Chapter 656

2015 EDITION

Workers' Compensation

GENERAL PROVISIONS

656.001 Short title. This chapter may be cited as the Workers' Compensation Law. [1965 c.285 §1; 1977 c.109 §1]

656.002 [Amended by 1957 c.718 §1; 1959 c.448 §1; 1965 c.285 §4; 1967 c.341 §2; 1969 c.125 §1; 1969 c.247 §1; 1973 c.497 §1; 1973 c.620 §1; repealed by 1975 c.556 §1 (656.003 and 656.005 enacted in lieu of 656.002)]

656.003 Application of definitions to construction of chapter. Except where the context otherwise requires, the definitions given in this chapter govern its construction. [1975 c.556 §2 (enacted in lieu of 656.002)]

656.004 [Repealed by 1981 c.535 §28 (656.012 enacted in lieu of 656.004)]

656.005 Definitions. (1) "Average weekly wage" means the Oregon average weekly wage in covered employment, as determined by the Employment Department, for the last quarter of the calendar year preceding the fiscal year in which the injury occurred.

(2) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent of a worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

(a) A spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time received or attempted by process of law to collect funds for support or maintenance is considered living in a state of abandonment.

(b) A person who intentionally causes the compensable injury to or death of an injured worker.

(3) "Board" means the Workers' Compensation Board.

(4) "Carrier-insured employer" means an employer who provides workers' compensation coverage with the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

(5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, a child born out of wedlock and a stepchild, if such stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. A dependent child who is an invalid is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, a dependent child who is an invalid is considered to be a child under 18 years of age.

(6) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

(b) "Compensable injury" does not include:

(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties;

(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

(C) Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption.

(c) A "disabling compensable injury" is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury.

(d) A "nondisabling compensable injury" is any injury which requires medical services only.

(8) "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Parent, grandparent, stepparent, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than parent, spouse in a marriage or children are not included within the term "dependent."

(11) "Director" means the Director of the Department of Consumer and Business Services.

(12)(a) "Doctor" or "physician" means a person duly licensed to practice one or more of the healing arts in any country or in any state, territory or possession of the United States within the limits of the license of the licentiate.

(b) Except as otherwise provided for workers subject to a managed care contract, "attending physician" means a doctor, physician or physician assistant who is primarily responsible for the treatment of a worker's compensable injury and who is:

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first, to any of the medical service providers listed in this subparagraph, a:

(i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

(ii) Physician assistant licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory or possession of the United States; or

(iii) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

(c) Except as otherwise provided for workers subject to a managed care contract, "attending physician" does not include a physician who provides care in a hospital emergency room and refers the injured worker to a primary care physician for follow-up care and treatment.

(d) "Consulting physician" means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 regarding treatment of a worker's compensable injury.

(13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, who contracts to pay a remuneration for and secures the right to direct and control the services of any person.

(b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of a temporary service provider is not the employer of temporary workers provided by the temporary service provider.

(c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning for that term provided in ORS 656.850.

(14) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

(15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.

(16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

(17) "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time.

(18) "Noncomplying employer" means a subject employer who has failed to comply with ORS 656.017.

(19) "Objective findings" in support of medical evidence are verifiable indications of injury or disease that may include, but are

not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. "Objective findings" does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable.

(20) "Palliative care" means medical service rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal or permanently alleviate or eliminate a medical condition.

(21) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer.

(22) "Payroll" means a record of wages payable to workers for their services and includes commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. However, "payroll" does not include overtime pay, vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments to reward workers for safe working practices. Bonus pay is limited to payments which are not anticipated under the contract of employment and which are paid at the sole discretion of the employer. The exclusion from payroll of bonus payments to reward workers for safe working practices is only for the purpose of calculations based on payroll to determine premium for workers' compensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter.

(23) "Person" includes partnership, joint venture, association, limited liability company and corporation.

(24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment, provided that:

(A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the worker has been diagnosed with such condition, or has obtained medical services for the symptoms of the condition regardless of diagnosis; and

(B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes the initial injury;

(ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the new medical condition; or

(iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment precedes the onset of the worsened condition.

(b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim for worsening in such claims pursuant to ORS 656.273 or 656.278.

(c) For the purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury.

(25) "Self-insured employer" means an employer or group of employers certified under ORS 656.430 as meeting the qualifications set out by ORS 656.407.

(26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident Insurance Fund Corporation created under ORS 656.752.

(27) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

(28) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

(29) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

(30) "Worker" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assist-

ance grant. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

(31) "Independent contractor" has the meaning for that term provided in ORS 670.600. [1975 c.556 §§3 to 19 (enacted in lieu of 656.002); 1977 c.109 §2; 1977 c.804 §1; 1979 c.839 §26; 1981 c.535 §30; 1981 c.723 §3; 1981 c.854 §2; 1983 c.740 §242; 1985 c.212 §1; 1985 c.507 §1; 1985 c.770 §1; 1987 c.373 §31; 1987 c.457 §1; 1987 c.713 §3; 1987 c.884 §25; 1989 c.762 §3; 1990 c.2 §3; 1993 c.739 §23; 1993 c.744 §18; 1995 c.93 §31; 1995 c.332 §1; 1997 c.491 §5; 2001 c.865 §1; 2003 c.811 §§1,2; 2007 c.241 §§6,7; 2007 c.252 §§1,2; 2007 c.365 §1; 2007 c.505 §§1,2; 2009 c.43 §§6,7; 2011 c.117 §1; 2015 c.629 §53]

Note: See notes under 656.202.

656.006 Effect on employers' liability law. This chapter does not abrogate the rights of the employee under the present employers' liability law, in all cases where the employee, under this chapter is given the right to bring suit against the employer of the employee for an injury.

656.008 Extension of laws relating to workers' compensation to federal lands and projects within state. Where not inconsistent with the Constitution and laws of the United States, the laws of this state relating to workers' compensation and the duties and powers of the Department of Consumer and Business Services hereby are extended to all lands and premises owned or held by the United States of America by deed or act of cession, by purchase or otherwise, which are within the exterior boundaries of the State of Oregon and to all projects, buildings, constructions, improvements and all property belonging to the United States within the exterior boundaries of the State of Oregon in the same way and to the same extent as if said premises and property were under the exclusive jurisdiction of the State of Oregon. [Amended by 1977 c.804 §2]

656.010 Treatment by spiritual means. Nothing in this chapter shall be construed to require a worker who in good faith relies on or is treated by prayer or spiritual means by a duly accredited practitioner of a well-recognized church to undergo any medical or surgical treatment nor shall such worker or the dependents of the worker be deprived of any compensation payments to which the worker would have been entitled if medical or surgical treatment were employed, and the employer or insurance carrier may pay for treatment by prayer or spiritual means. [1965 c.285 §41c]

656.012 Findings and policy. (1) The Legislative Assembly finds that:

(a) The performance of various industrial enterprises necessary to the enrichment and economic well-being of all the citizens of this state will inevitably involve injury to some of the workers employed in those enterprises;

(b) The method provided by the common law for compensating injured workers involves long and costly litigation, without commensurate benefit to either the injured workers or the employers, and often requires the taxpayer to provide expensive care and support for the injured workers and their dependents; and

(c) An exclusive, statutory system of compensation will provide the best societal measure of those injuries that bear a sufficient relationship to employment to merit incorporation of their costs into the stream of commerce.

(2) In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable, while providing for access to adequate representation for injured workers;

(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable;

(d) To encourage maximum employer implementation of accident study, analysis and prevention programs to reduce the economic loss and human suffering caused by industrial accidents; and

(e) To provide the sole and exclusive source and means by which subject workers, their beneficiaries and anyone otherwise entitled to receive benefits on account of injuries or diseases arising out of and in the course of employment shall seek and qualify for remedies for such conditions.

(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner. [1981 c.535 §29 (enacted in lieu of 656.004); 1995 c.332 §4; amendments by 1995 c.332 §4a repealed by 1999 c.6 §1; amendments by 1999 c.6 §3 repealed by 2001 c.865 §23; 2015 c.521 §1]

Note: Section 11, chapter 521, Oregon Laws 2015, provides:

Sec. 11. Section 10 of this 2015 Act [656.383] and the amendments to ORS 656.012, 656.262, 656.277, 656.313,

656.382, 656.385, 656.386 and 656.388 by sections 1 to 8 of this 2015 Act apply to orders issued and attorney fees incurred on or after the effective date of this 2015 Act [January 1, 2016], regardless of the date on which the claim was filed. [2015 c.521 §11]

Note: See notes under 656.202.

656.016 [1965 c.285 §5; 1967 c.341 §3; repealed by 1975 c.556 §20 (656.017 enacted in lieu of 656.016)]

COVERAGE

656.017 Employer required to pay compensation and perform other duties; state not authorized to be direct responsibility employer. (1) Every employer subject to this chapter shall maintain assurance with the Director of the Department of Consumer and Business Services that subject workers of the employer and their beneficiaries will receive compensation for compensable injuries as provided by this chapter and that the employer will perform all duties and pay other obligations required under this chapter, by qualifying:

(a) As a carrier-insured employer; or

(b) As a self-insured employer as provided by ORS 656.407.

(2) Notwithstanding ORS chapter 278, this state shall provide compensation insurance for its employees through the State Accident Insurance Fund Corporation.

(3) Any employer required by the statutes of this state other than this chapter or by the rules, regulations, contracts or procedures of any agency of the federal government, this state or a political subdivision of this state to provide or agree to provide workers' compensation coverage, either directly or through bond requirements, may provide such coverage by any method provided in this section. [1975 c.556 §21 (enacted in lieu of 656.016); 1977 c.659 §1; 1979 c.815 §1; 1981 c.854 §3; 1985 c.731 §30]

656.018 Effect of providing coverage; exclusive remedy. (1)(a) The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter.

(b) This subsection shall not apply to claims for indemnity or contribution asserted by a railroad, as defined in ORS 824.020, or by a corporation, individual or association of individuals which is subject to regulation pursuant to ORS chapter 757 or 759.

(c) Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.

(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment are in lieu of any remedies they might otherwise have for such injuries, diseases, symptom complexes or similar conditions against the worker's employer under ORS 654.305 to 654.336 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury, disease, symptom complex or similar condition.

(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the Department of Consumer and Business Services, and to the contracted agents, employees, partners, limited liability company members, general partners, limited liability partners, limited partners, officers and directors of the employer, the employer's insurer, the self-insured employer's claims administrator and the department, except that the exemption from liability shall not apply:

(a) If the willful and unprovoked aggression by a person otherwise exempt under this subsection is a substantial factor in causing the injury, disease, symptom complex or similar condition;

(b) If the worker and the person otherwise exempt under this subsection are not engaged in the furtherance of a common enterprise or the accomplishment of the same or related objectives;

(c) If the failure of the employer to comply with a notice posted pursuant to ORS 654.082 is a substantial factor in causing the injury, disease, symptom complex or similar condition; or

(d) If the negligence of a person otherwise exempt under this subsection is a substantial factor in causing the injury, disease, symptom complex or similar condition and the negligence occurs outside of the capacity that qualifies the person for exemption under this section.

(4) The exemption from liability given an employer under this section applies to a worker leasing company and the client to whom workers are provided when the worker

leasing company and the client comply with ORS 656.850 (3).

(5)(a) The exemption from liability given an employer under this section applies to a temporary service provider, as that term is used in ORS 656.850, and also extends to the client to whom workers are provided when the temporary service provider complies with ORS 656.017.

(b) The exemption from liability given a client under paragraph (a) of this subsection is also extended to the client's insurer, the self-insured client's claims administrator, the department, and the contracted agents, employees, officers and directors of the client, the client's insurer, the self-insured client's claims administrator and the department, except that the exemption from liability shall not apply:

(A) If the willful and unprovoked aggression by a person otherwise exempt under this subsection is a substantial factor in causing the injury, disease, symptom complex or similar condition;

(B) If the worker and the person otherwise exempt under this subsection are not engaged in the furtherance of a common enterprise or the accomplishment of the same or related objectives;

(C) If the failure of the client to comply with a notice posted pursuant to ORS 654.082 is a substantial factor in causing the injury, disease, symptom complex or similar condition; or

(D) If the negligence of a person otherwise exempt under this subsection is a substantial factor in causing the injury, disease, symptom complex or similar condition and the negligence occurs outside of the capacity that qualifies the person for exemption under this subsection.

(6) Nothing in this chapter shall prohibit payment, voluntarily or otherwise, to injured workers or their beneficiaries in excess of the compensation required to be paid under this chapter.

(7) The exclusive remedy provisions and limitation on liability provisions of this chapter apply to all injuries and to diseases, symptom complexes or similar conditions of subject workers arising out of and in the course of employment whether or not they are determined to be compensable under this chapter. [1965 c.285 §6; 1975 c.115 §1; 1977 c.514 §1; 1977 c.804 §3a; 1987 c.447 §110; 1989 c.600 §1; 1993 c.628 §6; 1995 c.332 §5; amendments by 1995 c.332 §5a repealed by 1999 c.6 §1; 1995 c.733 §76; 1997 c.275 §§6,7; 1997 c.491 §§1,2; amendments by 1999 c.6 §4 repealed by 2001 c.865 §23; 2013 c.488 §1]

Note: See notes under 656.202.

656.019 Civil negligence action for claim denied on basis of failure to meet major contributing cause standard; statute of limitations. (1)(a) An injured worker may pursue a civil negligence action for a work-related injury that has been determined to be not compensable because the worker has failed to establish that a work-related incident was the major contributing cause of the worker's injury only after an order determining that the claim is not compensable has become final. The injured worker may appeal the compensability of the claim as provided in ORS 656.298, but may not pursue a civil negligence claim against the employer until the order affirming the denial has become final.

(b) Nothing in this subsection grants a right for a person to pursue a civil negligence action that does not otherwise exist in law.

(2)(a) Notwithstanding any other statute of limitation provided in law, a civil negligence action against an employer that arises because a workers' compensation claim has been determined to be not compensable because the worker has failed to establish that a work-related incident was the major contributing cause of the worker's injury must be commenced within the later of two years from the date of injury or 180 days from the date the order affirming that the claim is not compensable on such grounds becomes final.

(b) Notwithstanding paragraph (a) of this subsection, a person may not commence a civil negligence action for a work-related injury that has been determined to be not compensable because the worker has failed to establish that a work-related incident was the major contributing cause of the worker's injury, if the period within which such action may be commenced has expired prior to the filing of a timely workers' compensation claim for the work-related injury. [2001 c.865 §15]

656.020 Damage actions by workers against noncomplying employers; defenses outlawed. Actions for damages may be brought by an injured worker or the legal representative of the injured worker against any employer who has failed to comply with ORS 656.017 or is in default under ORS 656.560. Except for the provisions of ORS 656.578 to 656.593 and this section, such noncomplying employer is liable as the noncomplying employer would have been if this chapter had never been enacted. In such actions, it is no defense for the employer to show that:

(1) The injury was caused in whole or in part by the negligence of a fellow-servant of the injured worker.

