appropriate**. The worker may request a hearing pursuant to ORS 656.319.

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

"(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or **if the insurer or the corporation, on behalf of the self-insured employer,** unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall 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 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 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 subject to review under ORS 656.704. **A self-insured employer may seek compensation from the corporation if the corporation's unreasonable delay resulted in liability to the self-insured employer under this paragraph.**

"(b) When 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 provide for penalties based on a percentage of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of the settlement proceeds allocated to the claimant's attorney as an attorney fee.

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

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

"(b) If the attorney is not willing or available to participate in an interview at a time reasonably chosen by the insurer or **the corporation, on behalf of the** self-insured employer**,** within 14 days of the request for interview and the insurer or [*self-insured employer*] **the corporation** has cause to believe that the attorney's unwillingness or unavailability is unreasonable and is preventing the worker from complying within 14 days of the request for interview, the insurer or [*self-insured employer*] **the corporation** shall notify the director. If the director determines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess a civil penalty against the attorney of not more than $1,000.

"(15) If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury

or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or **the corporation, on behalf of the** self-insured employer**,** may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or [*self-insured employer*] **the corporation** to accept or deny the claim within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or **the corporation, as appropriate,** [*self-insured employer*] to accept or deny the claim.

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

"SECTION 6. ORS 656.264 is amended to read:

"656.264. (1) Insurers and self-insured employers shall report to the Director of the Department of Consumer and Business Services compensable injuries, denied claims, claims disposition and payments [*made by them*] **the**

insurers or the State Accident Insurance Fund Corporation, on behalf of a self-insured employer, made under this chapter.

"(2) The director may require insurers and self-insured employers to report other information as required to carry out this chapter.

"(3) The director may prescribe the interval and the form of such reports and establish sanctions for the enforcement of reporting requirements.

"SECTION 7. ORS 656.267 is amended to read:

"656.267. (1) To initiate omitted medical condition claims under ORS 656.262 (6)(d) or new medical condition claims under this section, the worker must clearly request formal written acceptance of a new medical condition or an omitted medical condition from the insurer or **from the State Accident Insurance Fund Corporation on behalf of a** self-insured employer. A claim for a new medical condition or an omitted condition is not made by the receipt of medical billings, nor by requests for authorization to provide medical services for the new or omitted condition, nor by actually providing such medical services. The insurer or **the corporation, on behalf of the** self-insured employer**,** is not required to accept each and every diagnosis or medical condition with particularity, as long as the acceptance tendered reasonably apprises the claimant and the medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical or omitted condition claim at any time.

"(2)(a) Claims properly initiated for new medical conditions and omitted medical conditions related to an initially accepted claim shall be processed pursuant to ORS 656.262.

"(b) If an insurer or **the corporation, on behalf of a** self-insured employer**,** denies a claim for a new medical or omitted medical condition, the claimant may request a hearing on the denial pursuant to ORS 656.283.

"(3) Notwithstanding subsection (2) of this section, claims for new medical or omitted medical conditions related to an initially accepted claim that have

been determined to be compensable and that were initiated after the rights under ORS 656.273 expired shall be processed as requests for relief under the Workers' Compensation Board's own motion jurisdiction pursuant to ORS 656.278 (1)(b).

"SECTION 8. ORS 656.268 is amended to read:

"656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when:

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

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

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

"(d) An insurer or **the corporation, on behalf of the** self-insured em-

ployer**,** finds that a worker who has been receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

"(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

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

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

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

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

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

"(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician or the nurse practitioner who may authorize temporary disability under ORS 656.245;

"(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pat-

tern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

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

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

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

"(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;

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

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

"(5)(a) Findings by the insurer or **the corporation, on behalf of the** self-insured employer**,** regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director.

"(b) The insurer or **the corporation, on behalf of the** self-insured employer**,** shall issue a notice of closure of the claim to the worker, to the worker's attorney if the worker is represented, and to the director. If the

worker is deceased at the time the notice of closure is issued, the insurer or [*self-insured employer*] **the corporation** shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

"(c) The notice of closure must inform:

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

"(B) The worker of:

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

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

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

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

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

"(vi) The aggravation rights; and

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

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

"(d) If the insurer or **the corporation, on behalf of the** self-insured

employer**,** has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or [*self-insured employer*] **the corporation** shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:

"(A) The decision not to close;

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

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

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

"(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or **by the corporation, on behalf of a** self-insured employer**,** may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

"(f) If an insurer or **the corporation, on behalf of a** self-insured employer**,** has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue

in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. **A self-insured employer may seek compensation from the corporation if the corporation's incorrect notice or refusal to close a claim resulted in liability to the self-insured employer under this paragraph.**

"(g) If, upon reconsideration of a claim closed by an insurer or **by the corporation on behalf of a** self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or [*self-insured employer*] **the corporation** could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from a determination order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f), the penalty shall not be assessed. **A self-insured employer may seek compensation from the corporation if the corporation's closure of the claim resulted in liability to the self-insured employer after reconsideration under this paragraph.**

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

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

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

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

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

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

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

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

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

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

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

proceeding.

