

House Bill 3467

Sponsored by Representative GRAYBER, Senator TAYLOR

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**.

Requires employer to report to insurer any worksite accident or injury for which injured worker receives onsite treatment.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to employer's report to insurer after worksite injuries; creating new provisions; amending
3 ORS 656.262; and declaring an emergency.

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

5 **SECTION 1. (1)(a) An employer shall report any claim or accident that may result in a**
6 **compensable injury claim to the employer's insurer not later than five days after the em-**
7 **ployer received notice or otherwise knew or should have known of the claim or accident.**

8 **(b) Any accident or injury for which the injured worker receives onsite treatment from**
9 **a medical service provider described in subsection (6)(c) of this section or an emergency**
10 **medical service provider requires an employer to report to the employer's insurer in ac-**
11 **cordance with this section.**

12 **(2) The employer's report shall include:**

13 **(a) The date, time, cause and nature of the accident or injury.**

14 **(b) Whether the accident or injury arose out of and in the course of employment.**

15 **(c) Whether the employer recommends or opposes acceptance of the claim, and the rea-**
16 **sons for the employer's recommendation or opposition.**

17 **(d) The name and address of any health insurance provider for the injured worker.**

18 **(e) Any other details the insurer may require.**

19 **(3) Failure to report in accordance with this section subjects the offending employer to**
20 **a charge for reimbursing the insurer for any penalty the insurer is required to pay under**
21 **ORS 656.262 (11) because of the failure.**

22 **(4) An employer is not required to report in accordance with this section if the injured**
23 **worker requires no medical treatment, or only first aid treatment, from a medical service**
24 **provider.**

25 **(5) An employer shall inform an injured worker that:**

26 **(a) The injured worker may seek medical treatment for the accident or injury from a**
27 **medical service provider of the worker's choice;**

28 **(b) The injured worker has the right to file a claim for workers' compensation; and**

29 **(c) The injured worker's choice of medical service provider and right to file a claim for**
30 **worker's compensation are protected under ORS 659A.040.**

31 **(6) As used in this section:**

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 (a) **“First aid” means medical treatment that:**

2 (A) **Requires an injured worker to be away from work for less than an hour; and**

3 (B) **Does not require an injured worker to seek medical treatment for the same accident**
 4 **or injury more than once.**

5 (b) **“Health insurance” has the meaning given that term in ORS 731.162.**

6 (c) **“Medical service provider” includes a medical service provider who is employed by the**
 7 **employer or who provides medical treatment under an agreement with the employer.**

8 **SECTION 2.** ORS 656.262 is amended to read:

9 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 10 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 11 claims as required in this chapter.

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

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

18 [(A) *The date, time, cause and nature of the accident and injuries.*]

19 [(B) *Whether the accident arose out of and in the course of employment.*]

20 [(C) *Whether the employer recommends or opposes acceptance of the claim, and the reasons there-*
 21 *for.*]

22 [(D) *The name and address of any health insurance provider for the injured worker.*]

23 [(E) *Any other details the insurer may require.*]

24 [(b) *Failure to so report subjects the offending employer to a charge for reimbursing the insurer*
 25 *for any penalty the insurer is required to pay under subsection (11) of this section because of such*
 26 *failure. As used in this subsection, “health insurance” has the meaning for that term provided in ORS*
 27 *731.162.*]

28 **(3) Employers shall report to their insurers in accordance with section 1 of this 2023 Act**
 29 **any claims or accidents that may result in a compensable injury claim.**

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

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

42 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
 43 injured in the course and scope of that public office, full official salary paid to the holder of that
 44 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
 45 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, “public

1 office” has the meaning for that term provided in ORS 260.005.

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

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

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

20 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
21 worker’s attending physician or nurse practitioner authorized to provide compensable medical ser-
22 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
23 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
24 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
25 to retroactively authorize the payment of temporary disability more than 14 days prior to its issu-
26 ance.

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

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

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

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

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

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

34 (b) The notice of acceptance shall:

35 (A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 been formally accepted.

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

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

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

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

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

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

44 (b) If the attorney is not willing or available to participate in an interview at a time reasonably
45 chosen by the insurer or self-insured employer within 14 days of the request for interview and the

1 insurer or self-insured employer has cause to believe that the attorney's unwillingness or unavail-
 2 ability is unreasonable and is preventing the worker from complying within 14 days of the request
 3 for interview, the insurer or self-insured employer shall notify the director. If the director deter-
 4 mines that the attorney's unwillingness or unavailability is unreasonable, the director shall assess
 5 a civil penalty against the attorney of not more than \$1,000.