(2) The negligence of the injured worker, other than a willful act committed for the purpose of sustaining the injury, contributed to the accident.

(3) The injured worker had knowledge of the danger or assumed the risk that resulted in the injury. [1965 c.285 §7]

656.021 Person performing work under ORS chapter 701 as subject employer. Notwithstanding ORS 656.029 (1), a person who is licensed pursuant to an application under ORS 701.046 and is acting under a contract to perform work described by ORS chapter 701 shall be considered the subject employer for all individuals employed by that person. [1989 c.870 §13; 1999 c.402 §7; 2007 c.836 §48]

656.022 [Repealed by 1965 c.285 §95]

656.023 Who are subject employers. Every employer employing one or more subject workers in the state is subject to this chapter. [1965 c.285 §8]

656.024 [Amended by 1959 c.448 §2; repealed by 1965 c.285 §95]

656.025 Individuals engaged in commuter ridesharing not subject workers; conditions. (1) For the purpose of this chapter, an individual is not a subject worker while commuting in a voluntary commuter ridesharing arrangement unless:

(a) The worker is reimbursed for travel expenses incurred therein;

(b) The worker receives payment for commuting time from the employer; or

(c) The employer makes an election to provide coverage for the worker pursuant to ORS 656.039.

(2) As used in this section "voluntary commuter ridesharing arrangement" means a carpool or vanpool arrangement in which participation is not required as a condition of employment and in which not more than 15 persons are transported to and from their places of employment, in a single daily round trip where the driver also is on the way to or from the driver's place of employment. [1981 c.227 §4]

656.026 [Amended by 1957 c.440 §1; 1959 c.448 §3; repealed by 1965 c.285 §95]

656.027 Who are subject workers. All workers are subject to this chapter except those nonsubject workers described in the following subsections:

(1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection "domestic servant" means any worker engaged in household domestic service by private employment contract, including, but not limited to, home health workers.

(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker.

(3)(a) A worker whose employment is casual and either:

(A) The employment is not in the course of the trade, business or profession of the employer; or

(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

(b) For the purpose of this subsection, "casual" refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $500.

(4) A person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States.

(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state.

(6) Firefighter and police employees of any city having a population of more than 200,000 that provides a disability and retirement system by ordinance or charter.

(7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor.

(b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor must qualify as an independent contractor. Any sole proprietor licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(8) Except as provided in subsection (23) of this section, partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor.

(9) Except as provided in subsection (25) of this section, members, including members who are managers, of limited liability companies, regardless of the nature of the work performed. However, members, including members who are managers, of limited liability companies with more than one member, while engaged in work performed in direct connection with the construction, al-

teration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, are subject workers. When labor or services are performed under contract, the limited liability company must qualify as an independent contractor.

(10) Except as provided in subsection (24) of this section, corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers, subject to the following limitations:

(a) If the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS chapter 308A, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption.

(b) If the activities of the corporation involve the commercial harvest of timber and all officers of the corporation are members of the same family and are parents, daughters or sons, daughters-in-law or sons-in-law or grandchildren, then all such officers may elect to be nonsubject workers. For all other corporations involving the commercial harvest of timber, the maximum number of exempt corporate officers for the corporation shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor.

(11) A person performing services primarily for board and lodging received from any religious, charitable or relief organization.

(12) A newspaper carrier utilized in compliance with the provisions of ORS 656.070 and 656.075.

(13) A person who has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for performance of services as an athlete other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance, or any amateur sports official who is certified by a recognized Oregon or national certifying authority, which requires or provides liability and accident insurance for such officials. A roster of recognized Oregon and national certifying authorities will be maintained by the Department of Consumer and Business Services, from lists of certifying organizations submitted by the Oregon School Activities Association and the Oregon Park and Recreation Society.

(14) Volunteer personnel participating in the ACTION programs, organized under the Domestic Volunteer Service Act of 1973, P.L. 93-113, known as the Foster Grandparent Program and the Senior Companion Program, whether or not the volunteers receive a stipend or nominal reimbursement for time and travel expenses.

(15) A person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment. As used in this subsection "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or piling.

(b) A motor vehicle used in the transportation of rocks, gravel, sand, dirt or asphalt concrete.

(c) A motor vehicle used in the transportation of property by a for-hire motor carrier that is required under ORS 825.100 or 825.104 to possess a certificate or permit or to be registered.

(16) A person engaged in the transportation of the public for recreational down-river boating activities on the waters of this state pursuant to a federal permit when the person furnishes the equipment necessary for the activity. As used in this subsection, "recreational down-river boating activities" means those boating activities for the purpose of recreational fishing, swimming or sightseeing utilizing a float craft with oars or paddles as the primary source of power.

(17) A person who receives no wage other than ski passes or other noncash remuneration for performing volunteer:

(a) Ski patrol activities; or

(b) Ski area program activities sponsored by a ski area operator, as defined in ORS 30.970, or by a nonprofit corporation or organization.

(18) A person 19 years of age or older who contracts with a newspaper publishing company or independent newspaper dealer or contractor to distribute newspapers to the general public and perform or undertake any necessary or attendant functions related thereto.

(19) A person performing foster parent or adult foster care duties pursuant to ORS 412.001 to 412.161 and 412.991 or ORS chapter 411, 418, 430 or 443.

(20) A person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or

nominal reimbursements or vouchers for meals, lodging or expenses.

(21) A person performing services under a property tax work-off program established under ORS 310.800.

(22) A person who performs service as a caddy at a golf course in an established program for the training and supervision of caddies under the direction of a person who is an employee of the golf course.

(23)(a) Partners who are actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in a partnership. If all partners are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such partners may elect to be nonsubject workers. For all other partnerships licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt partners shall be whichever is the greater of the following:

(A) Two partners; or

(B) One partner for each 10 partnership employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the partnership qualifies as an independent contractor. Any partnership licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(24)(a) Corporate officers who are directors of a corporation actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed. If all officers of the corporation are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such officers may elect to be nonsubject workers. For all other corporations licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt corporate officers shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the corporation qualifies as an independent contractor. Any corporation licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(25)(a) Limited liability company members who are members of a company actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the company, regardless of the nature of the work performed. If all members of the company are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such members may elect to be nonsubject workers. For all other companies licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt company members shall be whichever is the greater of the following:

(A) Two company members; or

(B) One company member for each 10 company employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the company qualifies as an independent contractor. Any company licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(26) A person serving as a referee or assistant referee in a youth or adult recreational soccer match whose services are retained on a match-by-match basis.

(27) A person performing language translator or interpreter services that are provided for others through an agent or broker.

(28) A person who operates, and who has an ownership or leasehold interest in, a passenger motor vehicle that is operated as a taxicab or for nonemergency medical transportation. As used in this subsection:

(a) "Lease" means a contract under which the lessor provides a vehicle to a lessee for consideration.

(b) "Leasehold" includes, but is not limited to, a lease for a shift or a longer period.

(c) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers or to provide errand services to locations selected by the third party.

(d) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district. [1965 c.285 §9; 1971 c.386 §1; 1977 c.683 §1; 1977 c.817 §2; 1977 c.835 §7; 1979 c.821 §1; 1981 c.225 §1; 1981 c.444 §1; 1981 c.535 §3; 1981 c.839 §1; 1983 c.341 §1; 1983 c.541 §1; 1983 c.579 §3; 1985 c.431 §1; 1985 c.706 §2; 1987 c.94 §168; 1987 c.414 §161; 1987 c.800 §2; 1989 c.762 §4; 1990 c.2 §4; 1991 c.469 §1; 1991 c.707 §1; 1993 c.18 §138a; 1993 c.494 §2; 1993 c.777 §10; 1995 c.93 §32; 1995 c.216 §§3,3a; 1995 c.332 §6; 1997 c.337 §1; 1999 c.314 §91; 1999 c.402 §8; 2001 c.363 §1; 2001 c.765 §4; 2003 c.677 §1; 2005 c.167 §1; 2007 c.465 §6; 2007 c.541 §9; 2007 c.721 §1; 2007 c.836 §49; 2008 c.32 §§2,3]

656.028 [Amended by 1959 c.448 §4; repealed by 1965 c.285 §95]

656.029 Obligation of person awarding contract to provide coverage for workers under contract; exceptions; effect of failure to provide coverage. (1) If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer.

(2) If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation insurance coverage for all such individuals. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer.

(3) As used in this section:

(a) "Person" includes partnerships, joint ventures, associations, corporations, limited liability companies, governmental agencies and sole proprietorships.

(b) "Sole proprietorship" means a business entity or individual who performs labor without the assistance of others. [1979 c.864 §2; 1981 c.725 §1; 1981 c.854 §4; 1983 c.397 §1; 1983 c.579 §2a; 1985 c.706 §1; 1989 c.762 §5; 1995 c.93 §34; 1995 c.332 §6a]

656.030 [Repealed by 1959 c.448 §14]

656.031 Coverage for municipal volunteer personnel. (1) Except as provided in ORS 404.215, all municipal personnel, other than those employed full-time, part-time, or substitutes therefor, shall, for the purpose of this chapter, be known as volunteer personnel and shall not be considered as workers unless the municipality has filed the election provided by this section.

(2) The county, city or other municipality utilizing volunteer personnel as specified in subsection (1) of this section may elect to have such personnel considered as subject workers for purposes of this chapter. Such election shall be made by filing a written application to the insurer, or in the case of a self-insured employer, the Director of the Department of Consumer and Business Services, that includes a resolution of the governing body declaring its intent to cover volunteer personnel as provided in subsection (1) of this section and a description of the work to be performed by such personnel. The application shall also state the estimated total number of volunteer personnel on a roster for each separate category for which coverage is elected. The county, city or other municipality shall notify the insurer, or in the case of self-insurers, the director, of changes in the estimated total number of volunteers.

(3) Upon receiving the written application the insurer or self-insured employer may fix assumed wage rates for the volunteer personnel, which may be used only for purposes of computations under this chapter, and shall require the regular payment of premiums or assessments based upon the estimated total numbers of such volunteers carried on the roster for each category being covered. The self-insured employer shall submit such assumed wage rates to the director. If the director finds that the rates are unreasonable, the director may fix appropriate rates to be used for purposes of this section.

(4) The county, city or municipality shall maintain separate official membership rosters for each category of volunteers. A certi-

fied copy of the official membership roster shall be furnished the insurer or director upon request. Persons covered under this section are entitled to the benefits of this chapter and they are entitled to such benefits if injured as provided in ORS 656.202 while performing any duties arising out of and in the course of their employment as volunteer personnel, if the duties being performed are among those:

(a) Described on the application of the county, city or municipality; and

(b) Required of similar full-time paid employees.

(5) The filing of claims for benefits under this section is the exclusive remedy of a volunteer or a beneficiary of the volunteer for injuries compensable under this chapter against the state, its political subdivisions, their officers, employees, or any employer, regardless of negligence. [Formerly 656.088; 1969 c.527 §1; 1977 c.72 §1; 1979 c.815 §2; 1981 c.854 §5; 1981 c.874 §1; 2009 c.718 §14a]

656.032 [Amended by 1959 c.451 §1; repealed by 1965 c.285 §95]

656.033 Coverage for participants in work experience or school directed professional training programs. (1) All persons participating as trainees in a work experience program or school directed professional education project of a school district as defined in ORS 332.002 in which such persons are enrolled, including persons with mental retardation in training programs, are considered as workers of the district subject to this chapter for purposes of this section. Trainees placed in a work experience program with their resident school district as the training employer shall be subject workers under this section when the training and supervision are performed by noninstructional personnel.

(2) A school district conducting a work experience program or school directed professional education project shall submit a written statement to the insurer, or in the case of self-insurers, the Director of the Department of Consumer and Business Services, that includes a description of the work to be performed by such persons and an estimate of the total number of persons enrolled.

(3) The premium cost for coverage under this section shall be based on an assumed hourly wage which is approved by the Director of the Department of Consumer and Business Services. Such assumed wage is to be used only for calculation purposes under this chapter and without regard to ORS chapter 652 or ORS 653.010 to 653.565 and 653.991. A self-insured district shall submit such assumed wage rates to the director. If the director finds that the rates are unreasonable, the director may fix appropriate rates to be used for purposes of this section.

(4) The school district shall furnish the insurer, or in the case of self-insurers, the director, with an estimate of the total number of persons enrolled in its work experience program or school directed professional education project and shall notify the insurer or director of any significant changes therein. Persons covered under this section are entitled to the benefits of this chapter. However, such persons are not entitled to benefits under ORS 656.210 or 656.212. They are entitled to such benefits if injured as provided in ORS 656.156 and 656.202 while performing any duties arising out of and in the course of their participation in the work experience program or school directed professional education project, provided the duties being performed are among those:

(a) Described on the application of the school district; and

(b) Required of similar full-time paid employees.

(5) The filing of claims for benefits under this section is the exclusive remedy of a trainee or a beneficiary of the trainee for injuries compensable under this chapter against the state, its political subdivisions, the school district board, its members, officers and employees, or any employer, regardless of negligence.

(6) The provisions of this section shall be inapplicable to any trainee who has earned wages for such employment.

(7) As used in this section, "school directed professional education project" means an on-campus or off-campus project supervised by school personnel and which is an assigned activity of a local professional education program approved pursuant to operating procedures of the State Board of Education. A school directed professional education project must be of a practicum experience nature, performed outside of a classroom environment and extending beyond initial instruction or demonstration activities. Such projects are limited to logging, silvicultural thinning, slash burning, fire fighting, stream enhancement, woodcutting, reforestation, tree surgery, construction, printing and manufacturing involving formed metals.

(8) Notwithstanding subsection (1) of this section, a school district may elect to make trainees subject workers under this chapter for school directed professional education projects not enumerated in subsection (7) of this section by making written request to the district's insurer, or in the case of a self-insured district, the director, with coverage to begin no sooner than the date the request

is received by the insurer or director. The request for coverage shall include a description of the work to be performed under the project and an estimate of the number of participating trainees. The insurer or director shall accept a request that meets the criteria of this section. [1967 c.374 §2; 1979 c.814 §2a; 1979 c.815 §3; 1981 c.874 §2; 1987 c.489 §1; 1989 c.491 §63; 1991 c.534 §1; 1995 c.343 §52; 2007 c.70 §285]

656.034 [Amended by 1959 c.441 §1; 1959 c.448 §5; repealed by 1965 c.285 §95]

656.035 Status of workers in separate occupations of employer. If an employer is engaged in an occupation in which the employer employs one or more subject workers and is also engaged in a separate occupation in which there are no subject workers, the employer is not subject to this chapter as to that separate occupation, nor are the workers wholly engaged in that occupation subject to this chapter. [1965 c.285 §10]

656.036 [Amended by 1957 c.441 §2; 1959 c.448 §6; repealed by 1965 c.285 §95]

656.037 Exemption from coverage for persons engaged in certain real estate activities. A person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696 to a qualified real estate broker or qualified principal real estate broker, as defined in ORS 316.209, is not an employer of that qualified broker under the Workers' Compensation Law. A qualified real estate broker or qualified principal real estate broker is not entitled to benefits under the Workers' Compensation Law unless such individual has obtained coverage for such benefits pursuant to ORS 656.128. [1983 c.597 §5; 2001 c.300 §71]

656.038 [Repealed by 1965 c.285 §95]

656.039 Election of coverage for workers not subject to law; procedure; cancellation; election of coverage for home health care workers. (1) An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a carrier-insured employer, the election shall be made by filing written notice thereof with the insurer with a copy to the Director of the Department of Consumer and Business Services. The effective date of coverage is governed by ORS 656.419 (3). If the employer is or becomes a self-insured employer, the election shall be made by filing written notice thereof with the director, the effective date of coverage to be the date specified in the notice.