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

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

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

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

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

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

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

"(A) If a party requests the director to resume the reconsideration proceeding before the expiration of the delay period;

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

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

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

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

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

eration proceeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due for work disability under the closure shall be suspended, and the worker shall receive temporary disability compensation and any permanent disability payments due for impairment while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer or **the corporation, on behalf of the** self-insured employer**,** shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or **the corporation, on behalf of the** self-insured employer**,** shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

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

"(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of

temporary disability payments which were payable but not paid.

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

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

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

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

"SECTION 9. ORS 656.273 is amended to read:

"656.273. (1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the

original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable. A worsened condition is not established by either or both of the following:

"(a) The worker's absence from work for any given amount of time as a result of the worker's condition from the original injury; or

"(b) Inpatient treatment of the worker at a hospital for the worker's condition from the original injury.

"(2) To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer. In the event the insurer or self-insured employer cannot be located, is unknown, or has ceased to exist, the claim shall be filed with the Director of the Department of Consumer and Business Services.

"(3) A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative and the worker's attending physician. When an insurer or self-insured employer receives a completed aggravation form, the insurer [*or self-insured employer*] shall process the claim **and the self-insured employer shall immediately forward the claim to the State Accident Insurance Fund Corporation for processing**.

"(4) The claim for aggravation must be filed within five years:

"(a) After the first notice of closure made under ORS 656.268 for a disabling claim; or

"(b) After the date of injury, provided the claim has been classified as nondisabling for at least one year after the date of acceptance.

"(5) The director may order the claimant, the insurer or self-insured employer to pay for such medical opinion.

"(6) A claim submitted in accordance with this section shall be processed

by the insurer or **the corporation, on behalf of the** self-insured employer**,** in accordance with the provisions of ORS 656.262. The first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer or paying agent of the subject employer receives a written report that verifies the worker's inability to work resulting from a compensable worsening under subsection (1) of this section and that establishes by medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury.

"(7) A request for hearing on any issue involving a claim for aggravation must be made to the Workers' Compensation Board in accordance with ORS 656.283.

"(8) If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award.

"SECTION 10. ORS 656.277 is amended to read:

"656.277. (1)(a) A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or **the State Accident Insurance Fund Corporation, on behalf of the** self-insured employer**,** shall classify the claim as disabling or nondisabling within 14 days of the request. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or [*self-insured employer*] **the corporation** by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or **the corporation on behalf of the** self-insured employer. If any party objects to the classification of the

director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order.

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

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

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

"(a) When a notice of claim denial is filed;

"(b) When the status of the claim is as described in subsection (1) or (2) of this section; or

"(c) When otherwise required by the director.

"SECTION 11. ORS 656.278 is amended to read:

"656.278. (1) Except as provided in subsection (7) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that results in the inability of the worker to work and requires hospitalization or inpatient or outpatient surgery, or other curative treatment prescribed in lieu of hospitalization that is necessary to enable the injured worker to return to work. In such cases, the payment of temporary disability compensation in accordance with ORS 656.210, 656.212 (2) and 656.262 (4) may be provided from the time the attending physician authorizes temporary disability compensation for the hospitalization, surgery or other curative treatment until

the worker's condition becomes medically stationary;

"(b) The worker submits and obtains acceptance of a claim for a compensable new medical condition or an omitted medical condition pursuant to ORS 656.267 and the claim is initiated after the rights under ORS 656.273 have expired. In such cases, the payment of temporary disability compensation in accordance with the provisions of ORS 656.210, 656.212 (2) and 656.262 (4) may be provided from the time the attending physician authorizes temporary disability compensation for the hospitalization, surgery or other curative treatment until the worker's condition becomes medically stationary, and the payment of permanent disability benefits may be provided after application of the standards for the evaluation and determination of disability as may be adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726; or

"(c) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the payment of medical benefits may be provided.

"(2) Benefits provided under subsection (1) of this section:

"(a) Do not include vocational assistance benefits under ORS 656.340;

"(b) Do not include temporary disability compensation for periods of time during which the claimant did not qualify as a 'worker' pursuant to ORS 656.005 (30);

"(c) Do not include medical services provided pursuant to ORS 656.245 except as provided under subsection (1)(c) of this section; and

"(d) May include permanent disability benefits for additional impairment to an injured body part that has previously been the basis of a permanent partial disability award, but only to the extent that the permanent partial disability rating exceeds the permanent partial disability rated by the prior award or awards.

"(3) An order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS

656.273 is not an order or award, as the case may be, made by the board on its own motion.

"(4) Pursuant to ORS 656.298, any party may appeal an order or award made by the board on its own motion.

