

**A-Engrossed**  
**House Bill 4138**

Ordered by the House February 21  
Including House Amendments dated February 21

Sponsored by Representative GRAYBER, Senator JAMA; Representatives ALONSO LEON, CAMPOS, HUDSON, MEEK, NOSSE, POWER, RUIZ, SANCHEZ, VALDERRAMA, WITT, Senators LIEBER, MANNING JR (Pre-session filed.)

**SUMMARY**

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

Amends provisions of workers' compensation law related to [*payments of benefits, notice to workers, recovery of overpayments and errors in claims processing*] **authorization of temporary disability, claim closure and overpayments of compensation.**

**A BILL FOR AN ACT**

1  
2 Relating to workers' compensation benefits; creating new provisions; and amending ORS 656.262 and  
3 656.268.

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

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

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

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

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

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

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

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

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

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

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

25 (4)(a) The first installment of temporary disability compensation shall be paid no later than the  
26 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-

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

1 bility, if the attending physician or nurse practitioner authorized to provide compensable medical  
 2 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-  
 3 after, temporary disability compensation shall be paid at least once each two weeks, except where  
 4 the Director of the Department of Consumer and Business Services determines that payment in in-  
 5 stallments should be made at some other interval. The director may by rule convert monthly benefit  
 6 schedules to weekly or other periodic schedules.

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

11 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is  
 12 injured in the course and scope of that public office, full official salary paid to the holder of that  
 13 public office shall be deemed timely payment of temporary disability payments pursuant to ORS  
 14 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public  
 15 office" has the meaning for that term provided in ORS 260.005.

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

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

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

34 (g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after  
 35 the worker's attending physician or nurse practitioner authorized to provide compensable medical  
 36 services under ORS 656.245 ceases to authorize temporary disability or for any period of time not  
 37 authorized by the attending physician or nurse practitioner. No authorization of temporary disability  
 38 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective  
 39 to retroactively authorize the payment of temporary disability more than [14] 45 days prior to its  
 40 issuance.

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

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

45 **(ii) During periods in which there is a dispute over the identity of, or treatment by, an**

1 **attending physician or nurse practitioner that affects the worker's ability to obtain authori-**  
2 **zation of temporary disability; or**

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

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

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

14 **(j)(A) The insurer or self-insured employer may not end temporary disability benefits**  
15 **until written notice has been mailed or delivered to the worker and the worker's attorney,**  
16 **if the worker is represented. The notice must state the reason that temporary disability**  
17 **benefits are no longer due and payable.**

18 **(B) The worker's attending physician or nurse practitioner may retroactively authorize**  
19 **temporary disability for up to 45 days prior to the date of the notice.**

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

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

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

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

44 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by  
45 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of

1 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-  
 2 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance  
 3 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-  
 4 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial  
 5 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has  
 6 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other  
 7 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance  
 8 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a  
 9 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the  
 10 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer  
 11 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may  
 12 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-  
 13 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the  
 14 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured  
 15 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that  
 16 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other  
 17 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative  
 18 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are  
 19 payable from the date any such benefits were terminated under the denial. Except as provided in  
 20 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not  
 21 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer  
 22 a copy of the notice of acceptance.

23 (b) The notice of acceptance shall:

24 (A) Specify what conditions are compensable.

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

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

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

31 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-  
 32 ment Assistance Program under ORS 656.622.

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

35 (c) An insurer's or self-insured employer's acceptance of a combined or consequential condition  
 36 under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude  
 37 the insurer or self-insured employer from later denying the combined or consequential condition if  
 38 the otherwise compensable injury ceases to be the major contributing cause of the combined or  
 39 consequential condition.

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

1 hearing or other proceeding on the claim a de facto denial of a condition based on information in  
2 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-  
3 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

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

14 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-  
15 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-  
16 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)  
17 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-  
18 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable  
19 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-  
20 garding that condition.

21 (8) The assigned claims agent in processing claims under ORS 656.054 shall send notice of ac-  
22 ceptance or denial to the noncomplying employer.

23 (9) If an insurer or any other duly authorized agent of the employer for such purpose, on record  
24 with the Director of the Department of Consumer and Business Services denies a claim for com-  
25 pensation, written notice of such denial, stating the reason for the denial, and informing the worker  
26 of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the  
27 claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the  
28 insurer. The worker may request a hearing pursuant to ORS 656.319.