(2) Any election under subsection (1) of this section may be canceled by written notice thereof to the insurer or, in the case of a self-insured employer, by notice thereof to the director. The cancellation is effective at 12 midnight ending the day the notice is received by the insurer or the director, unless a later date is specified in the notice. The insurer shall, within 10 days after receipt of a notice of cancellation under this section, send a copy of the notice to the director.

(3) When necessary the insurer or the director shall fix assumed minimum or maximum wages for persons made subject workers under this section.

(4) Notwithstanding any other provision of this section, a person or employer not subject to this chapter who elects to become covered may apply to an insurer for coverage. An insurer other than the State Accident Insurance Fund Corporation may provide such coverage. However, the State Accident Insurance Fund Corporation shall accept any written notice filed and provide coverage as provided in this section if all subject workers of the employers will be insured with the State Accident Insurance Fund Corporation and the coverage of those subject workers is not considered by the State Accident Insurance Fund Corporation to be a risk properly assignable to the assigned risk pool.

(5)(a) The Home Care Commission created by ORS 410.602 shall elect coverage on behalf of persons who employ home care workers to make home care workers subject workers.

(b) As used in this subsection, "home care worker" has the meaning given that term in ORS 410.600. [1965 c.285 §11; 1975 c.556 §22; 1979 c.839 §1; 1981 c.854 §6; 1983 c.816 §1; 1985 c.212 §2; 2007 c.241 §8; 2007 c.835 §1; 2010 c.100 §9; 2014 c.116 §12]

656.040 [Amended by 1959 c.448 §7; repealed by 1965 c.285 §95]

656.041 City or county may elect to provide coverage for jail inmates. (1) As used in this section, unless the context requires otherwise:

(a) "Authorized employment" means the employment of an inmate on work authorized by the governing body of a city or county.

(b) "Inmate" means a person sentenced by any court or legal authority, whether in default of the payment of a fine or committed for a definite number of days, to serve sentence in a city or county jail or other place of incarceration except state and federal institutions. "Inmate" includes a person who performs community service pursuant to ORS 137.128, whether or not the person is incarcerated.

(2) A city or county may elect to have inmates performing authorized employment considered as subject workers of the city or county for purposes of this chapter. Such election shall be made by a written applica-

tion to the insurer, or in the case of a self-insured employer, the Director of the Department of Consumer and Business Services, that includes a resolution of the governing body declaring its intent to cover inmates as provided in this section and a description of the work to be performed by such inmates. The application shall also state the estimated total number of inmates for which coverage is requested. The county or city shall notify the insurer or director of changes in the estimated total number of inmates performing authorized employment.

(3) Upon receiving the written application the insurer or self-insured employer may fix assumed wage rates for the inmates, which may be used only for purposes of computations under this chapter, and shall require the regular payment of premiums or assessments based upon the estimated total number of such inmates for which coverage is requested. The self-insured employer shall submit such assumed wage rates to the director. If the director finds that the rates are unreasonable, the director may fix appropriate rates to be used for purposes of this section.

(4) The city or county shall maintain a separate list of inmates performing authorized employment. A certified copy of the list shall be furnished the insurer or director upon request. Inmates covered under this section are entitled to the benefits of this chapter and they are entitled to such benefits if injured as provided in ORS 656.202 while performing any duties arising out of and in the course of their participation in the authorized employment, provided the duties being performed are among those described on the application of the city or county.

(5) The filing of claims for benefits under this section is the exclusive remedy of an inmate or a beneficiary of the inmate for injuries compensable under this chapter against a city or county and its officers and employees, regardless of negligence. [1967 c.472 §§2,3; 1977 c.807 §1; 1979 c.815 §4; 1981 c.854 §7; 1981 c.874 §3; 1983 c.706 §2]

656.042 [Amended by 1959 c.448 §8; repealed by 1965 c.285 §95]

656.043 Governmental agency paying wages responsible for providing coverage. Except as otherwise provided in ORS 656.029 to 656.033 and 656.041, but notwithstanding any other provision of law, the state or any city, county, district, or agency thereof, that pays the wages of a subject worker is responsible for providing workers' compensation insurance coverage for that worker. [1987 c.414 §183]

656.044 State Accident Insurance Fund Corporation may insure liability under Longshoremen's and Harbor Workers' Compensation Act; procedure; cancellation. (1) The State Accident Insurance Fund Corporation may insure Oregon employers against their liability for compensation under the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 901 to 950) or any Act amendatory or supplementary thereto or in lieu thereof, as fully as any private insurance carrier.

(2) The State Accident Insurance Fund Corporation may, from time to time, fix rates of contributions to be paid by such employers. These rates shall be based upon the costs of inspection and other administration, the hazard of the occupation and the accident experience of the employers. The State Accident Insurance Fund Corporation may require a minimum annual premium, contributions, assessments and fees from such employers.

(3) All claims for compensation and other costs arising from such insurance shall be paid from the Industrial Accident Fund.

(4) The State Accident Insurance Fund Corporation or any employer may cancel any insurance coverage issued under this section by giving notice as required by the Longshoremen's and Harbor Workers' Compensation Act, or the rules or regulations made in pursuance thereof. [Amended by 1965 c.285 §13; 1981 c.876 §2]

656.046 Coverage of persons in college work experience and professional education programs. (1) All persons registered at a college and participating as unpaid trainees in a work experience program who are subject to the direction of noncollege-employed supervisors, and those trainees participating in college directed professional education projects, are considered workers of the college subject to this chapter for purposes of this section. However, trainees who are covered by the Federal Employees Compensation Act shall not be subject to the provisions of this section.

(2) A college conducting a work experience program or college directed professional education project shall submit a written statement to the insurer, or in the case of self-insurers, to the Director of the Department of Consumer and Business Services, that includes a description of the work to be performed by such persons and an estimate of the total number of persons enrolled in the program or project.

(3) Persons covered under this section are entitled to the benefits of this chapter. However, such persons are not entitled to benefits under ORS 656.210 or 656.212. They are entitled to such benefits if injured as

provided in ORS 656.156 and 656.202 while performing any duties arising out of and in the course of their participation in the work experience program or college directed professional education project, provided the duties being performed are among those:

(a) Described on the application of the college; and

(b) Required of similar full-time paid employees.

(4) The filing of claims for benefits under this section is the exclusive remedy of a trainee or a beneficiary of the trainee for injuries compensable under this chapter against the state, its political subdivisions, the college district board, members, officers and employees of the board or any employer, regardless of negligence.

(5) A college may elect to make trainees subject to this chapter for college directed professional education projects not enumerated in subsection (8) of this section or for work experience programs under the direction of college-employed supervisors by filing a written request with the insurer of the college, or in the case of self-insured colleges, with the director. Coverage under such election shall become effective no sooner than the date of receipt by the insurer. The coverage request shall include a description of the work to be performed and an estimate of the number of participating trainees. The insurer or director shall accept a request that meets the criteria of this section.

(6) The provisions of this section shall be inapplicable to any trainee who has earned wages for such employment.

(7) As used in this section, "college" means any community college district or community college service district as defined in ORS chapter 341.

(8) As used in this section, "college directed professional education project" means an assigned on-campus or off-campus project that is a component of a program approved by the college board or the operating procedures of the Higher Education Coordinating Commission and involves work that provides practical experience beyond the initial instruction and demonstration phases, performed outside of the college classroom or laboratory environment and requiring substantial hands-on participation by trainees. Such projects are further limited to logging, silvicultural thinning, slash burning, fire fighting, stream enhancement, woodcutting, reforestation, tree surgery, construction, printing and manufacturing involving formed metals. [1991 c.534 §3; 1993 c.18 §139; 1995 c.343 §53; 2013 c.747 §189]

656.052 Prohibition against employment without coverage; proposed order declaring noncomplying employer; effect of failure to comply. (1) No person shall engage as a subject employer unless and until the person has provided coverage pursuant to ORS 656.017 for subject workers the person employs.

(2) Whenever the Director of the Department of Consumer and Business Services has reason to believe that any person has violated subsection (1) of this section, the director shall serve upon the person a proposed order declaring the person to be a noncomplying employer and containing the amount, if any, of civil penalty to be assessed pursuant to ORS 656.735 (1).

(3) If any person fails to comply with ORS 656.017 after an order declaring the person to be a noncomplying employer has become final by operation of law or on appeal, the circuit court of the county in which the person resides or in which the person employs workers shall, upon the commencement of a suit by the director for that purpose, permanently enjoin the person from employing subject workers without complying with ORS 656.017. Upon the filing of such a suit, the court shall set a day for hearing and shall cause notice thereof to be served upon the noncomplying employer. The hearing shall be not less than five days from the service of the notice.

(4) The court may award reasonable attorney fees to the director if the director prevails in an action under subsection (3) of this section. The court may award reasonable attorney fees to a defendant who prevails in an action under subsection (3) of this section if the court determines that the director had no objectively reasonable basis for asserting the claim or no reasonable basis for appealing an adverse decision of the trial court. [Amended by 1957 c.574 §2; 1965 c.285 §14; 1967 c.341 §4; 1973 c.447 §1; 1987 c.234 §1; 1990 c.2 §5; 1995 c.332 §6b; 1995 c.696 §43]

656.054 Claim of injured worker of noncomplying employer; procedure for disputing acceptance of claim; recovery of costs from noncomplying employer; restrictions. (1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The Director of the Department of Consumer and Business Services shall refer the claim for such an injury to an assigned claims agent within 60 days of the date the director has notice of the claim. At the time of referral of the claim, the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. A claim for compensation made by

such a worker shall be processed by the assigned claims agent in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first installment of compensation is to be paid, pursuant to ORS 656.262 (4), shall not begin to run until the director has referred the claim to the assigned claims agent. At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim. If an order becomes final holding the claim to be compensable, the employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim.

(2) In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Workers' Benefit Fund incurred under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, disputed claim settlements pursuant to ORS 656.289 and claim disposition agreements pursuant to ORS 656.236, whether or not the noncomplying employer agrees and executes such documents, reasonable administrative costs and claims processing costs provided by contract, attorney fees related to compensability issues and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Workers' Benefit Fund. The director shall recover such costs from the employer. The director periodically shall pay the assigned claims agent from the Workers' Benefit Fund for any costs the assigned claims agent incurs under this section in accordance with the terms of the contract. When the director prevails in any action brought pursuant to this subsection, the director is entitled to recover from the noncomplying employer court costs and attorney fees incurred by the director.

(3) Periodically, or upon the request of a noncomplying employer in a particular claim, the director shall audit the files of the State Accident Insurance Fund Corporation and any assigned claims agents to validate the amount reimbursed pursuant to subsection (2) of this section. The conditions for granting or denying of reimbursement shall be specified in the contract with the assigned claims agent. The contract at least shall provide for denial of reimbursement if, upon such audit, any of the following are found to apply:

(a) Compensation has been paid as a result of untimely, inaccurate, or improper claims processing;

(b) Compensation has been paid negligently for treatment of any condition unrelated to the compensable condition;

(c) The compensability of an accepted claim is questionable and the rationale for acceptance has not been reasonably documented in accordance with generally accepted claims management procedures;

(d) The separate payments of compensation have not been documented in accordance with generally accepted accounting procedures; or

(e) The payments were made pursuant to a disposition agreement as provided by ORS 656.236 without the prior approval of the director.

(4) The State Accident Insurance Fund Corporation and any assigned claims agent may request review under ORS 656.704 of any disapproval of reimbursement made by the director under this section.

(5) Claims of injured workers of noncomplying employers may be assigned and reassigned by the director for claims processing regardless of the date of the worker's injury.

(6) In selecting an assigned claims agent, the director must consider the assigned claims agent's ability to deliver timely and appropriate benefits to injured workers, the ability to control both claims cost and administrative cost and such other factors as the director considers appropriate.

(7) If no qualified entity agrees to be an assigned claims agent, the director may require one or more of the three highest premium producing insurers to be assigned claims agents. Notwithstanding any other provision of law, the director's selection of assigned claims agents shall be made at the sole discretion of the director. Such selections shall not be subject to review by any court or other administrative body.

(8) Any assigned claims agent, except the State Accident Insurance Fund Corporation, may employ legal counsel of its choice for representation under this section.

(9) As used in this section, "assigned claims agent" means an insurer, casualty adjuster or a third party administrator with whom the director contracts to manage claims of injured workers of noncomplying employers. [Amended by 1959 c.448 §9; 1965 c.285 §15; 1967 c.341 §5; 1971 c.72 §1; 1973 c.447 §2; 1979 c.839 §2; 1981 c.854 §8; 1983 c.816 §2; 1987 c.234 §2; 1987 c.250 §3; 1991 c.679 §1; 1995 c.332 §7; 1995 c.641 §17; 1999 c.1020 §1; 2003 c.14 §399; 2003 c.170 §1; 2005 c.26 §1]

Note: See notes under 656.202.

Note: Section 9, chapter 332, Oregon Laws 1995, provides:

Sec. 9. The amendments to ORS 656.054 by section 7 of this 1995 Act do not remove the authority of the Director of the Department of Consumer and Business Services to audit files of the State Accident Insurance

Fund Corporation for claims against noncomplying employers assigned to the State Accident Insurance Fund Corporation prior to the effective date of this 1995 Act [June 7, 1995]. [1995 c.332 §9]

656.056 Subject employers must post notice of manner of compliance. (1) All subject employers shall display in a conspicuous manner about their works, and in a sufficient number of places reasonably to inform their workers of the fact, printed notices furnished by the Director of the Department of Consumer and Business Services stating that they are subject to this chapter and the manner of their compliance with this chapter.

(2) No employer who is not currently a subject employer shall post or permit to remain on or about the place of business or premises of the employer any notice that the employer is subject to, and complying with, this chapter. [Amended by 1965 c.285 §16]

656.070 Definitions for ORS 656.027, 656.070 and 656.075. As used in ORS 656.027, 656.075 and this section:

(1) "Newspaper" has the meaning for that term provided in ORS 193.010.