"(5) The insurer or **the corporation, on behalf of the** self-insured employer**,** may voluntarily reopen any claim to provide benefits allowable under this section or to grant additional medical or hospital care to the claimant. The board shall establish procedures for the resolution of disputes arising out of a voluntary reopening of a claim under this section.

"(6) Any claim reopened under this section shall be closed by the insurer or **the corporation, on behalf of the** self-insured employer**,** in a manner prescribed by the board, including, when appropriate, an award of permanent disability benefits as determined under subsections (1)(b) and (2)(d) of this section. The board shall also prescribe a process to be followed if the worker objects to the claim closure.

"(7) The provisions of this section do not authorize the board, on its own motion, to modify, change or terminate former findings or orders:

"(a) That a claimant incurred no injury or incurred a noncompensable injury; or

"(b) Approving disposition of a claim under ORS 656.236 or 656.289 (4).

"SECTION 12. ORS 656.283 is amended to read:

"656.283. (1) Subject to ORS 656.319, any party or the Director of the Department of Consumer and Business Services may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.704.

"(2) A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the Workers' Compensation Board.

"(3)(a) The board shall refer the request for hearing to an Administrative Law Judge for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing may not be postponed:

"(A) Except in extraordinary circumstances beyond the control of the requesting party; and

"(B) For more than 120 days after the date of the postponed hearing.

"(b) When a hearing set pursuant to paragraph (a) of this subsection is postponed because of the need to join one or more potentially responsible employers or insurers, the assigned Administrative Law Judge shall reschedule the hearing as expeditiously as possible after all potentially responsible employers and insurers have been joined in the proceeding and the medical record has been fully developed. The board shall adopt rules for hearings on claims involving one or more potentially responsible employers and insurers that:

"(A) Require the parties to participate in any prehearing conferences required to expedite the hearing; and

"(B) Authorize the Administrative Law Judge conducting the hearing to:

"(i) Establish a prehearing schedule for investigation of the claim, including but not limited to the interviewing of the claimant;

"(ii) Make prehearing rulings necessary to promote full discovery and completion of the medical record required for determination of the issues arising from the claim; and

"(iii) Specify what is required of the claimant to meet the obligation to reasonably cooperate with the investigation of claims.

"(c) Nothing in paragraph (b) of this subsection alters the obligation of an insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** to accept or deny a claim for compensation as required under this chapter.

"(d) If a hearing has been postponed in accordance with paragraph (b) of

this subsection:

"(A) The director may not consider the timeliness of a denial issued in the claim that is the subject of the hearing for the purpose of imposing a penalty against an insurer or self-insured employer that is potentially responsible for the claim; and

"(B) The 120-day maximum postponement established under paragraph (a) of this subsection for rescheduling a hearing does not apply.

"(4)(a) At least 60 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. Hearings shall be held in the county where the worker resided at the time of the injury or such other place selected by the Administrative Law Judge.

"(b) The 60-day prior notice required by paragraph (a) of this subsection:

"(A) May be waived by agreement of the parties and the board if waiver of the notice will result in an earlier date for the hearing.

"(B) Does not apply to hearings in cases assigned to the Expedited Claim Service under ORS 656.291, cases involving stayed compensation under ORS 656.313 (1)(b) and requests for hearing that are consolidated with an existing case with an existing hearing date.

"(5) A record of all proceedings at the hearing shall be kept but need not be transcribed unless a party requests a review of the order of the Administrative Law Judge. Transcription shall be in written form as provided by ORS 656.295 (3).

"(6) Except as otherwise provided in this section and rules of procedure established by the board, the Administrative Law Judge is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Neither the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used. Impeachment evidence consisting of medical or voca-

tional reports not used during the course of a hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. Impeachment evidence other than medical or vocational reports that is not presented as evidence at hearing is not subject to disclosure. Evaluation of the worker's disability by the Administrative Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Evidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. If the Administrative Law Judge finds that the claim has been closed prematurely, the Administrative Law Judge shall issue an order rescinding the notice of closure.

"(7) Any party shall be entitled to issuance and service of subpoenas under the provisions of ORS 656.726 (2)(c). Any party or representative of the party may serve such subpoenas.

"(8) After a party requests a hearing and before the hearing commences, the board, by rule, may require the requesting party, if represented by an attorney, to notify the Administrative Law Judge in writing that the attorney has conferred with the other party and that settlement has been

achieved, subject to board approval, or that settlement cannot be achieved.

"SECTION 13. ORS 656.313 is amended to read:

"656.313. (1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order before the Hearings Division, a request for Workers' Compensation Board review or court appeal or request for review of an order of the Director of the Department of Consumer and Business Services regarding vocational assistance stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs;

"(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed;

"(C) Death benefits payable to a surviving spouse prior to remarriage, to children or dependents that accrue from the date of the order appealed from until the order appealed from is reversed; and

"(D) Vocational benefits ordered by the director pursuant to ORS 656.340 (16). If a denial of vocational benefits is upheld by a final order, the insurer or self-insured employer shall be reimbursed from the Workers' Benefit Fund pursuant to ORS 656.605 for all costs incurred in providing vocational benefits as a result of the order that was appealed.