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

36 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to  
37 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,  
38 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the  
39 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-  
40 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable  
41 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court  
42 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-  
43 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and  
44 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed  
45 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under

1 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the  
2 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this  
3 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-  
4 ment and payment of the additional amount and attorney fees described in this subsection. The  
5 action of the director and the review of the action taken by the director shall be subject to review  
6 under ORS 656.704.

7 (b) When the director does not have exclusive jurisdiction over proceedings regarding the as-  
8 sessment and payment of the additional amount and attorney fees described in this subsection, the  
9 provisions of this subsection shall apply in the other proceeding.

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

17 (b) The director shall adopt by rule a matrix for the assessment of the penalties and attorney  
18 fees authorized under this subsection. The matrix shall provide for penalties based on a percentage  
19 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of  
20 the settlement proceeds allocated to the claimant's attorney as an attorney fee.

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

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

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

40 (15) If the director finds that a worker fails to reasonably cooperate with an investigation in-  
41 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the  
42 claim for a worsened condition, the director shall suspend all or part of the payment of compen-  
43 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after  
44 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure  
45 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim

1 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the  
 2 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the  
 3 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291  
 4 that the worker fully and completely cooperated with the investigation, that the worker failed to  
 5 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-  
 6 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-  
 7 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain  
 8 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-  
 9 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order  
 10 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or  
 11 self-insured employer to accept or deny the claim.

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

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

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

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

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

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

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

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

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

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

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

37 (4)(a) The first installment of temporary disability compensation shall be paid no later than the  
 38 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-  
 39 bility, if the attending physician or nurse practitioner authorized to provide compensable medical  
 40 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-  
 41 after, temporary disability compensation shall be paid at least once each two weeks, except where  
 42 the Director of the Department of Consumer and Business Services determines that payment in in-  
 43 stallments should be made at some other interval. The director may by rule convert monthly benefit  
 44 schedules to weekly or other periodic schedules.

45 (b) Notwithstanding any other provision of this chapter, if a self-insured employer pays to an

1 injured worker who becomes disabled the same wage at the same pay interval that the worker re-  
 2 ceived at the time of injury, such payment shall be deemed timely payment of temporary disability  
 3 payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made.

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

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

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

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

27 (g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after  
 28 the worker’s attending physician or nurse practitioner authorized to provide compensable medical  
 29 services under ORS 656.245 ceases to authorize temporary disability or for any period of time not  
 30 authorized by the attending physician or nurse practitioner. No authorization of temporary disability  
 31 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective  
 32 to retroactively authorize the payment of temporary disability more than [14] 45 days prior to its  
 33 issuance.

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

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

38 **(ii) During periods in which there is a dispute over the identity of, or treatment by, an**  
 39 **attending physician or nurse practitioner that affects the worker’s ability to obtain authori-**  
 40 **zation of temporary disability; or**

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

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



1 practitioner authorized to provide compensable medical services under ORS 656.245.

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

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

11 **(B) The worker's attending physician or nurse practitioner may retroactively authorize**  
12 **temporary disability for up to 45 days prior to the date of the notice.**

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

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

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

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

37 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by  
38 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of  
39 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-  
40 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance  
41 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-  
42 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial  
43 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has  
44 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other  
45 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance

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

16 (b) The notice of acceptance shall:

17 (A) Specify what conditions are compensable.

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

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

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

24 (E) Inform the claimant of assistance available to employers and workers from the Reemploy-  
25 ment Assistance Program under ORS 656.622.

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

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

33 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice  
34 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the  
35 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The  
36 insurer or self-insured employer has 60 days from receipt of the communication from the worker to  
37 revise the notice or to make other written clarification in response. A worker who fails to comply  
38 with the communication requirements of this paragraph or ORS 656.267 may not allege at any  
39 hearing or other proceeding on the claim a de facto denial of a condition based on information in  
40 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-  
41 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

42 (7)(a) After claim acceptance, written notice of acceptance or denial of claims for aggravation  
43 or new medical or omitted condition claims properly initiated pursuant to ORS 656.267 shall be  
44 furnished to the claimant by the insurer or self-insured employer within 60 days after the insurer  
45 or self-insured employer receives written notice of such claims. A worker who fails to comply with

1 the communication requirements of subsection (6) of this section or ORS 656.267 may not allege at  
2 any hearing or other proceeding on the claim a de facto denial of a condition based on information  
3 in the notice of acceptance from the insurer or self-insured employer.