(2) "Newspaper carrier" means an individual age 18 years or younger who contracts with a newspaper publishing company or independent newspaper dealer or contractor to distribute newspapers to the general public and performs or undertakes any necessary or attendant functions related thereto, but receives no salary or wages, other than sales incentives or bonuses, for the performance of those duties from the newspaper publishing company or independent newspaper dealer or contractor. "Newspaper carrier" includes any individual appointed or utilized on a temporary basis by a newspaper carrier, a newspaper publishing company or independent newspaper dealer or contractor to perform any or all of the duties of a newspaper carrier. [1977 c.835 §3; 1981 c.535 §52]

656.075 Exemption from coverage for newspaper carriers; casualty insurance and other requirements. An individual qualifies for the exemption provided in ORS 656.027 only if the newspaper publishing company or independent newspaper dealer or contractor utilizing the individual:

(1) Encourages any minor so utilized to remain in school and attend classes;

(2) Encourages any minor so utilized to not allow newspaper carrier duties to interfere with any school activities of the individual;

(3) Provides accident insurance coverage for the individual while the individual is engaged in newspaper carrier duties that is at least equal to the following:

(a) $250,000 unallocated hospital and medical benefits;

(b) $10 per week lost time benefits for a period of 52 weeks; and

(c) $5,000 accidental death and dismemberment benefit; and

(4) Provides the individual with a clear, written explanation or description of the amount and the terms and conditions of the insurance coverage required by this section, including a specific statement that the insurance coverage is in lieu of benefits under the Workers' Compensation Law. [1977 c.835 §4; 1981 c.535 §53]

656.082 [Repealed by 1965 c.285 §95]

656.084 [Amended by 1959 c.448 §10; repealed by 1965 c.285 §95a]

656.086 [Repealed by 1965 c.285 §95]

656.088 [Amended by 1955 c.320 §1; 1965 c.285 §17; renumbered 656.031]

656.090 [Amended by 1953 c.673 §2; 1959 c.448 §11; repealed by 1965 c.285 §97]

656.120 [1969 c.527 §3; repealed by 1979 c.815 §9]

656.122 [Repealed by 1965 c.285 §95]

656.124 [Amended by 1957 c.554 §1; repealed by 1965 c.285 §95]

656.126 Coverage while temporarily in or out of state; judicial notice of other state's laws; agreements between states relating to conflicts of jurisdiction; limitation on compensation for claims in this state and other jurisdictions. (1) If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of this chapter as though the worker were injured within this state.

(2) Any worker from another state and the employer of the worker in that other state are exempted from the provisions of this chapter while that worker is temporarily within this state doing work for the employer:

(a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;

(b) If the extraterritorial provisions of this chapter are recognized in that other state; and

(c) If employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state.

The benefits under the workers' compensation insurance Act or similar laws of the other state, or other remedies under a like Act or laws, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the worker while working for that employer in this state.

(3) A certificate from the duly authorized officer of the Department of Consumer and Business Services or similar department of another state certifying that the employer of the other state is insured therein and has provided extraterritorial coverage insuring workers while working within this state is prima facie evidence that the employer carries that workers' compensation insurance.

(4) Whenever in any appeal or other litigation the construction of the laws of another jurisdiction is required, the courts shall take judicial notice thereof.

(5) The Director of the Department of Consumer and Business Services shall have authority to enter into agreements with the workers' compensation agencies of other states relating to conflicts of jurisdiction where the contract of employment is in one state and the injuries are received in the other state, or where there is a dispute as to the boundaries or jurisdiction of the states and when such agreements have been executed and made public by the respective state agencies, the rights of workers hired in such other state and injured while temporarily in Oregon, or hired in Oregon and injured while temporarily in another state, or where the jurisdiction is otherwise uncertain, shall be determined pursuant to such agreements and confined to the jurisdiction provided in such agreements.

(6) When a worker has a claim under the workers' compensation law of another state, territory, province or foreign nation for the same injury or occupational disease as the claim filed in Oregon, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under Oregon workers' compensation law. The worker shall be entitled to the full amount of compensation due under Oregon law. If Oregon compensation is more than the compensation under another law, or compensation paid the worker under another law is recovered from the worker, the insurer shall pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law. [Amended by 1955 c.723 §1; 1957 c.474 §1; 1977 c.804 §4; 1989 c.684 §1; 1995 c.332 §10; 1997 c.234 §1]

656.128 Sole proprietors, limited liability company members, partners, independent contractors may elect coverage by insurer; cancellation. (1) Any person who is a sole proprietor, or a member, including a member who is a manager, of a limited liability company, or a member of a partnership, or an independent contractor pursuant to ORS 670.600, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter.

(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. The person shall promptly notify the insurer whenever the status of the person as an employer of subject workers changes. Any subject worker employed by such a person after the effective date of the election of the person shall, upon being employed, be considered covered automatically by the same workers' compensation insurance policy that covers such person.

(3) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.

(4) Any person subject to this chapter as a worker as provided in this section may cancel such election by giving written notice to the insurer. The cancellation shall become effective at 12 midnight ending the day of filing the notice with the insurer. [Amended by 1957 c.440 §2; 1959 c.448 §12; 1965 c.285 §18; 1969 c.400 §1; 1975 c.556 §23; 1981 c.854 §9; 1981 c.876 §3; 1993 c.777 §11; 1995 c.93 §33; 1995 c.332 §11; 2007 c.241 §9]

656.130 [Amended by 1957 c.574 §3; repealed by 1959 c.448 §14]

656.132 Coverage of minors. (1) A minor working at an age legally permitted under the laws of this state is considered sui juris for the purpose of this chapter. No other person shall have any cause of action or right to compensation for an injury to such minor worker, except as expressly provided in this chapter, but in the event of a lump-sum payment becoming due under this chapter to such minor worker, the control and management of any sum so paid shall be within the jurisdiction of the courts as in the case of other property of minors.

(2) If an employer subject to this chapter in good faith employed a minor under the age permitted by law, believing the minor to be of lawful age, and the minor sustains an injury or suffers death in such employment, the minor is conclusively presumed to have

accepted the provisions of this chapter. The Director of the Department of Consumer and Business Services may determine conclusively the good faith of such employer unless the employer possessed at the time of the accident resulting in such injury or death a certificate from some duly constituted authority of this state authorizing the employment of the minor in the work in which the minor was then engaged. Such certificate is conclusive evidence of the good faith of such employer.

(3) If the employer holds no such certificate and the director finds that the employer did not employ such minor in good faith, the minor is entitled to the benefits of this chapter, but the employer shall pay to the Consumer and Business Services Fund by way of penalty a sum equal to 25 percent of the amount paid out or set apart under such statutes on account of the injury or death of such minor, but such penalty shall be not less than $100 nor exceed $500. [Amended by 1959 c.448 §13; 1985 c.212 §3]

656.135 Coverage of deaf school work experience trainees. (1) As used in this section "school" means the Oregon School for the Deaf.

(2) All persons participating as trainees in a work experience program of the school are considered as workers of the school subject to this chapter for purposes of this section.

(3) On behalf of a school conducting a work experience program, the Department of Education shall submit a written statement to the State Accident Insurance Fund Corporation that includes a description of the work to be performed by such persons.

(4) Upon receiving the written statement, the corporation may fix assumed wage rates for the persons enrolled in the work experience program, without regard to ORS chapter 652 or ORS 653.010 to 653.565 and 653.991, which may be used only for purposes of computations under this chapter.

(5) The Department of Education shall furnish the corporation with a list of the names of those enrolled in work experience programs in the school and shall notify the corporation of any changes therein. Only those persons whose names appear on such list prior to their personal injury by accident are entitled to the benefits of this chapter and they are entitled to such benefits if injured as provided in ORS 656.156 and 656.202 while performing any duties arising out of and in the course of their participation in the work experience program, provided the duties being performed are among those:

(a) Described on the application of the department; and

(b) Required of similar full-time paid employees.

(6) The filing of claims for benefits under this section is the exclusive remedy of a trainee or beneficiary of the trainee for injuries compensable under this chapter against the state, the school, the department, its officers and employees, or any employer, regardless of negligence.

(7) The provisions of this section shall be inapplicable to any trainee who is earning wages for such employment. [1969 c.406 §2; 2007 c.858 §83; 2009 c.562 §35]

656.138 Coverage of apprentices, trainees participating in related instruction classes. (1) All persons registered as apprentices or trainees and participating in related instruction classes conducted by a school district, community college district or education service district in accordance with the requirements of ORS 660.002 to 660.210 or section 50, title 29, United States Code as of September 13, 1975, are considered as workers of the school district, community college district or education service district subject to this chapter.

(2) A school district, community college district or education service district conducting related instruction classes shall submit a written statement to the insurer, or in the case of self-insurers, the Director of the Department of Consumer and Business Services, that includes a description of the related instruction to be given to such apprentices or trainees and an estimate of the total number of persons enrolled.

(3) Upon receiving the written statement, the insurer, or in the case of self-insurers, the director, may fix assumed wage rates for those apprentices or trainees participating in related instruction classes, which may be used only for the purposes of computations under this chapter.

(4) The State Apprenticeship and Training Council shall furnish the insurer, or in the case of self-insurers, the director, and the school district, community college district or education service district with an estimate of the total number of apprentices or trainees approved by it for participation in related instruction classes subject to coverage under this section and any significant changes in the estimated total. Apprentices and trainees as provided in subsection (1) of this section are entitled to benefits under this chapter.

(5) The filing of claims for benefits under the authority of this section is the exclusive remedy of apprentices or trainees or their beneficiaries for injuries compensable under this chapter against the state, its political subdivisions, the school district, community college district or education service district,

their members, officers and employees, or any employer, regardless of negligence.

(6) This section does not apply to any apprentice or trainee who has earned wages for performing such duties. [1971 c.634 §2; 1975 c.775 §1; 1979 c.815 §5]

656.140 Coverage of persons operating equipment for hire. (1) Any person, or persons operating as partners, who have an ownership or leasehold interest in equipment and are engaged in the business of operating such equipment for hire, may elect to cover themselves under the Workers' Compensation Law by filing with an insurer a written application to become entitled as subject workers to the benefits of the Workers' Compensation Law.

(2) As used in this section "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or pilings.

(b) A motor vehicle used in the transportation of rocks, gravel, sand or dirt.

(c) A backhoe or other similar equipment used for digging and filling ditches or trenches.

(d) A tractor.

(e) Any other motor vehicle or heavy equipment of a kind commonly operated for hire.

(3) The insurer may accept such application and fix a classification and an assumed monthly wage at which such person, or persons operating as partners, shall be carried on the payroll as workers for purposes of computations under this chapter.

(4) When the application is accepted, such person, or persons operating as partners, become subject workers. Thereupon, such person, or persons operating as partners, shall be subject to this chapter as a subject employer notwithstanding ORS 656.023 and shall be entitled to benefits as subject workers.

(5) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.

(6) Any person, or persons operating as partners, electing coverage under this section, have the same duties and responsibilities of any other subject employer in the event they hire one or more subject workers.

(7) The rights given to a person, or persons operating as partners, and their beneficiaries pursuant to this section for injuries compensable under this chapter are in lieu of any remedies they might otherwise have for such injuries against the person for whom services are being performed. [1969 c.463 §2; 1975 c.556 §24; 1981 c.854 §10; 1981 c.876 §4]

656.152 [Amended by 1957 c.718 §2; repealed by 1965 c.285 §95]

656.154 Injury due to negligence or wrong of a person not in the same employ as injured worker; remedy against such person. If the injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker, or if death results from the injury, the spouse, children or other dependents, as the case may be, may elect to seek a remedy against such third person. [Amended by 1959 c.504 §1; 1975 c.152 §1; 1985 c.212 §4]

656.156 Intentional injuries. (1) If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker shall receive any payment whatsoever under this chapter.

(2) If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes. [Amended by 1965 c.285 §20]

656.160 Effect of incarceration on receipt of compensation. (1) Notwithstanding any other provision of this chapter, an injured worker is not eligible to receive compensation under ORS 656.210 or 656.212 for periods of time during which the worker is incarcerated for the commission of a crime.

(2) As used in this section, an individual is not "incarcerated" if the individual is on parole or work release status. [1990 c.2 §50]

656.170 Validity of provisions of certain collective bargaining agreements; alternative dispute resolution systems; exclusive medical service provider lists; authority of director. (1) In a collective bargaining agreement between a private employer or groups of employers engaged in construction, construction maintenance or activities limited to rock, sand, gravel, cement and asphalt operations, heavy duty mechanics, surveying or construction inspection, and a union that is the recognized or certified exclusive bargaining representative, a provision establishing either of the following is valid and binding:

(a) An alternative dispute resolution system governing disputes between employees, employers and their insurers that supplements or replaces all or part of the dispute resolution processes of this chapter, including but not limited to provisions:

(A) Establishing any limitations on the liability of the employer while determinations regarding the compensability of an injury are being made;

(B) Describing the method for resolving disputes involving compensability of injuries under the alternative dispute resolution system and the amount of compensation due for a compensable injury and for medical and legal services;

(C) Relating to the payment of compensation for injuries incurred when the collective bargaining agreement is terminated or when an injured worker is no longer subject to the agreement; and

(D) Establishing arbitration and mediation procedures; or

(b) The use of a list of medical service providers that the parties may agree is the exclusive source of all medical treatment provided under this chapter.

(2) Any decision, order or award of compensation issued under an agreed upon alternative dispute resolution system adopted under subsection (1)(a) of this section is subject to review in the same manner as provided for the review of an order of an Administrative Law Judge pursuant to the provisions of this chapter.

(3) Nothing in this section allows a collective bargaining agreement that diminishes the entitlement of an employee to compensation as provided in this chapter. The portion of an agreement that violates this subsection is void. Notwithstanding any other provision of law, original jurisdiction over the compliance of a proposed collective bargaining agreement with this subsection is with the Director of the Department of Consumer and Business Services. The director shall determine the compliance of the agreement with this subsection prior to the agreement becoming operative. The decision of the director is subject to review as provided under ORS 656.704. [1999 c.841 §2; 2005 c.26 §2]

656.172 Applicability of and criteria for establishing program under ORS 656.170. (1) ORS 656.170 applies only to:

(a) An employer incurring or projecting an annual workers' compensation insurance premium in Oregon of at least $250,000 or an employer that paid an annual workers' compensation insurance premium in Oregon of at least $250,000 in one of the three years prior to the year in which the collective bargaining agreement takes effect.

(b) An employer who qualifies as a self-insured employer under ORS 656.407 and 656.430 that is incurring or projecting annual workers' compensation costs of at least $250,000 or who has had annual workers' compensation costs of at least $250,000 in one of the three years prior to the year in which the collective bargaining agreement takes effect.

(c) A group of employers who combine for the purpose of obtaining workers' compensation insurance as provided by ORS 737.316 and incur or project annual workers' compensation premiums of at least $1 million.

(d) A group of employers who qualify as a self-insured employer group under ORS 656.430 and incur or project annual workers' compensation costs of at least $1 million.