"(b) If ultimately found payable under a final order, benefits withheld under this subsection, and attorney fees and costs, shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment. The board shall expedite review of appeals in which payment of compensation has been stayed under this section.

"(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal.

"(3) If an insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** denies the compensability of all or any portion of a claim submitted for medical services, the insurer or [*self-insured employer*] **the corporation** shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. Except for medical services payable in accordance with ORS 656.247, after receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy. If the injured worker has no health insurance, such bills may be submitted to the injured worker. A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined.

"(4) Except for medical services payable in accordance with ORS 656.247:

"(a) When the compensability issue has been finally determined or when disposition or settlement of the claim has been made pursuant to ORS 656.236 or 656.289 (4), the insurer or **the corporation, on behalf of the** self-insured employer**,** shall notify each affected service provider and health insurance provider of the results of the disposition or settlement.

"(b) If the services are determined to be compensable, the insurer or self-insured employer shall reimburse each health insurance provider for the amount of claims paid by the health insurance provider pursuant to this section. Such reimbursement shall be in addition to compensation or medical benefits the worker receives. Medical service reimbursement shall be paid directly to the health insurance provider.

"(c) If the services are settled pursuant to ORS 656.289 (4), the insurer or self-insured employer shall reimburse, out of the settlement proceeds, each medical service provider for billings received by the insurer or self-insured

employer on and before the date on which the terms of settlement are agreed as specified in the settlement document that are not otherwise partially or fully reimbursed.

"(d) Reimbursement under this section shall be made only for medical services related to the claim that would be compensable under this chapter if the claim were compensable and shall be made at one-half the amount provided under ORS 656.248. In no event shall reimbursement made to medical service providers exceed 40 percent of the total present value of the settlement amount, except with the consent of the worker. If the settlement proceeds are insufficient to allow each medical service provider the reimbursement amount authorized under this subsection, the insurer or self-insured employer shall reduce each provider's reimbursement by the same proportional amount. Reimbursement under this section shall not prevent a medical service provider or health insurance provider from recovering the balance of amounts owing for such services directly from the worker, unless the worker agrees to pay all medical service providers directly from the settlement proceeds the amount provided under ORS 656.248.

"(5) As used in this section, 'health insurance' has the meaning for that term provided in ORS 731.162.

"SECTION 14. ORS 656.325 is amended to read:

"656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. No more than three independent medical examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination

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

"(b) When a worker is requested by the director, the insurer or **the corporation, on behalf of the** self-insured employer**,** to attend an independent medical examination, the examination must be conducted by a physician selected from a list of qualified physicians established by the director under ORS 656.328.

"(c) The director shall adopt rules applicable to independent medical examinations conducted pursuant to paragraph (a) of this subsection that:

"(A) Provide a worker the opportunity to request review by the director of the reasonableness of the location selected for an independent medical examination. Upon receipt of the request for review, the director shall conduct an expedited review of the location selected for the independent medical examination and issue an order on the reasonableness of the location of the examination. The director shall determine if there is substantial evidence for the objection to the location for the independent medical examination based on a conclusion that the required travel is medically contraindicated or other good cause establishing that the required travel is unreasonable. The determinations of the director about the location of independent medical examinations are not subject to review.

"(B) Impose a monetary penalty against a worker who fails to attend an independent medical examination without prior notification or without justification for not attending the examination. A penalty imposed under this subparagraph may be imposed only on a worker who is not receiving temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may offset any future compensation payable to the worker to recover any penalty imposed under this subparagraph from a claim with the same insurer or self-insured employer. When a penalty is recovered from temporary disability or permanent total disability benefits, the amount re-

covered from each payment may not exceed 25 percent of the benefit payment without prior authorization from the worker.

"(C) Impose a sanction against a medical service provider that unreasonably fails to provide in a timely manner diagnostic records required for an independent medical examination.

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

"(e) If the worker has made a timely request for a hearing on a denial of compensability as required by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pursuant to paragraph (a) of this subsection and the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 does not concur with the report or reports, the worker may request an examination to be conducted by a physician selected by the director from the list described in ORS 656.328. The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.

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

"(g) A worker who objects to the location of an independent medical examination must request review by the director under paragraph (c)(A) of this

subsection within six business days of the date the notice of the independent medical examination was mailed.

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

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

"(4) When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to this chapter, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate.

"(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment

prior to claim determination and the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered.

"(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers.

"(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 approves employment in a modified job whether or not such a job is available.

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

"SECTION 15. ORS 656.327 is amended to read:

"656.327. (1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer must request administrative review of the treatment by the director prior to requesting a hearing on the issue and so notify the parties.

"(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the Workers' Compensation Board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.