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

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

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

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

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

30 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to  
31 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,  
32 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the  
33 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-  
34 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable  
35 attorney fees. In assessing fees, the director, an Administrative Law Judge, the board or the court  
36 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-  
37 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and  
38 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed  
39 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under  
40 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the  
41 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this  
42 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-  
43 ment and payment of the additional amount and attorney fees described in this subsection. The  
44 action of the director and the review of the action taken by the director shall be subject to review  
45 under ORS 656.704.

1 (b) When the director does not have exclusive jurisdiction over proceedings regarding the as-  
2 sessment and payment of the additional amount and attorney fees described in this subsection, the  
3 provisions of this subsection shall apply in the other proceeding.

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

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

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

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

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

34 (15) If the director finds that a worker fails to reasonably cooperate with an investigation in-  
35 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the  
36 claim for a worsened condition, the director shall suspend all or part of the payment of compen-  
37 sation after notice to the worker. If the worker does not cooperate for an additional 30 days after  
38 the notice, the insurer or self-insured employer may deny the claim because of the worker's failure  
39 to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim  
40 within 60 days is suspended during the time of the worker's noncooperation. After such a denial, the  
41 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the  
42 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291  
43 that the worker fully and completely cooperated with the investigation, that the worker failed to  
44 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-  
45 sonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Ad-

1 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain  
2 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-  
3 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order  
4 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or  
5 self-insured employer to accept or deny the claim.

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

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

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

16 **SECTION 4.** ORS 656.268 is amended to read:

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

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

31 (b) The accepted injury is no longer the major contributing cause of the worker's combined or  
32 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because  
33 the accepted injury is no longer the major contributing cause of the worker's combined or conse-  
34 quential condition or conditions, and there is sufficient information to determine permanent disabili-  
35 ty, the likely permanent disability that would have been due to the current accepted condition shall  
36 be estimated.[.]

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

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

45 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-

1 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-  
2 duced by any sums earned during the training.

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

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

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

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

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

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

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

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

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

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

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

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

31 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician  
32 or nurse practitioner who has authorized temporary disability benefits under ORS 656.245 for a home  
33 care worker or a personal support worker who has been made a subject worker pursuant to ORS  
34 656.039 advises the home care worker or personal support worker and documents in writing that the  
35 home care worker or personal support worker is released to return to modified employment, appro-  
36 priate modified employment is offered in writing by the Home Care Commission or a designee of the  
37 commission to the home care worker or personal support worker for any client of the Department  
38 of Human Services who employs a home care worker or personal support worker and the worker  
39 fails to begin the employment.

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

42 (b) The insurer or self-insured employer shall issue a notice of closure of the claim to the  
43 worker, to the worker's attorney if the worker is represented, and to the director. If the worker is  
44 deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail  
45 the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last

1 known address and may mail copies of the notice of closure to any known or potential beneficiaries  
2 to the estate of the deceased worker.

3 (c) The notice of closure must inform:

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

6 (B) The worker of:

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

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

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

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

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

19 (vi) The aggravation rights; and

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

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

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

28 (A) The decision not to close;

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

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

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

33 (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the no-  
34 tice of closure, the objecting party first must request reconsideration by the director under this  
35 section. A worker's request for reconsideration must be made within 60 days of the date of the no-  
36 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for  
37 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under  
38 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.  
39 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not  
40 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within  
41 one year of the date the notice of closure was mailed to the estate of the worker under paragraph  
42 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be  
43 based only on disagreement with the findings used to rate impairment and must be made within  
44 seven days of the date of the notice of closure.

45 (f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant

1 to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing  
2 on the claim and if a finding is made at the hearing that the notice of closure or refusal to close  
3 was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid  
4 to the worker in an amount equal to 25 percent of all compensation determined to be then due the  
5 claimant.