(e) Employers covered by a wrap-up insurance policy provided by an owner or general contractor and authorized by ORS 737.602 and 737.604, and that requires payment of annual workers' compensation premiums of $1 million or more for coverage of those employees covered by the wrap-up insurance policy.

(2) An employer or group of employers may not establish or continue a program established under ORS 656.170 until:

(a) The employer has provided the Director of the Department of Consumer and Business Services with the following:

(A) Upon original application and whenever the collective bargaining agreement is renegotiated, a copy of the collective bargaining agreement and an estimate of the number of employees covered by the collective bargaining agreement;

(B) Upon original application and annually thereafter, a valid license when that license is required as a condition of doing business in Oregon;

(C) Upon original application and annually thereafter, a signed, sworn statement that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement;

(D) Upon original application and annually thereafter, the name, address and telephone number of the contact person of the employer or group of employers; and

(E) A statement from the insurer or self-insured employer that the insurer or self-insured employer is willing to insure the risk under the terms of the collective bargaining agreement; and

(b) The director has approved the proposed program.

(3) A collective bargaining representative may not establish or continue to participate in a program established under ORS 656.170 until:

(a) The collective bargaining representative has provided the following to the director:

(A) Upon original application and annually thereafter, a copy of the most recent LM-2 or LM-3 filing with the United States Department of Labor, and a signed, sworn statement that the document is a true and correct copy; and

(B) Upon original application and annually thereafter, the name, address and telephone number of the contact person for the collective bargaining representative; and

(b) The director has approved the proposed program.

(4) When an employer, a group of employers or a collective bargaining representative has met the eligibility requirements of this section, the director shall issue a letter to the employer, group of employers or collective bargaining representative indicating that such eligibility has been established. [1999 c.841 §3; 2007 c.71 §207]

656.174 Rules. The Director of the Department of Consumer and Business Services shall adopt rules necessary for the implementation of the provisions of ORS 656.170 and 656.172. The rules must include, but are not limited to procedures for:

(1) Establishing and operating an alternative dispute resolution system;

(2) Resolution of disputes involving multiple claims when one or more of the claims are not subject to the collective bargaining agreement; and

(3) Providing benefits to injured workers whose compensable claims are covered under an alternative dispute resolution system after the expiration of the collective bargaining agreement or termination of any arrangement for the provision of benefits under ORS 656.170 and 656.172. [1999 c.841 §4]

APPLICABILITY PROVISIONS

656.202 Compensation payable to subject worker in accordance with law in effect at time of injury; exceptions; notice regarding payment. (1) If any subject worker sustains a compensable injury, the worker or the beneficiaries of the worker, if the injury results in death, shall receive compensation as provided in this chapter, regardless of whether the worker was employed by a complying or noncomplying employer.

(2) Except as otherwise provided by law, payment of benefits for injuries or deaths under this chapter shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred.

(3) When compensation is paid to a claimant or other payment is made to the provider of service pursuant to this chapter, the insurer or self-insured employer shall notify the payment recipient in writing of the specific purpose of the payment. When applicable, the notice shall indicate the time period for which the payment is made and the reimbursable expenses or other bills and charges covered. If any portion of the claim is denied, the notice shall identify that portion of the claimed amounts that is not being paid.

(4) Notwithstanding subsections (1) to (3) of this section, the amendments to ORS 656.325 by section 4, chapter 723, Oregon Laws 1981, and ORS 656.335 (1993 Edition) apply to all workers regardless of the date of injury.

(5) This section does not apply to vocational assistance benefits.

(6) Notwithstanding subsection (2) of this section, the increase in benefits to the surviving spouse of an injured worker made by the amendment to ORS 656.204 (2)(c) (1993 Edition) by section 1, chapter 108, Oregon Laws 1985, applies to a surviving spouse who remarries after September 20, 1985, regardless of the date of injury or death of the worker.

(7) Notwithstanding subsection (2) of this section, the increase in benefits to the surviving spouse of an injured worker made by the amendments to ORS 656.204 (3)(a) and (b) (1997 Edition) by section 2, chapter 927, Oregon Laws 1999, applies to a surviving spouse who remarries on or after October 23, 1999, regardless of the date of injury or death of the worker. [Amended by 1953 c.669 §4; 1953 c.670 §4; 1957 c.718 §3; 1959 c.450 §1; 1965 c.285 §21; 1977 c.430 §6; 1981 c.770 §1; subsection (4) enacted as 1981 c.723 §8; 1985 c.108 §3; 1985 c.600 §6; 1985 c.706 §6; 1985 c.770 §6; 1995 c.332 §12; 1999 c.927 §1]

(Implementation of 1990 Laws)

Note: Section 54, chapter 2, Oregon Laws 1990, provides:

Sec. 54. (1) Except for amendments to ORS 656.027, 656.211, 656.214 (2) and 656.790, this 1990 Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section.

(2) Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990.

(3) Amendments by this 1990 Act to ORS 656.214 (5), the amendments to ORS 656.268 (4), (5), (6), (7) and (8), ORS 656.283 (7), 656.295, 656.319, 656.325, 656.382 and 656.726 shall apply to all claims which become medically stationary after July 1, 1990. [1990 c.2 §54]

(Implementation of 1995 Laws)

Note: Section 66, chapter 332, Oregon Laws 1995, provides:

Sec. 66. (1) Notwithstanding any other provision of law, chapter 332, Oregon Laws 1995, applies to all claims or causes of action existing or arising on or after June 7, 1995, regardless of the date of injury or the date a claim is presented, and chapter 332, Oregon Laws 1995, is intended to be fully retroactive unless a specific exception is stated in chapter 332, Oregon Laws 1995.

(2) The amendments to ORS 656.204 and 656.265 by sections 13 and 29, chapter 332, Oregon Laws 1995, and the amendments to ORS 656.210 (2)(a) by section 15, chapter 332, Oregon Laws 1995, apply only to injuries occurring on or after June 7, 1995.

(3) Sections 8 and 9, chapter 332, Oregon Laws 1995, and the amendments to ORS 656.054, 656.248 and 656.622 by sections 7, 26 and 49, chapter 332, Oregon Laws 1995, become operative January 1, 1996.

(4) The amendments to ORS 656.268 (4), (5), (6) and (9), 656.319 (4) and 656.726 (3)(f) by sections 30, 39 and 55, chapter 332, Oregon Laws 1995, shall apply only to claims that become medically stationary on or after June 7, 1995.

(5)(a) The amendments to statutes by chapter 332, Oregon Laws 1995, and new sections added to ORS chapter 656 by chapter 332, Oregon Laws 1995, do not apply to any matter for which an order or decision has become final on or before June 7, 1995.

(b) Notwithstanding paragraph (a) of this subsection, the amendments to ORS 656.262 (6) creating new paragraph (c) and the amendments to the subsection designated (10) by section 28, chapter 332, Oregon Laws 1995, apply to all claims without regard to any previous order or closure.

(6) The amendments to statutes by chapter 332, Oregon Laws 1995, and new sections added to ORS chapter 656 by chapter 332, Oregon Laws 1995, do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to June 7, 1995.

(7) The amendments to ORS 656.506 by section 63, chapter 332, Oregon Laws 1995, first become operative October 1, 1995. [1995 c.332 §66; 1999 c.6 §2]

(Implementation of 1997 Laws)

Note: Section 2, chapter 605, Oregon Laws 1997, provides:

Sec. 2. Notwithstanding any other provision of law to the contrary, the amendments to ORS 656.262 by section 1 of this Act apply to all claims or causes of action existing or arising on or after the effective date of this Act [July 25, 1997], regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive. [1997 c.605 §2]

Note: Section 6, chapter 639, Oregon Laws 1997, provides:

Sec. 6. Notwithstanding any other provision of law, the amendments to ORS 656.593 by section 4 of this Act apply to all claims or causes of action existing on or arising on or after the effective date of this Act [July 25, 1997], regardless of the date of injury or the date a claim is presented, and the amendments to ORS 656.593 by section 4 of this Act are intended to be fully retroactive. [1997 c.639 §6]

(Implementation of 2001 Laws)

Note: Section 22, chapter 865, Oregon Laws 2001, provides:

Sec. 22. (1) Section 14 of this 2001 Act [656.247] and the amendments to ORS 656.005, 656.210, 656.262, 656.266, 656.308, 656.313, 656.325 (5), 656.386, 656.605 and 656.804 by sections 1, 2, 3, 4, 5, 7, 8, 9, 13 and 13a of this 2001 Act apply to all claims with a date of injury on or after January 1, 2002.

(2) Section 10 of this 2001 Act [656.267] and the amendments to ORS 656.278 and 656.625 by sections 11 and 11a of this 2001 Act apply to all claims regardless of date of injury.

(3) The amendments to ORS 656.268 (6) by section 12 of this 2001 Act apply to any claim with a date of closure on or after January 1, 2002.

(4) The amendments to ORS 656.325 (1) by section 13 of this 2001 Act apply to any claim with a date of denial on or after January 1, 2002. [2001 c.865 §22]

(Implementation of 2003 Laws)

Note: Section 2, chapter 429, Oregon Laws 2003, provides:

Sec. 2. The amendments to ORS 656.268 by section 1 of this 2003 Act apply to all claims first closed on or after the effective date of this 2003 Act [January 1, 2004]. [2003 c.429 §2]

Note: Sections 13 and 15, chapter 657, Oregon Laws 2003, provide:

Sec. 13. The amendments to ORS 656.206, 656.214, 656.268, 656.307, 656.325 and 656.726 by sections 1, 3, 5, 7, 9 and 11 of this 2003 Act apply to injuries occurring on or after January 1, 2005. [2003 c.657 §13]

Sec. 15. The amendments to ORS 656.206, 656.214, 656.268, 656.307, 656.325 and 656.726 by sections 2, 4, 6, 8, 10 and 12 of this 2003 Act apply to injuries occurring on or after January 1, 2008. [2003 c.657 §15]

Note: Section 3, chapter 756, Oregon Laws 2003, provides:

Sec. 3. The amendments to ORS 656.262 and 656.385 by sections 1 and 2 of this 2003 Act apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 2003 Act [January 1, 2004], regardless of the date of injury. [2003 c.756 §3]

(Implementation of 2005 Laws)

Note: Section 4, chapter 188, Oregon Laws 2005, provides:

Sec. 4. (1) The amendments to ORS 656.267, 656.278 and 656.298 by sections 1, 2 and 3 of this 2005 Act apply to all claims existing or arising on or after the effective date of this 2005 Act [January 1, 2006].

(2) Notwithstanding subsection (1) of this section, the amendments to ORS 656.267, 656.278 and 656.298 by sections 1, 2 and 3 of this 2005 Act do not apply to any matter for which an order has become final prior to the effective date of this 2005 Act. [2005 c.188 §4]

Note: Section 5, chapter 221, Oregon Laws 2005, provides:

Sec. 5. The amendments to ORS 656.268 by sections 1 and 2 of this 2005 Act apply to notices of closure issued on or after January 1, 2006. [2005 c.221 §5]

Note: Section 7, chapter 461, Oregon Laws 2005, provides:

Sec. 7. The amendments to ORS 656.206, 656.268, 656.319 and 656.605 by sections 1 to 6 of this 2005 Act apply to all claims for which a notice of closure is issued under ORS 656.206 or 656.268 on or after the effective date of this 2005 Act [January 1, 2006]. [2005 c.461 §7]

Note: Section 2, chapter 624, Oregon Laws 2005, provides:

Sec. 2. The amendments to ORS 656.283 by section 1 of this 2005 Act apply to requests for hearing made on or after the effective date of this 2005 Act [January 1, 2006]. [2005 c.624 §2]

Note: Section 5, chapter 653, Oregon Laws 2005, provides:

Sec. 5. The amendments to ORS 656.214 and 656.726 by sections 1 and 3 of this 2005 Act apply to injuries occurring on or after January 1, 2006. [2005 c.653 §5]

Note: Section 8, chapter 675, Oregon Laws 2005, provides:

Sec. 8. The amendments to ORS 656.325 and 656.780 by sections 1, 2 and 3 of this 2005 Act apply to all claims in which an independent medical examination required under ORS 656.325 is scheduled on or after the effective date of this 2005 Act [January 1, 2006]. [2005 c.675 §8]

(Implementation of 2007 Laws)

Note: Section 3, chapter 17, Oregon Laws 2007, provides:

Sec. 3. (1) The amendments to ORS 656.298 (3) and (5) by section 1 of this 2007 Act apply to petitions for judicial review filed on or after the effective date of this 2007 Act [January 1, 2008].

(2) The provisions of ORS 656.298 (9) apply to petitions for judicial review pending with the appellate court on the effective date of this 2007 Act and to petitions for judicial review filed on or after the effective date of this 2007 Act. [2007 c.17 §3]

Note: Section 2, chapter 908, Oregon Laws 2007, provides:

Sec. 2. The amendments to ORS 656.386 by section 1 of this 2007 Act apply to workers' compensation claims in which the order on the compensability of the claim denial has not become final on or before the effective date of this 2007 Act [January 1, 2008]. [2007 c.908 §2]

Note: Section 4, chapter 908, Oregon Laws 2007, provides:

Sec. 4. The amendments to ORS 656.388 by section 3 of this 2007 Act apply to all claims in which an order that grants attorney fees is issued after the effective date of this 2007 Act [January 1, 2008], regardless of the date of injury. [2007 c.908 §4]

(Implementation of 2009 Laws)

Note: Section 6, chapter 526, Oregon Laws 2009, provides:

Sec. 6. Regardless of the date of injury, the amendments to ORS 656.262, 656.308, 656.382, 656.385 and 656.386 by sections 1 to 5 of this 2009 Act apply to all claims for which an order is issued on or after the effective date of this 2009 Act [January 1, 2010]. [2009 c.526 §6]

(Implementation of 2011 Laws)

Note: Section 2, chapter 80, Oregon Laws 2011, provides:

Sec. 2. The amendments to ORS 656.313 by section 1 of this 2011 Act apply to settlements of workers' compensation claims entered into on or after the effective date of this 2011 Act [January 1, 2012]. [2011 c.80 §2]

Note: Section 5, chapter 99, Oregon Laws 2011, provides:

Sec. 5. The amendments to ORS 656.206, 656.247, 656.268 and 656.325 by sections 1 to 4 of this 2011 Act apply to requests for reconsideration made on or after the effective date of this 2011 Act [January 1, 2012]. [2011 c.99 §5]

(Implementation of 2013 Laws)

Note: Section 2, chapter 103, Oregon Laws 2013, provides:

Sec. 2. The amendments to ORS 656.340 by section 1 of this 2013 Act apply to all claims by workers who are eligible for or actively engaged in vocational training on or after the effective date of this 2013 Act [January 1, 2014]. [2013 c.103 §2]

Note: Section 2, chapter 488, Oregon Laws 2013, provides:

Sec. 2. The amendments to ORS 656.018 by section 1 of this 2013 Act apply to all claims or causes of action arising on or after the effective date of this 2013 Act [June 24, 2013]. [2013 c.488 §2]

COMPENSATION AND MEDICAL BENEFITS

656.204 Death. If death results from the accidental injury, payments shall be made as follows:

(1)(a) The cost of final disposition of the body and funeral expenses, including but not limited to transportation of the body, shall be paid, not to exceed 20 times the average weekly wage in any case.