"(c) The insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** shall not deny the claim for medical services nor shall the worker request a hearing on any issue under this section until the director issues an order under subsection (2) of this section.

"(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS 656.325 (1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request review under ORS 656.704. The administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. The worker is not obligated to pay for medical treatment determined not to be compensable under this subsection.

"(3) Upon request of either party, the director may delegate to a physician

or a panel of physicians the review of medical treatment under this section. At least one member of any such panel shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed. No member of any such panel shall be a physician whose treatment is the subject of review. The panel shall be chosen in such manner as the director may prescribe, in consultation with the committee referred to in ORS 656.790. The physician or panel shall submit findings to the director within the time limits as prescribed by the director.

"(4) The physician or the panel of physicians and the medical arbiter or panel of medical arbiters appointed pursuant to ORS 656.268 acting pursuant to the authority of the director are agents of the Department of Consumer and Business Services and are subject to the provisions of ORS 30.260 to 30.300. The findings of the physician or panel of physicians, the medical arbiter or panel of medical arbiters, all of the records and all communications to or before a panel or arbiter are privileged and are not discoverable or admissible in any proceeding other than those proceedings under this chapter. No member of a panel or a medical arbiter shall be examined or subject to administrative or civil liability regarding participation in or the findings of the panel or medical arbiter or any matter before the panel or medical arbiter other than in proceedings under this chapter.

"(5) The costs of review of medical treatment by the physician or panel of physicians pursuant to this section and costs incurred by the worker in attending any examination required under this section, including child care, transportation, lodging and meals, shall be paid by the insurer or self-insured employer.

"SECTION 16. ORS 656.331 is amended to read:

"656.331. (1) Notwithstanding any other provision of this chapter, if an injured worker is represented by an attorney and the attorney has given written notice of such representation:

"(a) The Director of the Department of Consumer and Business Services,

the insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

"(b) An insurer or **the corporation, on behalf of a** self-insured employer**,** shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits.

"(2) The director shall adopt rules necessary to carry out the provisions of subsection (1)(b) of this section.

"SECTION 17. ORS 656.403 is amended to read:

"656.403. (1) A self-insured employer directly assumes the responsibility for providing compensation due subject workers and their beneficiaries under this chapter.

"(2) The claims of subject workers and their beneficiaries resulting from injuries while employed by a self-insured employer shall be handled in the manner [*provided by this chapter*] **specified in ORS 656.262 (1)(b)**. A self-insured employer is subject to the rules of the Director of the Department of Consumer and Business Services with respect to such claims.

"(3) Security deposited by a self-insured employer shall not relieve any such employer from full and primary responsibility for [*claims administration and*] payment of compensation under this chapter. This subsection applies to a self-insured employer even though the self-insured employer insures or reinsures all or any portion of risks under this chapter with an insurance company authorized to do business in this state or with any other insurer with whom insurance can be placed or secured pursuant to ORS 744.305 to 744.405 (1985 Replacement Part).

"(4) When a self-insured employer is a worker leasing company required to be licensed pursuant to ORS 656.850 and 656.855, the company also shall comply with the worker leasing company regulatory provisions of ORS

chapters 656 and 737 and with such rules as may be adopted pursuant to ORS 656.726 and 731.244 for the supervision and regulation of worker leasing companies.

"SECTION 18. ORS 656.407 is amended to read:

"656.407. (1) An employer shall establish proof with the Director of the Department of Consumer and Business Services that the employer is qualified either:

"(a) As a carrier-insured employer by causing proof of coverage provided by an insurer to be filed with the director; or

"(b) As a self-insured employer by establishing proof that the employer has [*an adequate staff qualified to process claims promptly and has*] the financial ability to make certain the prompt payment of all compensation and other payments that may become due to the director under this chapter.

"(2) Except as provided in subsection (3) of this section, a self-insured employer shall establish proof of financial ability by:

"(a) Demonstrating acceptable financial viability based on information required by the director by rule; and

"(b) Providing security that the director determines acceptable by rule. The security must be in an amount reasonably sufficient to insure payment of compensation and other payments that may become due to the director but not less than the employer's normal expected annual claim liabilities and in no event less than $100,000. In arriving at the amount of security required under this subsection, the director may take into consideration the financial ability of the employer to pay compensation and other payments and probable continuity of operation. The security shall be held by the director to secure the payment of compensation for injuries to subject workers of the employer and to secure other payments that may become due from the employer to the director under this chapter. Moneys received as security under this subsection shall be deposited with the State Treasurer in an account separate and distinct from the General Fund. Interest earned by the account

shall be credited to the account. The amount of security may be increased or decreased from time to time by the director.

