

House Bill 4138

Sponsored by Representative GRAYBER, Senator JAMA; Representatives CAMPOS, MEEK, RUIZ, SANCHEZ, VALDERRAMA, WITT, Senators LIEBER, MANNING JR (Presession 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 **as introduced**.

Amends provisions of workers' compensation law related to payments of benefits, notice to workers, recovery of overpayments and errors in claims processing.

A BILL FOR AN ACT

1
2 Relating to workers' compensation benefits; amending ORS 656.262, 656.268 and 656.319.

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

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

5 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
6 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
7 claims as required in this chapter.

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

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

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

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

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

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

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

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

24 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
25 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-
26 bility, if the attending physician or nurse practitioner authorized to provide compensable medical
27 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-
28 after, temporary disability compensation shall be paid at least once each two weeks, except where
29 the Director of the Department of Consumer and Business Services determines that payment in in-
30 stallments should be made at some other interval. The director may by rule convert monthly benefit
31 schedules to weekly or other periodic schedules.

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

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

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

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

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

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

28 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
 29 worker’s attending physician or nurse practitioner authorized to provide compensable medical ser-
 30 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
 31 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
 32 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
 33 to retroactively authorize the payment of temporary disability more than *[14 days prior to its issu-*
 34 *ance]* **60 days prior to notice provided under paragraph (j) of this subsection. This paragraph**
 35 **does not apply during periods in which compensability is in dispute.**

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

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

1 **(j) The insurer or self-insured employer may not suspend temporary disability compen-**
2 **sation without notifying the worker in writing that the temporary disability benefits will end.**
3 **Notice provided under this paragraph must be mailed within five business days of receipt of**
4 **information that temporary disability benefits will end. The notice must state the reason for**
5 **ending the temporary disability benefits.**

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

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

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

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

1 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
 2 a copy of the notice of acceptance.

3 (b) The notice of acceptance shall:

4 (A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 44 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 45 claims as required in this chapter.

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

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

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

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

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

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

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

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

17 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
 18 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-
 19 bility, if the attending physician or nurse practitioner authorized to provide compensable medical
 20 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-
 21 after, temporary disability compensation shall be paid at least once each two weeks, except where
 22 the Director of the Department of Consumer and Business Services determines that payment in in-
 23 stallments should be made at some other interval. The director may by rule convert monthly benefit
 24 schedules to weekly or other periodic schedules.

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

29 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
 30 injured in the course and scope of that public office, full official salary paid to the holder of that
 31 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
 32 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public
 33 office" has the meaning for that term provided in ORS 260.005.

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

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

1 appointment.

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

7 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
 8 worker's attending physician or nurse practitioner authorized to provide compensable medical ser-
 9 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
 10 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
 11 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
 12 to retroactively authorize the payment of temporary disability more than *[14 days prior to its issu-*
 13 *ance]* **60 days prior to notice provided under paragraph (j) of this subsection. This paragraph**
 14 **does not apply during periods in which compensability is in dispute.**

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

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

25 **(j) The insurer or self-insured employer may not suspend temporary disability compen-**
 26 **sation without notifying the worker in writing that the temporary disability benefits will end.**
 27 **Notice provided under this paragraph must be mailed within five business days of receipt of**
 28 **information that temporary disability benefits will end. The notice must state the reason for**
 29 **ending the temporary disability benefits.**

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

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

45 (c) The adjusted amount established under paragraph (b) of this subsection shall be effective on

1 January 1 following the establishment of the amount and shall apply to claims with a date of injury
 2 on or after the effective date of the adjusted amount.

3 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
 4 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
 5 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
 6 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
 7 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
 8 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
 9 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
 10 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
 11 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
 12 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
 13 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
 14 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
 15 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
 16 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
 17 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
 18 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured
 19 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
 20 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
 21 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
 22 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
 23 payable from the date any such benefits were terminated under the denial. Except as provided in
 24 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
 25 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
 26 a copy of the notice of acceptance.