(b) The insurer or self-insured employer shall pay bills submitted for disposition and funeral expenses up to the benefit limit established in paragraph (a) of this subsection. If any part of the benefit remains unpaid 60 days after claim acceptance, the insurer or self-insured employer shall pay the unpaid amount to the estate of the worker.

(2)(a) If the worker is survived by a spouse, monthly benefits shall be paid in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs.

(b) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 10 percent of the average weekly wage for each child of the deceased who is substantially dependent on the spouse for support, until such child becomes 18 years of age.

(c) If the worker is survived by a spouse, monthly benefits also shall be paid in an amount equal to 4.35 times 25 percent of the average weekly wage for each child of the deceased who is not substantially dependent on the spouse for support, until such child becomes 18 years of age.

(d) If a surviving spouse receiving monthly payments dies, leaving a child who is entitled to compensation on account of the death of the worker, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age or the child's entitlement to benefits under sub-

section (8) of this section ceases, whichever is later.

(e) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(f) In no event shall the total monthly benefits provided for in this subsection exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child will be reduced proportionally.

(3)(a) Upon remarriage, a surviving spouse shall be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payments for each child shall continue as before.

(b) If, after the date of the subject worker's death, the surviving spouse cohabits with another person for an aggregate period of more than one year and a child has resulted from the relationship, the surviving spouse shall be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payment for any child who is entitled to compensation on account of the death of the worker shall continue as before.

(4)(a) If the worker does not leave a spouse but leaves a child under 18 years of age, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age.

(b) If a child who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(c) In no event shall the total benefits provided for in this subsection exceed 4.35 times 133-1/3 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each child will be reduced proportionally.

(5)(a) If the worker leaves a dependent other than a surviving spouse or a child, a monthly payment shall be made to each dependent equal to 50 percent of the average monthly support actually received by such dependent from the worker during the 12 months next preceding the occurrence of the accidental injury. If a dependent is under the age of 18 years at the time of the accidental injury, the payment to the dependent shall cease when such dependent becomes 18 years of age. The payment to any dependent shall cease under the same circumstances that would have terminated the dependency had the injury not happened.

(b) If the dependent who has become 18 years of age is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(c) In no event shall the total benefits provided for in this subsection exceed 4.35 times 10 percent of the average weekly wage. If the sum of the individual benefits exceeds this maximum, the benefit for each dependent will be reduced proportionally.

(6) If a child is an invalid at the time the child otherwise becomes ineligible for benefits under this section, the payment to the child shall continue while the child remains an invalid. If a person is entitled to payment because the person is an invalid, payment shall terminate when the person ceases to be an invalid.

(7) If, at the time of the death of a worker, the child of the worker or dependent has become 17 years of age but is under 18 years of age, the child or dependent shall receive the payment provided in this section for a period of one year from the date of the death. However, if after such period the child is a full-time high school student, benefits shall be paid as provided in subsection (8) of this section.

(8)(a) Benefits under this section which are to be paid as provided in this subsection shall be paid for the child or dependent until the child or dependent becomes 19 years of age. If, however, the child or dependent is attending higher education or begins attending higher education within six months of the date the child or dependent leaves high school, benefits shall be paid until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier.

(b) If a child or dependent who is eligible for benefits under this subsection has no surviving parent, the child or dependent shall receive 4.35 times 66-2/3 percent of the average weekly wage until the child or dependent becomes 23 years of age, ceases attending higher education or graduates from an approved institute or program, whichever is earlier.

(c) As used in this subsection, "attending higher education" means regularly attending community college, college or university, or regularly attending a course of vocational or technical training designed to prepare the participant for gainful employment. A child or dependent enrolled in an educational course load of less than one-half of that determined by the educational facility to constitute "full-time" enrollment is not "attending higher education."

(9) As used in this section, "average weekly wage" has the meaning for that term provided in ORS 656.211. [Amended by 1957 c.453

§1; 1965 c.285 §22; 1967 c.286 §1; 1969 c.521 §1; 1971 c.415 §1; 1973 c.497 §2; 1974 c.41 §4; 1981 c.535 §4; 1981 c.874 §15; 1985 c.108 §1; 1987 c.235 §1; 1991 c.473 §1; 1995 c.332 §13; 1999 c.927 §2; 2009 c.171 §1; 2015 c.629 §54]

Note: See notes under 656.202.

Note: Section 59, chapter 332, Oregon Laws 1995, provides:

Sec. 59. (1) Surviving spouses without children, whose entitlement to benefits under ORS 656.204 is based on an injury before September 20, 1985, shall have their benefits supplemented from the Retroactive Reserve. The total benefits payable, comprising the benefits in effect on the date of injury plus the Retroactive Reserve supplement, shall be equal to the total benefits payable under the formula prescribed for surviving spouses without children, whose entitlement to benefits is based on an injury occurring on September 20, 1985.

(2) The provisions of this section apply to benefits for periods beginning on and after the effective date of this 1995 Act [June 7, 1995]. [1995 c.332 §59]

656.206 Permanent total disability. (1) As used in this section:

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

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

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

(A) Worker's vocational capability; or

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

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

(e) "Regularly performing work" means the ability of the worker to discharge the essential functions of the job.

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

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

(2) When permanent total disability results from the injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages not to exceed 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50, whichever amount is lesser.

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

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

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

(6)(a) If a worker receiving permanent total disability benefits is found to be materially improved and capable of regularly performing work at a gainful and suitable occupation, the insurer or self-insured employer shall issue a notice of closure pursuant to ORS 656.268. Permanent total disability benefits shall be paid through the date of the notice of closure. Notwithstanding ORS 656.268 (5), if a worker objects to a notice of closure issued under this subsection, the worker must request a hearing. If the worker requests a hearing on the notice of closure before the Hearings Division of the Workers' Compensation Board within 30 days of the date of the notice of closure, the insurer or self-insured employer shall continue payment of permanent total disability benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the worker requests a hearing on the notice of closure more than 30 days from the date of the notice of closure but before the 60-day period for requesting a hearing expires, the insurer or self-insured employer shall resume paying permanent total disability benefits from the date the hearing is requested and shall continue payment of benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the notice

of closure is upheld by the Hearings Division, the insurer or self-insured employer shall be reimbursed from the Workers' Benefit Fund for the amount of permanent total disability benefits paid after the date of the notice of closure issued under this subsection.

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

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

(d) Notwithstanding section 54 (3), chapter 2, Oregon Laws 1990, the Hearings Division of the Workers' Compensation Board may request the director to order a medical arbiter examination of an injured worker who has requested a hearing under this subsection.

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

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

(9) Notwithstanding any other provisions of this chapter, if a worker receiving permanent total disability incurs a new compensable injury, the worker's entitlement to compensation for the new injury shall be limited to medical benefits pursuant to ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS 656.214 (2).

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

(11) For purposes of this section:

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

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

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

(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire.

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

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

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

(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability. [Amended by 1953 c.670 §4; 1955 c.553 §1; 1957 c.452 §1; 1959 c.517 §1; 1965 c.285 §22a; 1969 c.500 §2; 1973 c.614 §2; 1974 c.41 §5; 1975 c.506 §1; 1977 c.430 §1; 1981 c.874 §12; 1983 c.816 §3; 1995 c.332 §14; 1999 c.313 §13; 1999 c.927 §3; 2003 c.657 §§5,6; 2005 c.461 §§1,2; 2007 c.274 §3; 2011 c.99 §2]

Note: See notes under 656.202.

656.207 [1959 c.589 §2; repealed by 1965 c.285 §95]

656.208 Death during permanent total disability. (1) If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving a spouse or any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204.

(2) If any surviving spouse to whom the provisions of this section apply remarries, the payments on account of a child or children shall continue to be made to the child or children the same as before the remarriage. [Amended by 1957 c.453 §2; 1959 c.450 §2; 1965 c.285 §22b; 1969 c.521 §2; 1971 c.415 §2; 1973 c.497 §3; 1975 c.497 §2; 1985 c.108 §2]

656.209 Offsetting permanent total disability benefits against Social Security benefits. (1) With the authorization of the Department of Consumer and Business Services, the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal Social Security.

(a) If the benefit amount to which the worker is entitled pursuant to this chapter exceeds the worker's federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount the worker would have received pursuant to this chapter had such reduction not been made.

(b) If the benefit amount to which the worker is entitled pursuant to this chapter is less than the worker's federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount of combined benefits the worker receives below the federal benefit limitation.

(2) No reduction of permanent total disability benefits shall be made pursuant to this section unless authorized by the department.

(3) No reduction of benefits shall be authorized pursuant to this section except upon actual receipt of federal Social Security disability benefits by the injured worker.

(4) The effective date of the operation of any offset provided in this section shall be the date established in the authorization provided in subsection (1) of this section, whether the authorization was issued prior to or subsequent to May 8, 1979. [1977 c.430 §5; 1979 c.117 §3]

656.210 Temporary total disability; payment during medical treatment; election; rules. (1) When the total disability

is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 133 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is less. Notwithstanding the limitation imposed by this subsection, an injured worker who is not otherwise eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have the benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year.

(2)(a) For the purpose of this section, the weekly wage of workers shall be ascertained:

(A) For workers employed in one job at the time of injury, by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed; or

(B) For workers employed in more than one job at the time of injury, by adding all earnings the worker was receiving from all subject employment.

(b) Notwithstanding paragraph (a)(B) of this subsection, the weekly wage calculated under paragraph (a)(A) of this subsection shall be used for workers employed in more than one job at the time of injury unless the insurer, self-insured employer or assigned claims agent for a noncomplying employer receives:

(A) Within 30 days of receipt of the initial claim, notice that the worker was employed in more than one job with a subject employer at the time of injury; and

(B) Within 60 days of the date of mailing a request for verification, verifiable documentation of wages from such additional employment.

(c) Notwithstanding ORS 656.005 (7)(c), an injury to a worker employed in more than one job at the time of injury is not disabling if no temporary disability benefits are payable for time lost from the job at injury. Claim costs incurred as a result of supplemental temporary disability benefits paid as provided in subsection (5) of this section may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services if the injured worker is not eligible for permanent disability benefits or temporary disability benefits for time lost from the job at injury.

(d) For the purpose of this section:

(A) The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.

(B) The benefits of a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits shall be based on the wage of the worker at the worker's last regular employment.

(e) As used in this subsection, "regularly employed" means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage.

(3) No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.

(4) When an injured worker with an accepted disabling compensable injury is required to leave work for a period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent, until such time as the worker is determined to be medically stationary. However, benefits under this subsection are not payable if wages are paid for the period of absence by the employer.

(5)(a) The insurer of the employer at injury or the self-insured employer at injury, may elect to be responsible for payment of supplemental temporary disability benefits to a worker employed in more than one job at the time of injury. In accordance with rules adopted by the director, if the worker's weekly wage is determined under subsection (2)(a)(B) of this section, the insurer or self-insured employer shall be reimbursed from

the Workers' Benefit Fund for the amount of temporary disability benefits paid that exceeds the amount payable pursuant to subsection (2)(a)(A) of this section had the worker been employed in only one job at the time of injury. Such reimbursement shall include an administrative fee payable to the insurer or self-insured employer pursuant to rules adopted by the director.

(b) If the insurer or self-insured employer elects not to pay the supplemental temporary disability benefits for a worker employed in more than one job at the time of injury, the director shall either administer and pay the supplemental benefits directly or shall assign responsibility to administer and process the payment to a paying agent selected by the director.

(6) The director shall adopt rules for the payment and reimbursement of supplemental temporary disability benefits under this section. [Amended by 1955 c.713 §1; 1957 c.452 §2; 1959 c.517 §2; 1965 c.285 §22c; 1969 c.183 §1; 1969 c.500 §1; 1971 c.204 §1; 1973 c.614 §1; 1974 c.41 §6; 1975 c.507 §1; 1975 c.663 §1; 1985 c.507 §3; 1987 c.521 §1; 1987 c.713 §7; 1995 c.332 §15; 2001 c.865 §3; 2003 c.760 §1; 2007 c.241 §10; 2009 c.313 §1]

Note: See notes under 656.202.

656.211 "Average weekly wage" defined. As used in ORS 656.210 (1), "average weekly wage" means the average weekly wage of workers in covered employment in Oregon, as determined by the Employment Department, for the last quarter of the calendar year preceding the fiscal year in which compensation is paid and as computed by the Employment Department as of May 15 of each year. [1973 c.614 §4; 1990 c.2 §6]

Note: See notes under 656.202.

656.212 Temporary partial disability. When the disability is or becomes partial only and is temporary in character:

(1) No disability payment is recoverable for temporary disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.

(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210. [Amended by 1953 c.672 §2; 1995 c.332 §16; amendments by 1995 c.332 §16a repealed by 1999 c.6 §1; 1999 c.538 §1]

Note: See notes under 656.202.

656.214 Permanent partial disability. (1) As used in this section:

(a) "Impairment" means the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease determined in accordance with the standards provided under ORS 656.726, expressed as a percentage of the whole person.

(b) "Loss" includes permanent and complete or partial loss of use.

(c) "Permanent partial disability" means:

(A) Permanent impairment resulting from the compensable industrial injury or occupational disease; or

(B) Permanent impairment and work disability resulting from the compensable industrial injury or occupational disease.

(d) "Regular work" means the job the worker held at injury.

(e) "Work disability" means impairment modified by age, education and adaptability to perform a given job.

(2) When permanent partial disability results from a compensable injury or occupational disease, benefits shall be awarded as follows:

(a) If the worker has been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has returned to regular work at the job held at the time of injury, the award shall be for impairment only. Impairment shall be determined in accordance with the standards provided by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726 (4). Impairment benefits are determined by multiplying the impairment value times 100 times the average weekly wage as defined by ORS 656.005.

(b) If the worker has not been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has not returned to regular work at the job held at the time of injury, the award shall be for impairment and work disability. Work disability shall be determined in accordance with the standards provided by the director pursuant to ORS 656.726 (4). Impairment shall be determined as provided in paragraph (a) of this subsection. Work disability benefits shall be determined by multiplying the impairment value, as modified by the factors of age, education and adaptability to perform a given job, times 150 times the worker's weekly wage for the job at injury as calculated under ORS 656.210 (2). The factor for the worker's weekly wage

used for the determination of the work disability may be no more than 133 percent or no less than 50 percent of the average weekly wage as defined in ORS 656.005.

(3) Impairment benefits awarded under subsection (2)(a) of this section shall be expressed as a percentage of the whole person. Impairment benefits for the following body parts may not exceed:

(a) For the loss of one arm at or above the elbow joint, 60 percent.