"(3)(a) A city, county or a qualified self-insured employer group that wishes to be exempt from subsection (2) of this section may make written application therefor to the director. The application shall include a copy of the most recent annual audit of the city, county or qualified self-insured employer group filed with the Secretary of State under ORS 297.405 to 297.740, information regarding the establishment of a loss reserve account for the payment of compensation to injured workers and such other information as the director may require. The director shall approve the application and the city, county or qualified self-insured employer group shall be exempt from subsection (2) of this section if the director finds that:

"(A) The city, county or qualified self-insured employer group has been self-insured in compliance with subsection (2) of this section for more than three consecutive years prior to making the application referred to in this subsection.

"(B) The city, county or qualified self-insured employer group has in effect a loss reserve account:

"(i) That is actuarially sound and that is adequately funded as determined by an annual audit under ORS 297.405 to 297.740 to pay all compensation to injured workers and amounts due the director pursuant to this chapter. A copy of the annual audit shall be filed with the director. Upon a finding that there is probable cause to believe that the loss reserve account is not actuarially sound, the director may require a city, county or qualified self-insured employer group to obtain an independent actuarial audit of the loss reserve account. The requirements of this subsection are in addition to and not in lieu of any other audit or reporting requirement otherwise prescribed by or pursuant to law.

"(ii) That is dedicated to and may be expended only for the payment of compensation and amounts due the director by the city, county or qualified

self-insured employer group under this chapter.

"(b) The director shall have the first lien and priority right to the full amount of the loss reserve account required to pay the present discounted value of all present and future claims under this chapter.

"(c) The city, county or qualified self-insured employer group shall notify the director no later than 60 days prior to any action to discontinue the loss reserve account. The city, county or qualified self-insured employer group shall advise the director of the plans of the city, county or qualified self-insured employer group to submit the security deposits required in subsection (2) of this section, or obtain coverage as a carrier-insured employer prior to the date the loss reserve account ceases to exist. If the city, county or qualified self-insured employer group elects to discontinue self-insurance, it shall submit such security as the director may require to insure payment of all compensation and amounts due the director for the period the city, county or qualified self-insured employer group was self-insured.

"(d) In order to requalify as a self-insured employer, the city, county or qualified self-insured employer group must deposit prior to discontinuance of the loss reserve account such security as is required by the director pursuant to subsection (2) of this section.

"(e) Notwithstanding ORS 656.440, if prior to the date of discontinuance of the loss reserve account the director has not received the security deposits required in subsection (2) of this section, the certificate of self-insurance of the city, county or qualified self-insured employer group is automatically revoked as of that date.

"(4) As used in this section, 'qualified self-insured employer group' means a self-insured employer group that is a municipal corporation or a public corporation, as those terms are defined in ORS 297.405.

"SECTION 19. ORS 656.455 is amended to read:

"656.455. (1)**(a)** Every self-insured employer shall maintain a place of business in this state where the employer shall keep complete records of all

claims for compensation made to the employer under this chapter or a self-insured employer may, under the conditions prescribed by ORS 731.475 (3), keep such records in this state at places operated by service companies. The records shall be retained in, and may be removed from, this state or disposed of, in accordance with the rules of the Director of the Department of Consumer and Business Services adopted pursuant to ORS 731.475. Such records shall be available to the director for examination and audit at all reasonable times upon notice by the director to the employer.

"**(b) The State Accident Insurance Fund Corporation shall keep complete records of claims that a self-insured employer has referred to the corporation for processing under ORS 656.262 (1)(b) and shall make the records available for examination and auditing by the director in the same manner as the records of the self-insured employer are available for examination and auditing under paragraph (a) of this subsection.**

"(2) With the permission of the director, a self-insured employer may keep all claims records and process claims from a location outside of the state. The director shall by rule prescribe the conditions and procedure for obtaining permission of the director. The director may revoke permission for failure of the employer to comply with the rules. If the permission of an employer is revoked by the director, the employer shall be allowed 60 days after the order of revocation becomes final to comply with subsection (1) of this section. The expenses of the director to examine and audit the records of a self-insured employer outside of this state shall be paid by the employer.

"(3) Notwithstanding subsection (1) of this section, a self-insured employer may not have at any one time more than three locations where [*claims are processed or*] records are maintained.

"SECTION 20. ORS 656.752 is amended to read:

"656.752. (1) The State Accident Insurance Fund Corporation is created for the purpose of transacting workers' compensation insurance and rein-

surance business. The State Accident Insurance Fund Corporation also may insure an Oregon employer against any liability such employer may have on account of bodily injury to a worker of the employer arising out of and in the course of employment as fully as any private insurance carrier.

"(2) The functions of the State Accident Insurance Fund Corporation shall be:

"(a) To confer with and solicit employers and to determine, handle, audit and enforce collection of premiums, assessments and fees of insured employers insured with the State Accident Insurance Fund Corporation;

"(b) To make insurance available to as many Oregon employers as inexpensively as may be consistent with the overall integrity of the Industrial Accident Fund, in accordance with ORS 656.634 and sound principles of insurance;

"(c) To receive and handle and process the claims of workers and beneficiaries of workers injured in the employ of insured employers insured with the State Accident Insurance Fund Corporation **and with all self-insured employers, as provided in ORS 656.262 (1)(b)**; and

"(d) To perform all other functions which the laws of this state specifically authorize or which are necessary or appropriate to carry out the functions expressly authorized.