27 (b) The notice of acceptance shall:

28 (A) Specify what conditions are compensable.

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

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

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

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

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

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

44 (d) An injured worker who believes that a condition has been incorrectly omitted from a notice
 45 of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the

1 insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The
2 insurer or self-insured employer has 60 days from receipt of the communication from the worker to
3 revise the notice or to make other written clarification in response. A worker who fails to comply
4 with the communication requirements of this paragraph or ORS 656.267 may not allege at any
5 hearing or other proceeding on the claim a de facto denial of a condition based on information in
6 the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other pro-
7 vision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

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

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

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

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

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

41 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
42 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
43 the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the
44 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
45 rector, an Administrative Law Judge, the board or the court under this section shall be reasonable

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

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

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

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

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

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

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

45 (15) If the director finds that a worker fails to reasonably cooperate with an investigation in-

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

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

21 **SECTION 3.** ORS 656.268 is amended to read:

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

28 (a) The worker has become medically stationary and there is sufficient information to determine
 29 permanent disability.[:] **Notwithstanding any other provision of this chapter, no statement**
 30 **from the physician shall be effective to establish medically stationary status more than 60**
 31 **days before the worker, or the worker's attorney, if represented, is notified that the worker**
 32 **has become medically stationary.**

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

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

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

1 gainful and suitable occupation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (c) The notice of closure must inform:

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

8 (B) The worker of:

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

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

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

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

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

21 (vi) The aggravation rights; and

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

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

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

30 (A) The decision not to close;

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

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

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

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

1 seven days of the date of the notice of closure.

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

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

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

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

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

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

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

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

43 (d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be
44 completed within 18 working days from the date the reconsideration proceeding begins, and shall
45 be performed by a special evaluation appellate unit within the department. The deadline of 18

1 working days may be postponed by an additional 60 calendar days if within the 18 working days the
 2 department mails notice of review by a medical arbiter. If an order on reconsideration has not been
 3 mailed on or before 18 working days from the date the reconsideration proceeding begins, or within
 4 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was
 5 timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this sub-
 6 section, or within such additional time as provided in subsection (8) of this section when reconsi-
 7 deration is postponed further because the worker has failed to cooperate in the medical arbiter
 8 examination, reconsideration shall be deemed denied and any further proceedings shall occur as
 9 though an order on reconsideration affirming the notice of closure was mailed on the date the order
 10 was due to issue.

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

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

23 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
 24 656.283 within 30 days from the date of the reconsideration order.

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

27 (A) A request for reconsideration of a notice of closure has been made to the director within
 28 60 days of the date of the notice of closure;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 **(16) Except as provided under subsection (13) of this section, an insurer or self-insured**
45 **employer may not recover an overpayment from a worker's permanent disability compen-**

1 **sation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent**
 2 **of the worker's total award.**

3 **SECTION 4.** 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:

11 (a) The worker has become medically stationary and there is sufficient information to determine
 12 permanent disability. **Notwithstanding any other provision of this chapter, no statement from**
 13 **the physician shall be effective to establish medically stationary status more than 60 days**
 14 **before the worker, or the worker's attorney, if represented, is notified that the worker has**
 15 **become medically stationary.[;]**

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

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

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

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

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

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

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

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

41 (c) 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 modified employment, such employment is offered in writing to the worker
 44 and the worker fails to begin such employment. However, an offer of modified employment may be
 45 refused by the worker without the termination of temporary total disability benefits if the offer:

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

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

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

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

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

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

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

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

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

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

34 (c) The notice of closure must inform:

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

37 (B) The worker of:

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

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

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

44 (iv) The right of beneficiaries who were not mailed a copy of the notice of closure under para-
 45 graph (b) of this subsection to request reconsideration by the director under this section within one

1 year of the date the notice of closure was mailed to the estate of the worker under paragraph (b)
 2 of this subsection;

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

5 (vi) The aggravation rights; and

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

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

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

14 (A) The decision not to close;

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

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

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

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

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

37 (g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
 38 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
 39 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
 40 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
 41 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
 42 the claimant. If the increase in compensation results from information that the insurer or self-
 43 insured employer demonstrates the insurer or self-insured employer could not reasonably have
 44 known at the time of claim closure, from new information obtained through a medical arbiter ex-
 45 amination or from a determination order issued by the director that addresses the extent of the

1 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
 2 (4)(f), the penalty shall not be assessed.