(b) For the loss of one forearm at or above the wrist joint, or the loss of one hand, 47 percent.

(c) For the loss of one leg, at or above the knee joint, 47 percent.

(d) For the loss of one foot, 42 percent.

(e) For the loss of a great toe, six percent; for loss of any other toe, one percent.

(f) For partial or complete loss of hearing in one ear, that proportion of 19 percent which the loss bears to normal monaural hearing.

(g) For partial or complete loss of hearing in both ears, that proportion of 60 percent which the combined binaural hearing loss bears to normal combined binaural hearing. For the purpose of this paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. In the case of individuals with compensable hearing loss involving both ears, either the method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be used, depending upon which allows the greater award of impairment.

(h) For partial or complete loss of vision of one eye, that proportion of 31 percent which the loss of monocular vision bears to normal monocular vision. For the purposes of this paragraph, the term "normal monocular vision" shall be considered as Snellen 20/20 for distance and Snellen 14/14 for near vision with full sensory field.

(i) For partial loss of vision in both eyes, that proportion of 94 percent which the combined binocular visual loss bears to normal combined binocular vision. In all cases of partial loss of sight, the percentage of said loss shall be measured with maximum correction. For the purpose of this paragraph, combined binocular visual loss shall be calculated by taking three times the visual loss in the less damaged eye plus the visual loss in the more damaged eye and dividing that amount by four. In the case of individuals with compensable visual loss involving both eyes, either the method of calculation for monocular visual loss or that for combined binocular visual loss shall be used, depending upon which allows the greater award of impairment.

(j) For the loss of a thumb, 15 percent.

(k) For the loss of a first finger, eight percent; of a second finger, seven percent; of a third finger, three percent; of a fourth finger, two percent.

(4) The loss of one phalange of a thumb, including the adjacent epiphyseal region of the proximal phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange of a finger, including the adjacent epiphyseal region of the middle phalange, is considered equal to the loss of one-half of a finger. The loss of two phalanges of a finger, including the adjacent epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of 75 percent of a finger. The loss of more than one phalange of a thumb, excluding the epiphyseal region of the proximal phalange, is considered equal to the loss of an entire thumb. The loss of more than two phalanges of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of an entire finger. A proportionate loss of use may be allowed for an uninjured finger or thumb where there has been a loss of effective opposition.

(5) A proportionate loss of the hand may be allowed where impairment extends to more than one digit, in lieu of ratings on the individual digits.

(6) All permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning of symptoms may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization. [Amended by 1953 c.669 §4; 1955 c.716 §1; 1957 c.449 §1; 1965 c.285 §22d; 1967 c.529 §1; 1971 c.178 §1; 1977 c.557 §1; 1979 c.839 §27; 1981 c.535 §27; 1985 c.506 §3; 1987 c.884 §36; 1990 c.2 §7; 1995 c.332 §17; 1999 c.6 §7; 1999 c.876 §2; 2001 c.865 §6; 2003 c.657 §§1,2; 2005 c.653 §§3,4; 2007 c.274 §1]

Note: See notes under 656.202.

(Benefits, January 1, 1992, to December 31, 1995)

Note: Section 2, chapter 745, Oregon Laws 1991, provides:

Sec. 2. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995, the worker shall receive an amount equal to 71 percent of the average weekly wage times the number of degrees stated against the disability as provided in ORS 656.214 (2) to (4). However, as annual changes in the average weekly wage occur, the amount of the average weekly wage used in calculation of the benefit amount pursuant to this subsection shall not be more than five percent larger than the amount used in the previous year.

(2)(a) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (5), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995, the worker shall receive an amount equal to:

(A) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is equal to or less than 96, 24 percent of the average weekly wage times the number of degrees.

(B) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is more than 96 but equal to or less than 192, 24 percent of the average weekly wage times 96 plus 28 percent of the average weekly wage times the number of degrees in excess of 96.

(C) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is more than 192, 24 percent of the average weekly wage times 96 plus 28 percent of the average weekly wage times 96 plus 71 percent of the average weekly wage times the number of degrees in excess of 192.

(b) However, as annual changes in the average weekly wage occur, the amount of the average weekly wage used in calculation of the benefit amount pursuant to this subsection shall not be more than five percent larger than the amount used in the previous year.

(3) Benefits referred to in this section shall be paid on the basis of the benefit amount in effect on the date of injury.

(4) As used in this section, "average weekly wage" has the meaning for that term provided in ORS 656.211. [1991 c.745 §2; 1995 c.332 §18]

(Benefits, January 1, 1996, to December 31, 1997)

Note: Section 20, chapter 332, Oregon Laws 1995, provides:

Sec. 20. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 1996, and ending December 31, 1997, the worker shall receive $420 for each degree stated against the disability as provided in ORS 656.214 (2) to (4).

(2) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (5), for injuries occurring during the period beginning January 1, 1996, and ending December 31, 1997, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is equal to or less than 64, $130 times the number of degrees.

(b) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is more than 64 but equal to or less than 160, $130 times 64 plus $230 times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability as provided in ORS 656.214 (5) is more than 160, $130 times 64 plus $230 times 96 plus $625 times the number of degrees in excess of 160.

(3) Benefits referred to in this section shall be paid on the basis of the benefit amount in effect on the date of injury. [1995 c.332 §20; 1997 c.380 §1]

(Benefits, January 1, 1998, to October 23, 1999)

Note: Section 3, chapter 380, Oregon Laws 1997, provides:

Sec. 3. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 1998, and ending on the effective date of this 1999 Act [October 23, 1999], the worker shall receive $454 for each degree stated against the disability as provided in ORS 656.214 (2) to (4).

(2) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (6), for injuries occurring during the period beginning January 1, 1998, and ending on the effective date of this 1999 Act, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is equal to or less than 64, $137.80 times the number of degrees.

(b) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 64 but equal to or less than 160, $137.80 times 64 plus $243.80 times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 160, $137.80 times 64 plus $243.80 times 96 plus $662.50 times the number of degrees in excess of 160.

(3) Benefits referred to in this section shall be paid on the basis of the benefit amount in effect on the date of injury. [1997 c.380 §3; 1999 c.6 §6]

(Benefits, January 1, 2000, to December 31, 2004)

Note: Section 9, chapter 6, Oregon Laws 1999, provides:

Sec. 9. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 2000, and ending December 31, 2004, the worker shall receive $511.29 for each degree stated against the disability as provided in ORS 656.214 (2) to (4).

(2) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (6), for injuries occurring during the period beginning January 1, 2000, and ending December 31, 2004, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is equal to or less than 64, $153.00 times the number of degrees.

(b) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 64 but equal to or less than 160, $267.44 times 64 plus $153.00 times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 160, $153.00 times 64 plus $267.44 times 96 plus $709.79 times the number of degrees in excess of 160.

(3) Benefits referred to in this section shall be paid on the basis of the benefit amount in effect on the date of injury. [1999 c.6 §9]

Note: Sections 6a and 6b, chapter 865, Oregon Laws 2001, modify benefit amounts paid under section 9, chapter 6, Oregon Laws 1999, for injuries occurring during the period beginning January 1, 2000, and ending July 30, 2001. For benefit amounts paid for injuries occurring during the period beginning July 31, 2001, and ending December 31, 2001, see 656.214.

Note: Sections 6a and 6b, chapter 865, Oregon Laws 2001, provide:

Sec. 6a. (1) Workers injured between January 1, 2000, and the effective date of this 2001 Act [July 30, 2001] who were awarded permanent partial disability benefits before the effective date of this 2001 Act shall be paid by the Director of the Department of Consumer and Business Services from the Workers' Benefit Fund an amount equal to the amount that benefits calculated pursuant to section 6b of this 2001 Act are less than the

benefits calculated pursuant to ORS 656.214, as amended by section 6 of this 2001 Act.

(2) The amendments to ORS 656.214 by section 6 of this 2001 Act may not be applied to the benefits awarded to any injured worker during the period beginning January 1, 2000, and ending on the effective date of this 2001 Act in such a manner as to reduce the benefits awarded to that worker pursuant to section 6b of this 2001 Act. [2001 c.865 §6a]

Sec. 6b. (1) Notwithstanding any other provision of this chapter [ORS chapter 656], for injuries occurring in the period beginning January 1, 2000, and ending on the effective date of this 2001 Act [July 30, 2001], and for which awards have been made during that period, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is equal to or less than 64, $153.00 times the number of degrees.

(b) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 64 but equal to or less than 160, $267.44 times 64 plus $153.00 times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 160, $153.00 times 64 plus $267.44 times 96 plus $709.79 times the number of degrees in excess of 160.

(2) Notwithstanding any other provision of this chapter, for injuries occurring in the period beginning January 1, 2000, and ending on the effective date of this 2001 Act, and for which awards are made after the effective date of this 2001 Act, the worker shall receive payments as provided in ORS 656.214, as amended by section 6 of this 2001 Act. [2001 c.865 §6b]

(Benefits, January 1, 2002, to December 31, 2004)

Note: Section 6c, chapter 865, Oregon Laws 2001, provides:

Sec. 6c. (1) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (2), for injuries occurring during the period beginning January 1, 2002, and ending December 31, 2004, the worker shall receive $559.00 for each degree stated against the disability as provided in ORS 656.214 (2) to (4).

(2) Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214 (6), for injuries occurring during the period beginning January 1, 2002, and ending December 31, 2004, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is equal to or less than 64, $184.00 times the number of degrees.

(b) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 64 but equal to or less than 160, $184.00 times 64 plus $321.00 times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability as provided in ORS 656.214 (6) is more than 160, $184.00 times 64 plus $321.00 times 96 plus $748.00 times the number of degrees in excess of 160.

(3) Benefits referred to in this section shall be paid on the basis of the benefit amount in effect on the date of injury. [2001 c.865 §6c]

656.215 [1987 c.884 §36b; 1990 c.2 §8; repealed by 1991 c.745 §3]

656.216 Permanent partial disability; method of payment; effect of prior receipt of temporary disability payments. (1) Compensation for permanent partial disability may be paid monthly at 4.35 times the rate per week as provided for compensation for temporary total disability at the time the determination is made. In no case shall such payments be less than $108.75 per month.

(2) If a worker, who is entitled to compensation for a permanent disability, has received compensation for a temporary disability by reason of the same injury, compensation for such permanent disability shall be in addition to the payments which the worker has received on account of such temporary disability. [Amended by 1967 c.529 §2; 1973 c.459 §1; 1974 c.41 §7]

656.218 Continuance of permanent partial disability payments to survivors; effect of death prior to final claim disposition. (1) In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof has been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto.

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

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

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

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

(6) This section does not entitle any person to double payments on account of the death of a worker and a continuation of payments for permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal. [Amended by 1959 c.450 §3; 1973 c.355 §1; 1975 c.497 §3; 1981 c.854 §11; 1987 c.884 §16; 1999 c.313 §4; 2009 c.171 §2; 2015 c.144 §2]

Note: Section 3, chapter 144, Oregon Laws 2015, provides:

Sec. 3. The amendments to ORS 656.218 and 656.268 by sections 1 and 2 of this 2015 Act apply to notices of

closure issued on or after the effective date of this 2015 Act [May 21, 2015]. [2015 c.144 §3]

656.220 [Amended by 1957 c.718 §4; 1965 c.285 §24; repealed by 1975 c.505 §1]

656.222 Compensation for additional accident. Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities.

656.224 [Amended by 1953 c.674 §13; repealed by 1959 c.517 §5]

656.225 Compensability of certain preexisting conditions. In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

(2) In occupational disease or injury claims involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of an actual worsening of the preexisting condition and not just of its symptoms.

(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease. [1995 c.332 §3]

656.226 Cohabitants and children entitled to compensation. In case two unmarried individuals have cohabited in this state as spouses who are married to each other for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under this chapter the same as if the individuals had been legally married. [Amended by 1983 c.816 §4; 2015 c.629 §55]

656.228 Payments directly to beneficiary or custodian. (1) If compensation is payable for the benefit of a beneficiary other than the injured worker, the insurer or the self-insured employer may segregate any additional compensation payable on account of that beneficiary and make payment directly to the beneficiary, if sui juris; otherwise, to the guardian or person having custody of the beneficiary.

(2) Compensation paid to an injured worker who is a minor prior to receipt of notice by the insurer or the self-insured employer from the parent or guardian of the minor that the parent or guardian claims the compensation shall discharge the obligation to pay compensation to the extent of such payment. [Amended by 1957 c.477 §1; 1965 c.285 §25; 1981 c.854 §12]

656.230 Lump sum award payments. (1) When a worker has been awarded compensation for permanent partial disability, and the worker requests payment of all or part of the award in a lump sum payment, the insurer shall make the payment requested unless the:

(a) Worker has not waived the right to appeal the adequacy of the award;

(b) Award has not become final by operation of law;

(c) Payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) Worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726.

(2) Any unpaid balance of the award not paid in a lump sum payment shall be paid pursuant to ORS 656.216.

(3) In all cases where the award for permanent partial disability does not exceed $6,000, the insurer or the self-insured employer shall pay all of the award to the worker in a lump sum. [Amended by 1957 c.574 §4; 1959 c.449 §1; 1965 c.285 §23a; 1973 c.221 §1; 1981 c.854 §13; 1983 c.816 §15; 1995 c.332 §22; 2007 c.270 §1]

656.232 Payments to aliens residing outside of United States. (1) If a beneficiary is an alien residing outside of the United States or its dependencies, payment of the sums due such beneficiary may, in the discretion of the Director of the Department of Consumer and Business Services, be made to the consul general of the country in which such beneficiary resides on behalf of the beneficiary. The receipt of the consul general to the director for the amounts thus paid shall be a full and sufficient receipt for the payment of the funds thus due the beneficiary.

(2) If a beneficiary is an alien residing outside of the United States or its dependencies, the director may, in lieu of awarding such beneficiary compensation in the amount provided by this chapter, award such beneficiary such lesser sum by way of compensation which, according to the conditions and costs of living in the place of residence of such beneficiary will, in the opinion of the director, maintain the beneficiary in a like degree of comfort as a beneficiary of the same class residing in this state and receiv-

ing the full compensation authorized by this chapter. The director shall determine the amount of compensation benefits upon the basis of the rate of exchange between the United States and any foreign country as determined by the Federal Reserve Bank as of January 1 and July 1 of the year when paid.

(3) All benefit rights shall be canceled upon the commencement of a state of war between the United States and the country of a beneficiary's domicile.

656.234 Compensation not assignable nor to pass by operation of law; certain benefits subject to support obligations. (1) No moneys payable under this chapter on account of injuries or death are subject to assignment prior to their receipt by the beneficiary entitled thereto, nor shall they pass by operation of law. All such moneys and the right to receive them are exempt from seizure on execution, attachment or garnishment, or by the process of any court.