"(3) The State Accident Insurance Fund Corporation in its name may sue and be sued.

"(4) The State Accident Insurance Fund Corporation may authorize self-insured employers or other insurers to use any physical rehabilitation center operated by the State Accident Insurance Fund Corporation on such terms as the State Accident Insurance Fund Corporation deems reasonable.

"(5) The State Accident Insurance Fund Corporation in its own name, may acquire, lease, rent, own and manage real property. It may construct, equip and furnish buildings or other structures as are necessary to accommodate its needs. It may purchase, rent, lease or otherwise acquire for its use all

supplies, materials, equipment and services necessary to carry out its functions. It may sell or otherwise dispose of any property acquired under this subsection.

"(6) Any real property acquired and owned by the State Accident Insurance Fund Corporation under this section shall be subject to ad valorem taxation.

"(7) The State Accident Insurance Fund Corporation may furnish advice, services and excess workers' compensation and employer liability insurance to any employer qualified as a self-insured employer under the provisions of ORS 656.407, on such terms and conditions as the State Accident Insurance Fund Corporation deems reasonable.

"(8) With the approval of the Director of the Department of Consumer and Business Services, the State Accident Insurance Fund Corporation may provide reinsurance coverage to Oregon employers on such terms and conditions as the State Accident Insurance Fund Corporation deems reasonable.

"(9) The State Accident Insurance Fund Corporation may contract with the Oregon Department of Administrative Services to provide claim management services for claims filed under ORS 655.505 to 655.555 by adults in custody of institutions of the Department of Corrections.

"SECTION 21. ORS 656.780 is amended to read:

"656.780. (1) The Director of the Department of Consumer and Business Services shall:

"(a) Adopt by rule standards for certification of workers' compensation claims examiners that shall be administered by workers' compensation insurers, **the State Accident Insurance Fund Corporation on behalf of** self-insured employers and service companies; and

"(b) Develop or approve any training curriculum used by insurers, **the corporation on behalf of** self-insured employers and service companies that is related to interactions with independent medical examination providers required under ORS 656.325.

"(2)(a) Each insurer[*, self-insured employer*] and service company shall maintain records of the certification and training of their workers' compensation claims examiners. These records are subject to inspection and review by the director.

"(b) The director may impose a civil penalty against any insurer[*, self-insured employer*] or service company that fails to:

"(A) Maintain or produce certification and training records as required by the rules of the director; or

"(B) Provide training based on a curriculum approved by the director related to interactions with independent medical examination providers required under ORS 656.325.

"(3) Insurers, [*self-insured employers and*] **the corporation when processing claims on behalf of self-insured employers, and** service companies may employ only certified workers' compensation claims examiners to process workers' compensation claims. The director may impose a civil penalty against any insurer[*, self-insured employer*] or service company that violates this subsection.

"SECTION 22. ORS 656.802 is amended to read:

"656.802. (1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"(A) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.

"(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.

"(C) Any series of traumatic events or occurrences which requires medical

services or results in physical disability or death.

"(b) As used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by mental stress.

"(2)(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005 (7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

"(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005 (7).

"(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.

"(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section.

"(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

"(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment.

"(4) Death, disability or impairment of health of firefighters of any political division who have completed five or more years of employment as firefighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as firefighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a firefighter's employment. However, any such firefighter must have taken a physical examination upon becoming a firefighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the firefighter's employment.

"(5)(a) Death, disability or impairment of health of a nonvolunteer firefighter employed by a political division or subdivision who has completed five or more years of employment as a nonvolunteer firefighter is an occupational disease if the death, disability or impairment of health:

"(A) Is caused by brain cancer, colon cancer, stomach cancer, testicular cancer, prostate cancer, multiple myeloma, non-Hodgkin's lymphoma, cancer of the throat or mouth, rectal cancer, breast cancer or leukemia;

"(B) Results from the firefighter's employment as a nonvolunteer firefighter; and

"(C) Is first diagnosed by a physician after July 1, 2009.

"(b) Any condition or impairment of health arising under this subsection is presumed to result from the firefighter's employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the condition or impairment was not caused or contributed to in material part by the firefighter's employment.

"(c) Notwithstanding paragraph (b) of this subsection, the presumption

established under paragraph (b) of this subsection may be rebutted by clear and convincing evidence that the use of tobacco by the nonvolunteer firefighter is the major contributing cause of the cancer.

"(d) The presumption established under paragraph (b) of this subsection does not apply to prostate cancer if the cancer is first diagnosed by a physician after the firefighter has reached the age of 55. However, nothing in this paragraph affects the right of a firefighter to establish the compensability of prostate cancer without benefit of the presumption.