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

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

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

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

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

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

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

41 (d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be  
42 completed within 18 working days from the date the reconsideration proceeding begins, and shall  
43 be performed by a special evaluation appellate unit within the department. The deadline of 18  
44 working days may be postponed by an additional 60 calendar days if within the 18 working days the  
45 department mails notice of review by a medical arbiter. If an order on reconsideration has not been



1 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within  
2 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was  
3 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-  
4 section, or within such additional time as provided in subsection (8) of this section when reconsi-  
5 deration is postponed further because the worker has failed to cooperate in the medical arbiter  
6 examination, reconsideration shall be deemed denied and any further proceedings shall occur as  
7 though an order on reconsideration affirming the notice of closure was mailed on the date the order  
8 was due to issue.

9 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this  
10 subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-  
11 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-  
12 quests reconsideration, the period for reconsideration begins upon the earlier of the date of the  
13 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the  
14 worker or beneficiary of the right to request reconsideration or the date of expiration of the right  
15 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-  
16 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-  
17 ation proceeding, including the right to proceed with the reconsideration if the initiating party  
18 withdraws the request for reconsideration.

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

21 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS  
22 656.283 within 30 days from the date of the reconsideration order.

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

25 (A) A request for reconsideration of a notice of closure has been made to the director within  
26 60 days of the date of the notice of closure;

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

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

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

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

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

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

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

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

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

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

45 (8)(a) If the basis for objection to a notice of closure issued under this section is disagreement

1 with the impairment used in rating of the worker's disability, the director shall refer the claim to  
2 a medical arbiter appointed by the director.

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

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

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

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

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

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

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

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

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

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

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

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

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

44 (10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled  
45 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,

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

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

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

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

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

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

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

42 **(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured**  
43 **employer may not recover an overpayment from a worker's permanent partial disability**  
44 **compensation for overpayments, offsets or credits of wage loss in an amount that exceeds**  
45 **50 percent of the total compensation awarded to the worker.**

1       **(b) An insurer or self-insured employer may not declare an overpayment of any com-**  
2 **penensation that was paid more than two years prior to the date of the declaration.**

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

5       656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and  
6 as near as possible to a condition of self support and maintenance as an able-bodied worker. The  
7 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the  
8 Department of Consumer and Business Services, and determine the extent of the worker's permanent  
9 disability, provided the worker is not enrolled and actively engaged in training according to rules  
10 adopted by the director pursuant to ORS 656.340 and 656.726, when **one of the following conditions**  
11 **is met:**

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

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

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

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

33       (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-  
34 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-  
35 duced by any sums earned during the training.

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

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

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

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

44       (c) The attending physician or nurse practitioner who has authorized temporary disability ben-  
45 efits for the worker under ORS 656.245 advises the worker and documents in writing that the worker

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

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

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

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

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

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

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

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

19 (e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician  
20 or nurse practitioner who has authorized temporary disability benefits under ORS 656.245 for a home  
21 care worker or a personal support worker who has been made a subject worker pursuant to ORS  
22 656.039 advises the home care worker or personal support worker and documents in writing that the  
23 home care worker or personal support worker is released to return to modified employment, appro-  
24 priate modified employment is offered in writing by the Home Care Commission or a designee of the  
25 commission to the home care worker or personal support worker for any client of the Department  
26 of Human Services who employs a home care worker or personal support worker and the worker  
27 fails to begin the employment.

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

30 (b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker  
31 and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall  
32 notify the director of the closure in the manner the director prescribes by rule. If the worker is  
33 deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail  
34 the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last  
35 known address and may mail copies of the notice of closure to any known or potential beneficiaries  
36 to the estate of the deceased worker.

37 (c) The notice of closure must inform:

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

40 (B) The worker of:

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

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

44 (iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice  
45 of closure under paragraph (b) of this subsection to request reconsideration by the director under

1 this section within 60 days of the date of the notice of closure;

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

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

8 (vi) The aggravation rights; and

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

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

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

17 (A) The decision not to close;

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

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

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

22 (e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the no-  
23 tice of closure, the objecting party first must request reconsideration by the director under this  
24 section. A worker's request for reconsideration must be made within 60 days of the date of the no-  
25 tice of closure. If the worker is deceased at the time the notice of closure is issued, a request for  
26 reconsideration by a beneficiary of the worker who was mailed a copy of the notice of closure under  
27 paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure.  
28 A request for reconsideration by a beneficiary to the estate of a deceased worker who was not  
29 mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within  
30 one year of the date the notice of closure was mailed to the estate of the worker under paragraph  
31 (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be  
32 based only on disagreement with the findings used to rate impairment and must be made within  
33 seven days of the date of the notice of closure.