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

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

27 **SECTION 3.** ORS 656.262, as amended by section 1, chapter 47, Oregon Laws 2021, is amended
 28 to read:

29 656.262. (1) Processing of claims and providing compensation for a worker shall be the respon-
 30 sibility of the insurer or self-insured employer. All employers shall assist their insurers in processing
 31 claims as required in this chapter.

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

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

38 [(A) *The date, time, cause and nature of the accident and injuries.]*

39 [(B) *Whether the accident arose out of and in the course of employment.]*

40 [(C) *Whether the employer recommends or opposes acceptance of the claim, and the reasons there-*
 41 *for.]*

42 [(D) *The name and address of any health insurance provider for the injured worker.]*

43 [(E) *Any other details the insurer may require.]*

44 [(b) *Failure to so report subjects the offending employer to a charge for reimbursing the insurer*
 45 *for any penalty the insurer is required to pay under subsection (11) of this section because of such*

1 *failure. As used in this subsection, "health insurance" has the meaning for that term provided in ORS*
2 *731.162.]*

3 **(3) Employers shall report to their insurers in accordance with section 1 of this 2023 Act**
4 **any claims or accidents that may result in a compensable injury claim.**

5 (4)(a) The first installment of temporary disability compensation shall be paid no later than the
6 14th day after the subject employer has notice or knowledge of the claim and of the worker's disa-
7 bility, if the attending physician or nurse practitioner authorized to provide compensable medical
8 services under ORS 656.245 authorizes the payment of temporary disability compensation. There-
9 after, temporary disability compensation shall be paid at least once each two weeks, except where
10 the Director of the Department of Consumer and Business Services determines that payment in in-
11 stallments should be made at some other interval. The director may by rule convert monthly benefit
12 schedules to weekly or other periodic schedules.

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

17 (c) Notwithstanding any other provision of this chapter, when the holder of a public office is
18 injured in the course and scope of that public office, full official salary paid to the holder of that
19 public office shall be deemed timely payment of temporary disability payments pursuant to ORS
20 656.210 and 656.212 during the time the wage payments are made. As used in this subsection, "public
21 office" has the meaning for that term provided in ORS 260.005.

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

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

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

40 (g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the
41 worker's attending physician or nurse practitioner authorized to provide compensable medical ser-
42 vices under ORS 656.245 ceases to authorize temporary disability or for any period of time not au-
43 thorized by the attending physician or nurse practitioner. No authorization of temporary disability
44 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
45 to retroactively authorize the payment of temporary disability more than 14 days prior to its issu-

1 ance.

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

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

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

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

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

30 (6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by
31 the insurer or self-insured employer within 60 days after the employer has notice or knowledge of
32 the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke accept-
33 ance except as provided in this section. The insurer or self-insured employer may revoke acceptance
34 and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal ac-
35 tivity by the worker. If the worker requests a hearing on any revocation of acceptance and denial
36 alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has
37 the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other
38 illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance
39 of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a
40 claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the
41 worker, and later obtains evidence that the claim is not compensable or evidence that the insurer
42 or self-insured employer is not responsible for the claim, the insurer or self-insured employer may
43 revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of ac-
44 ceptance and denial is issued no later than two years after the date of the initial acceptance. If the
45 worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured

1 employer must prove, by a preponderance of the evidence, that the claim is not compensable or that
 2 the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other
 3 provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative
 4 Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are
 5 payable from the date any such benefits were terminated under the denial. Except as provided in
 6 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
 7 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
 8 a copy of the notice of acceptance.

9 (b) The notice of acceptance shall:

10 (A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

45 (c) When an insurer or self-insured employer determines that the claim qualifies for claim clo-

1 sure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-
2 ance that specifies which conditions are compensable. The procedures specified in subsection (6)(d)
3 of this section apply to this notice. Any objection to the updated notice or appeal of denied condi-
4 tions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable
5 after claim closure, the insurer or self-insured employer shall reopen the claim for processing re-
6 garding that condition.

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

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

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

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

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

42 (12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the
43 insurer or self-insured employer has failed to make the payment in accordance with the requirements
44 specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly no-
45 tify the insurer or self-insured employer in writing that the payment is past due. If the required

1 payment is not made within five business days after receipt of the notice by the insurer or self-
2 insured employer, the director may assess a penalty and attorney fee in accordance with a matrix
3 adopted by the director by rule.