"(e) The presumption established under paragraph (b) of this subsection does not apply to claims filed more than 84 months following the termination of the nonvolunteer firefighter's employment as a nonvolunteer firefighter. However, nothing in this paragraph affects the right of a firefighter to establish the compensability of the cancer without benefit of the presumption.

"(f) The presumption established under paragraph (b) of this subsection does not apply to volunteer firefighters.

"(g) Nothing in this subsection affects the provisions of subsection (4) of this section.

"(h) For purposes of this subsection, 'nonvolunteer firefighter' means a firefighter who performs firefighting services and receives salary, hourly wages equal to or greater than the state minimum wage, or other compensation except for room, board, lodging, housing, meals, stipends, reimbursement for expenses or nominal payments for time and travel, regardless of whether any such compensation is subject to federal, state or local taxation. 'Nominal payments for time and travel' includes, but is not limited to, payments for on-call time or time spent responding to a call or similar noncash benefits.

"(6) Notwithstanding ORS 656.027 (6), any city providing a disability and retirement system by ordinance or charter for firefighters and police officers not subject to this chapter shall apply the presumptions established under subsection (5) of this section when processing claims for firefighters covered

by the system.

"(7)(a) As used in this subsection:

"(A) 'Acute stress disorder' has the meaning given that term in the DSM-5.

"(B) 'Covered employee' means an individual who, on the date a claim is filed under this chapter:

"(i) Was employed for at least five years by, or experienced a single traumatic event that satisfies the criteria set forth in the DSM-5 as Criterion A for diagnosing post-traumatic stress disorder while employed by, the state, a political subdivision of the state, a special government body, as defined in ORS 174.117, or a public agency in any of these occupations:

"(I) A full-time paid firefighter;

"(II) A full-time paid emergency medical services provider;

"(III) A full-time paid police officer;

"(IV) A full-time paid corrections officer or youth correction officer;

"(V) A full-time paid parole and probation officer; or

"(VI) A full-time paid emergency dispatcher or 9-1-1 emergency operator; and

"(ii) Remains employed in an occupation listed in sub-subparagraph (i) of this subparagraph or separated from employment in the occupation not more than seven years previously.

"(C) 'DSM-5' means the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"(D) 'Post-traumatic stress disorder' has the meaning given that term in the DSM-5.

"(E) 'Psychiatrist' means a psychiatrist whom the Oregon Medical Board has licensed and certified as eligible to diagnose the conditions described in this subsection.

"(F) 'Psychologist' means a licensed psychologist, as defined in ORS

675.010, whom the Oregon Board of Psychology has certified as eligible to diagnose the conditions described in this subsection.

"(b) Notwithstanding subsections (2) and (3) of this section, if a covered employee establishes through a preponderance of persuasive medical evidence from a psychiatrist or psychologist that the covered employee has more likely than not satisfied the diagnostic criteria in the DSM-5 for post-traumatic stress disorder or acute stress disorder, any resulting death, disability or impairment of health of the covered employee shall be presumed to be compensable as an occupational disease. An insurer or **the State Accident Insurance Fund Corporation, on behalf of a** self-insured employer**,** may rebut the presumption only by establishing through clear and convincing medical evidence that duties as a covered employee were not of real importance or great consequence in causing the diagnosed condition.

"(c) An insurer's **acceptance,** or [*self-insured employer's*] **the corporation's** acceptance **on behalf of a self-insured employer,** of a claim of post-traumatic stress disorder or acute stress disorder under this subsection, whether the acceptance was voluntary or was a result of a judgment or order, does not preclude the insurer or the self-insured employer from later denying the current compensability of the claim if exposure as a covered employee to trauma that meets the diagnostic criteria set forth as Criterion A in the DSM-5 for post-traumatic stress disorder or acute stress disorder ceases being of real importance or great consequence in causing the disability, impairment of health or a need for treatment.

"(d) An insurer or **the corporation, on behalf of a** self-insured employer**,** may deny a claim under paragraph (c) of this subsection only on the basis of clear and convincing medical evidence.

"(e) Notwithstanding ORS 656.027 (6), a city that provides a disability or retirement system for firefighters and police officers by ordinance or charter that is not subject to this chapter, when accepting and processing claims for death, disability or impairment of health from firefighters and police officers

covered by the disability or retirement system, shall apply:

"(A) The provisions of this subsection; and

"(B) For claims filed under this subsection, the time limitations for filing claims that are set forth in ORS 656.807 (1) and (2).

"SECTION 23. The amendments to ORS 656.206, 656.218, 656.245, 656.247, 656.262, 656.264, 656.267, 656.268, 656.273, 656.277, 656.278, 656.283, 656.313, 656.325, 656.327, 656.331, 656.403, 656.407, 656.455, 656.752, 656.780 and 656.802 by sections 1 to 22 of this 2021 Act apply to claims that workers submit to self-insured employers on and after the effective date of this 2021 Act.

"SECTION 24. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.".