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

40 (g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director  
41 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker  
42 for permanent disability and the worker is found upon reconsideration to be at least 20 percent  
43 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and  
44 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due  
45 the claimant. If the increase in compensation results from information that the insurer or self-

1 insured employer demonstrates the insurer or self-insured employer could not reasonably have  
2 known at the time of claim closure, from new information obtained through a medical arbiter ex-  
3 amination or from a determination order issued by the director that addresses the extent of the  
4 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726  
5 (4)(f), the penalty shall not be assessed.

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

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

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

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

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

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

30 (d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be  
31 completed within 18 working days from the date the reconsideration proceeding begins, and shall  
32 be performed by a special evaluation appellate unit within the department. The deadline of 18  
33 working days may be postponed by an additional 60 calendar days if within the 18 working days the  
34 department mails notice of review by a medical arbiter. If an order on reconsideration has not been  
35 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within  
36 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was  
37 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-  
38 section, or within such additional time as provided in subsection (8) of this section when reconsid-  
39 eration is postponed further because the worker has failed to cooperate in the medical arbiter  
40 examination, reconsideration shall be deemed denied and any further proceedings shall occur as  
41 though an order on reconsideration affirming the notice of closure was mailed on the date the order  
42 was due to issue.

43 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this  
44 subsection begins upon receipt by the director of a worker's or a beneficiary's request for recon-  
45 sideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer re-

1 requests reconsideration, the period for reconsideration begins upon the earlier of the date of the  
2 request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the  
3 worker or beneficiary of the right to request reconsideration or the date of expiration of the right  
4 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-  
5 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-  
6 ation proceeding, including the right to proceed with the reconsideration if the initiating party  
7 withdraws the request for reconsideration.

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

10 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS  
11 656.283 within 30 days from the date of the reconsideration order.

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

14 (A) A request for reconsideration of a notice of closure has been made to the director within  
15 60 days of the date of the notice of closure;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

33 (10) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled  
34 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,  
35 any permanent disability payments due for work disability under the closure shall be suspended, and  
36 the worker shall receive temporary disability compensation and any permanent disability payments  
37 due for impairment while the worker is enrolled and actively engaged in the training. When the  
38 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-  
39 ployer shall again close the claim pursuant to this section if the worker is medically stationary or  
40 if the worker's accepted injury is no longer the major contributing cause of the worker's combined  
41 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the  
42 duration of temporary total or temporary partial disability compensation. Permanent disability  
43 compensation shall be redetermined for work disability only. If the worker has returned to work or  
44 the worker's attending physician has released the worker to return to regular or modified employ-  
45 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may

1 be appealed only in the same manner as are other notices of closure under this section.

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

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

11 (13) An insurer or self-insured employer may take a credit or offset of previously paid workers'  
12 compensation benefits or payments against any further workers' compensation benefits or payments  
13 due a worker from that insurer or self-insured employer when the worker admits to having obtained  
14 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction  
15 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-  
16 fits or payments obtained through fraud by a worker may not be included in any data used for  
17 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-  
18 tion licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the  
19 director.

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

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

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

31 **(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured**  
32 **employer may not recover an overpayment from a worker's permanent partial disability**  
33 **compensation for overpayments, offsets or credits of wage loss in an amount that exceeds**  
34 **50 percent of the total compensation awarded to the worker.**

35 **(b) An insurer or self-insured employer may not declare an overpayment of any com-**  
36 **penetration that was paid more than two years prior to the date of the declaration.**

37 **SECTION 6. (1) The amendments to ORS 656.268 by sections 4 and 5 of this 2022 Act apply**  
38 **to all claims that exist on, or arise on or after, January 1, 2024, regardless of the date of**  
39 **injury or the date on which the claim is filed.**

40 **(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.268 by**  
41 **sections 4 and 5 of this 2022 Act do not apply to disputes in which a final determination is**  
42 **made prior to January 1, 2024.**