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

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

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

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

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

44 (16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for
45 hearing for a claim for compensation involving more than one potentially responsible employer or

insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (14) of this section.

SECTION 4. ORS 656.262, as amended by section 1, chapter 47, Oregon Laws 2021, and section 2, chapter 73, Oregon Laws 2022, is amended to read:

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

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

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

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

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

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

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

[(E) Any other details the insurer may require.]

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

(3) Employers shall report to their insurers in accordance with section 1 of this 2023 Act any claims or accidents that may result in a compensable injury claim.

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

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

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

(d) Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 verification of

1 the worker's inability to work resulting from the claimed injury or disease and the physician or
 2 nurse practitioner cannot verify the worker's inability to work, unless the worker has been unable
 3 to receive treatment for reasons beyond the worker's control.

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

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

16 (g)(A) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after
 17 the worker's attending physician or nurse practitioner authorized to provide compensable medical
 18 services under ORS 656.245 ceases to authorize temporary disability or for any period of time not
 19 authorized by the attending physician or nurse practitioner. No authorization of temporary disability
 20 compensation by the attending physician or nurse practitioner under ORS 656.268 shall be effective
 21 to retroactively authorize the payment of temporary disability more than 45 days prior to its issu-
 22 ance.

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

24 (i) During periods in which there is a denial under the jurisdiction of the Workers' Compensa-
 25 tion Board that affects the worker's ability to obtain authorization of temporary disability;

26 (ii) During periods in which there is a dispute over the identity of, or treatment by, an attending
 27 physician or nurse practitioner that affects the worker's ability to obtain authorization of temporary
 28 disability; or

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

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

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

40 (j)(A) The insurer or self-insured employer may not end temporary disability benefits until writ-
 41 ten notice has been mailed or delivered to the worker and the worker's attorney, if the worker is
 42 represented. The notice must state the reason that temporary disability benefits are no longer due
 43 and payable.

44 (B) The worker's attending physician or nurse practitioner may retroactively authorize tempo-
 45 rary disability for up to 45 days prior to the date of the notice.

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

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

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

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

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

1 ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not
 2 include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer
 3 a copy of the notice of acceptance.

4 (b) The notice of acceptance shall:

5 (A) Specify what conditions are compensable.

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

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

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

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

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

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

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

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

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

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

1 guarding that condition.

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

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

11 (10) Merely paying or providing compensation shall not be considered acceptance of a claim or
 12 an admission of liability, nor shall mere acceptance of such compensation be considered a waiver
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 15 of such an order or notice of closure, shall not preclude an insurer or self-insured employer from
 16 subsequently contesting the compensability of the condition rated therein, unless the condition has
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18 (11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to
 19 pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim,
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 21 amounts then due plus any attorney fees assessed under this section. The fees assessed by the di-
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 24 shall consider the proportionate benefit to the injured worker. The board shall adopt rules for es-
 25 tablishing the amount of the attorney fee, giving primary consideration to the results achieved and
 26 to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed
 27 \$4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under
 28 this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the
 29 average weekly wage defined in ORS 656.211, if any. Notwithstanding any other provision of this
 30 chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assess-
 31 ment and payment of the additional amount and attorney fees described in this subsection. The
 32 action of the director and the review of the action taken by the director shall be subject to review
 33 under ORS 656.704.

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

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

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

1 of the settlement proceeds allocated to the claimant and for attorney fees based on a percentage of
 2 the settlement proceeds allocated to the claimant's attorney as an attorney fee.

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

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

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

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 23 volving an initial claim to establish a compensable injury or an aggravation claim to reopen the
 24 claim for a worsened condition, the director shall suspend all or part of the payment of compen-
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 29 worker shall not be granted a hearing or other proceeding under this chapter on the merits of the
 30 claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291
 31 that the worker fully and completely cooperated with the investigation, that the worker failed to
 32 cooperate for reasons beyond the worker's control or that the investigative demands were unrea-
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 34 ministrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain
 35 denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investi-
 36 gative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order
 37 the reinstatement of interim compensation if appropriate and remand the claim to the insurer or
 38 self-insured employer to accept or deny the claim.

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

43 **SECTION 5. Section 1 of this 2023 Act and the amendments to ORS 656.262 by sections**
 44 **2 to 4 of this 2023 Act apply to accidents and injuries that occur on or after the effective date**
 45 **of this 2023 Act.**

1 **SECTION 6. This 2023 Act being necessary for the immediate preservation of the public**
2 **peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect**
3 **on its passage.**

4