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

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

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

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

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

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

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

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

1 of the worker or beneficiary to request reconsideration. If a party elects not to file a separate re-
 2 quest for reconsideration, the party does not waive the right to fully participate in the reconsider-
 3 ation proceeding, including the right to proceed with the reconsideration if the initiating party
 4 withdraws the request for reconsideration.

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

7 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
 8 656.283 within 30 days from the date of the reconsideration order.

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

11 (A) A request for reconsideration of a notice of closure has been made to the director within
 12 60 days of the date of the notice of closure;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (B) If the director determines that the worker failed to attend the examination without good
 44 cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall
 45 postpone the reconsideration proceedings for up to 60 days from the date of the determination that

1 the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this
 2 or any prior opening of the claim until such time as the worker attends and cooperates with the
 3 examination or the request for reconsideration is withdrawn. Any additional evidence regarding
 4 good cause must be submitted prior to the conclusion of the 60-day postponement period.

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

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

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

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

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

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

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

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

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

44 (11) If the attending physician or nurse practitioner authorized to provide compensable medical
 45 services under ORS 656.245 has approved the worker's return to work and there is a labor dispute

1 in progress at the place of employment, the worker may refuse to return to that employment without
 2 loss of reemployment rights or any vocational assistance provided by this chapter.

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

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

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

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

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

28 **(16) Except as provided under subsection (13) of this section, an insurer or self-insured**
 29 **employer may not recover an overpayment from a worker's permanent disability compen-**
 30 **sation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent**
 31 **of the worker's total award.**

32 **SECTION 5.** ORS 656.319 is amended to read:

33 656.319. (1) With respect to objection by a claimant to denial of a claim for compensation under
 34 ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

35 (a) A request for hearing is filed not later than the 60th day after the mailing of the denial to
 36 the claimant; or

37 (b) The request is filed not later than the 180th day after mailing of the denial and the claimant
 38 establishes at a hearing that there was good cause for failure to file the request by the 60th day
 39 after mailing of the denial.

40 (2) Notwithstanding subsection (1) of this section, a hearing shall be granted even if a request
 41 therefor is filed after the time specified in subsection (1) of this section if the claimant can show
 42 lack of mental competency to file the request within that time. The period for filing under this
 43 subsection shall not be extended more than five years by lack of mental competency, nor shall it
 44 extend in any case longer than one year after the claimant regains mental competency.

45 (3) With respect to subsection (2) of this section, lack of mental competency shall apply only to

1 an individual suffering from such mental disorder, mental illness or nervous disorder as is required
2 for commitment or voluntary admission to a treatment facility pursuant to ORS 426.005 to 426.223
3 and 426.241 to 426.380 and the rules of the Oregon Health Authority.

4 (4) With respect to objections to a reconsideration order under ORS 656.268, a hearing on such
5 objections shall not be granted unless a request for hearing is filed within 30 days after the copies
6 of the reconsideration order were mailed to the parties.

7 (5) With respect to objection by a claimant to a notice of refusal to close a claim under ORS
8 656.268, a hearing on the objection shall not be granted unless the request for hearing is filed within
9 60 days after copies of the notice of refusal to close were mailed to the parties.

10 [(6) *A hearing for failure to process or an allegation that the claim was processed incorrectly shall*
11 *not be granted unless the request for hearing is filed within two years after the alleged action or in-*
12 *action occurred.*]

13 [(7)] (6) With respect to objection by a claimant to a notice of closure issued under ORS 656.206,
14 a hearing on the objection shall not be granted unless the request for hearing is filed within 60 days
15 after the notice of closure was mailed to the claimant.

16