(2) Notwithstanding any other provision of this section:

(a) Moneys payable under ORS 656.210 and 656.212 are subject to an order to enforce child support obligations, and spousal support when there is a current support obligation for a joint child of the obligated parent and the person to whom spousal support is owed, under ORS 25.378; and

(b) Moneys payable under ORS 656.206, 656.214, 656.236 and 656.289 (4) are subject to an order to enforce child support obligations under ORS 25.378.

(3) Notwithstanding the provisions of ORS 25.378 and 25.414, the amount of child support obligation subject to enforcement may not exceed:

(a) One-fourth of moneys paid under ORS 656.210 and 656.212 or the amount of the current support to be paid as continuing support, whichever is less, or, if there is no current support obligation and the withholding is for arrearages only, 15 percent of the moneys paid under ORS 656.210 and 656.212 or the amount previously paid as current support, whichever is less;

(b) One-half of moneys paid in a lump sum award under ORS 656.210 and 656.212 when the award becomes final by operation of law or waiver of the right to appeal its adequacy;

(c) One-half of moneys paid under ORS 656.206, 656.214 and 656.236; or

(d) One-half of the net proceeds paid to the worker in a disputed claim settlement under ORS 656.289 (4).

(4) Notwithstanding any other provision of this section, when withholding is only for arrearages assigned to this or another state, the Department of Justice may set a lesser amount to be withheld if the obligor demonstrates the withholding is prejudicial to the obligor's ability to provide for a child the obligor has a duty to support. [Amended by 1967 c.468 §1; 1989 c.520 §2; 1991 c.758 §3; 1993 c.48 §1; 1993 c.798 §22; 1995 c.272 §2; 2001 c.455 §26; 2003 c.73 §70; 2011 c.317 §2]

656.236 Compromise and release of claim matters except for medical benefits; approval by Administrative Law Judge or board; approval by director for certain reserve reimbursements; restriction on charging costs to workers; restriction on joinder as parties for responsibility determinations. (1)(a) The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe. For the purposes of this section, "matters regarding a claim" includes the disposition of a beneficiary's independent claim for compensation under this chapter. Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement. Each disposition shall be filed with the board for approval by the Administrative Law Judge who mediated the agreement or by the board. If the worker is not represented by an attorney, the worker may, at the worker's request, personally appear before the board. Submission of a disposition shall stay all other proceedings and payment obligations, except for medical services, on that claim. The disposition shall be approved in a final order unless:

(A) The Administrative Law Judge who mediated the agreement or the board finds the proposed disposition is unreasonable as a matter of law;

(B) The Administrative Law Judge who mediated the agreement or the board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or

(C) Within 30 days of submitting the disposition for approval, the worker, the insurer or self-insured employer requests the Administrative Law Judge who mediated the agreement or the board to disapprove the disposition.

(b) Notwithstanding paragraph (a)(C) of this subsection, a disposition may provide for waiver of the provisions of that subparagraph if the worker was represented by an attorney

at the time the worker signed the disposition.

(2) Notwithstanding any other provision of this chapter, an order approving disposition of a claim pursuant to this section is not subject to review. However, an order disapproving a disposition is subject to review pursuant to ORS 656.298. The board shall file with the Department of Consumer and Business Services a copy of each disposition that the Administrative Law Judge who mediated the agreement or the board approves. If the Administrative Law Judge who mediated the agreement or the board does not approve a disposition, the Administrative Law Judge or the board shall enter an order setting aside the disposition.

(3) Unless the terms of the disposition expressly provide otherwise, no payments, except for medical services, pursuant to a disposition are payable until the Administrative Law Judge who mediated the agreement or the board approves the disposition.

(4) If a worker is represented by an attorney in the negotiation of a disposition under this section, the insurer or self-insured employer shall pay to the attorney a fee prescribed by the Administrative Law Judge who mediated the agreement or the board.

(5) Except as otherwise provided in this chapter, none of the cost of workers' compensation to employers under this chapter, or in the court review of any claim therefor, shall be charged to a subject worker.

(6) Any claim in which the parties enter into a disposition under this section shall not be eligible for reimbursement of expenditures authorized by law from the Workers' Benefit Fund without the prior approval of the Director of the Department of Consumer and Business Services.

(7) Insurers or self-insured employers who are parties to an approved claim disposition agreement under this section shall not be joined as parties in subsequent proceedings under this chapter to determine responsibility for payment for any matter for which disposition is made by the agreement. Insurers or self-insured employers may be joined as parties in subsequent proceedings under this chapter to determine responsibility for medical services for claim conditions for which disposition is made by an approved claim disposition agreement, but no order in any subsequent proceedings may alter the obligations of an insurer or self-insured employer set forth in an approved claims disposition agreement, except as those obligations concern medical services.

(8) No release by a worker or beneficiary of any rights under this chapter is valid, except pursuant to a claim disposition agreement under this section or a release pursuant to ORS 656.593.

(9) Notwithstanding ORS 656.005 (21), as used in this section, "party" does not include a noncomplying employer. [1965 c.285 §28; 1985 c.212 §5; 1987 c.250 §4; 1990 c.2 §9; 1995 c.332 §24; 1995 c.641 §18; 1997 c.639 §5; 2007 c.17 §2; 2007 c.491 §1]

656.240 Deduction of benefits from sick leave payments paid to employees. Notwithstanding any other law, an employer, with the consent of the worker, may deduct from any sick leave payments made to an individual amounts equal to benefits received by the individual under this chapter with respect to the same injury that gave rise to the sick leave. However, the deduction of sick leave shall not exceed an amount determined by taking the worker's daily wage for the period less daily time loss benefits received under this chapter divided by the worker's daily wage. [1969 c.398 §2; 1983 c.816 §5]

656.242 [Amended by 1959 c.589 §1; repealed by 1965 c.285 §95]

656.244 [Amended by 1959 c.378 §1; repealed by 1965 c.285 §95]

656.245 Medical services to be provided; services by providers not members of managed care organizations; authorizing temporary disability compensation and making finding of impairment for disability rating purposes by certain providers; review of disputed claims for medical services; rules. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

(E) Services necessary to monitor the status, replacement or repair of prosthetic devices, braces and supports.

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

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

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

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

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

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

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

(d) When the medically stationary date in a disabling claim is established by the insurer or self-insured employer and is not based on the findings of the attending physician, the insurer or self-insured employer is responsible for reimbursement to affected medical service providers for otherwise compensable services rendered until the insurer or self-insured employer provides written notice to the attending physician of the worker's medically stationary status.

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

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

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

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

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

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

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

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

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

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

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

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the physician or nurse practitioner agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

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

(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured em-

ployer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician or nurse practitioner authorized to provide compensable medical services under this section who agrees to the conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.

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

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

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

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

(6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327. [1965 c.285 §23; 1979 c.839 §32; 1981 c.535 §31; 1981 c.854 §14; 1985 c.739 §4; 1987 c.884 §24; 1990 c.2 §10; 1995 c.332 §25; amendments by 1995 c.332 §25a repealed by 1999 c.6 §1; 1999 c.6 §10; 1999 c.582 §12; 1999 c.868 §1; 1999 c.926 §1; 2003 c.811 §§3,4; 2005 c.26 §§3,4; 2007 c.252 §§3,4; 2007 c.270 §§2,3; 2007 c.365 §2a; 2007 c.505 §§3,4; 2009 c.32 §1; 2009 c.36 §1; 2013 c.179 §1]

Note: See notes under 656.202.

656.246 [Repealed by 1965 c.285 §95]

656.247 Payment for medical services prior to claim acceptance or denial; review of disputed services; duty of health benefit plan to pay for certain medical services in denied claim. (1) Except for medical services provided to workers subject to ORS 656.245 (4)(b)(B), payment for medical services provided to a subject worker in response to an initial claim for a work-related injury or occupational disease from the date of the employer's notice or knowledge of the claim until the date the claim is accepted or denied shall be payable in accordance with subsection (4) of this section.

(2) Notwithstanding subsection (1) of this section, no payment shall be due from the insurer or self-insured employer if the insurer or self-insured employer denies the claim within 14 days of the date of the employer's notice or knowledge of the claim.

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

(b) Disputes about the amount of the fee or nonpayment of bills for medical treatment and services pursuant to this section shall be resolved pursuant to ORS 656.248.

(c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS 656.289 (4), all medical services

payable under subsection (1) of this section that are provided on or before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer or self-insured employer shall notify each affected service provider of the results of the settlement.

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

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

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

(d) As used in this subsection, "health benefit plan" has the meaning given that term in ORS 743B.005 and also means self-insured benefit plans and health benefit plans offered by the Oregon Educators Benefit Board and the Public Employees' Benefit Board. [2001 c.865 §14; 2005 c.26 §5; 2011 c.99 §3; 2014 c.94 §1]

Note: See notes under 656.202.

656.248 Medical service fee schedules; basis of fees; application to service provided by managed care organization; resolution of fee disputes; rules. (1) The Director of the Department of Consumer and Business Services, in compliance with ORS 656.794 and ORS chapter 183, shall promulgate rules for developing and publishing fee schedules for medical services provided under this chapter. These schedules shall represent the reimbursement generally received for the services provided. Where applicable, and to the extent the director determines practicable, these fee schedules shall be based upon any one or all of the following:

(a) The current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein;

(b) The average rates of fee schedules of the Oregon health insurance industry;

(c) A reasonable rate of markup for the sale of medical devices or other medical services;

(d) A commonly used and accepted medical service fee schedule; or

(e) The actual cost of providing medical services.

(2) Medical fees equal to or less than the fee schedules published under this section shall be paid when the vendor submits a billing for medical services. In no event shall that portion of a medical fee be paid that exceeds the schedules.

(3) In no event shall a provider charge more than the provider charges to the general public.

(4) If no fee has been established for a given service or procedure the director may, in compliance with ORS 656.794 and ORS chapter 183, promulgate a reasonable rate, which shall be the same within any given area for all primary health care providers to be paid for that service or procedure.

(5) At the request of the director and in the method and manner prescribed by rule, all providers of health insurance, as defined by ORS 731.162, shall cooperate and consult with the director in providing information reasonably necessary and available to develop the fee schedules prescribed under subsection (1) of this section. A provider shall not be required to provide information or data that the provider deems proprietary or confidential. However, the information provided shall be considered proprietary and shall not be released by the director. The director shall not require such information from a health insurance provider more than once per year and shall reimburse the provider's costs for providing the required information.

(6) Notwithstanding subsection (1) or (2) of this section, such rates or fees provided in subsections (1) and (2) of this section shall be adequate to insure at all times to the injured workers the standard of services and care intended by this chapter.

(7) The director shall update the schedule required by subsection (1) of this section annually. As appropriate and applicable, the update shall be based upon:

(a) A statistically valid survey by the director of medical service fees or markups;

(b) That information provided to the director by any person or state agency having access to medical service fee information;

(c) That information provided to the director pursuant to subsection (5) of this section; or

(d) The annual percentage increase or decrease in the physician's services component of the national Consumer Price Index published by the Bureau of Labor Statistics of the United States Department of Labor.

(8) The director is prohibited from adopting or administering rules which treat manipulation, when performed by an osteopathic physician, as anything other than a separate therapeutic procedure which is paid in addition to other services or office visits.

(9) The director may, by rule, establish a fee schedule for reimbursement for specific hospital services based upon the actual cost of providing the services.

(10) A medical service provider is not authorized to charge a fee for preparing or submitting a medical report form required by the director under this chapter.

(11) Notwithstanding any other provision of this section, fee schedules for medical services and hospital services shall apply to those services performed by a managed care organization certified pursuant to ORS 656.260, unless otherwise provided in the managed care contract.

(12) When a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider may request administrative review by the director. The decision of the director is subject to review under ORS 656.704.

(13) The director may exclude hospitals defined in ORS 442.470 from imposition of a fee schedule authorized by this section upon a determination of economic necessity. [Amended by 1965 c.285 §26; 1969 c.611 §1; 1971 c.329 §1; 1981 c.535 §5; 1983 c.816 §6; 1985 c.107 §1; 1985 c.739 §5; 1987 c.884 §42; 1990 c.2 §14; 1995 c.332 §26; 1999 c.233 §1; 2005 c.26 §6; 2009 c.36 §2]

Note: See notes under 656.202.

656.250 Limitation on compensability of physical therapist services. A physical therapist shall not provide compensable services to injured workers governed by this chapter except as allowed by a governing managed care organization contract or as authorized by the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245. [1993 c.211 §6; 2003 c.811 §§5,6; 2007 c.365 §3]

656.252 Medical report regulation; rules; duties of attending physician or nurse practitioner; disclosure of information; notice of changing attending physician or nurse practitioner; copies of medical service billings to be furnished to worker. (1) In order to ensure the prompt and correct reporting and payment of compensation in compensable injuries, the Director of the Department of Consumer and Business Services shall make rules governing audits of medical service bills and reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim to the injured worker's representative, the worker's employer, the employer's insurer and the Department of Consumer and Business Services. Such rules shall include, but not necessarily be limited to:

(a) Requiring attending physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to make the insurer or self-insured employer a first report of injury within 72 hours after the first service rendered.

(b) Requiring attending physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to submit follow-up reports within specified time limits or upon the request of an interested party.

(c) Requiring examining physicians and nurse practitioners authorized to provide compensable medical services under ORS 656.245 to submit their reports, and to whom, within a specified time.

(d) Such other reporting requirements as the director may deem necessary to insure that payments of compensation be prompt and that all interested parties be given information necessary to the prompt determination of claims.

(e) Requiring insurers and self-insured employers to audit billings for all medical services, including hospital services.

(2) The attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 shall do the following:

(a) Cooperate with the insurer or self-insured employer to expedite diagnostic and treatment procedures and with efforts to return injured workers to appropriate work.

(b) Advise the insurer or self-insured employer of the anticipated date for release of the injured worker to return to employment, the anticipated date that the worker will be medically stationary, and the next appointment date. Except when the attending physi-

cian or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has previously indicated that temporary disability will not exceed 14 days, the insurer or self-insured employer may request a medical report every 15 days, and the attending physician or nurse practitioner shall forward such reports.

(c) Advise the insurer or self-insured employer within five days of the date the injured worker is released to return to work. Under no circumstances shall the physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

(d) After a claim has been closed, advise the insurer or self-insured employer within five days after the treatment is resumed or the reopening of a claim is recommended. The attending physician under this paragraph need not be the same attending physician who released the worker when the claim was closed.

(3) In promulgating the rules regarding medical reporting the director may consult and confer with physicians and members of medical associations and societies.

(4) No person who reports medical information to a person referred to in subsection (1) of this section, in accordance with department rules, shall incur any legal liability for the disclosure of such information.

(5) Whenever an injured worker changes attending physicians or nurse practitioners authorized to provide compensable medical services under ORS 656.245, the newly selected attending physician or nurse practitioner shall so notify the responsible insurer or self-insured employer not later than five days after the date of the change or the date of first treatment. Every attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 who refers a worker to a consulting physician promptly shall notify the responsible insurer or self-insured employer of the referral.

(6) A provider of medical services, including hospital services, that submits a billing to the insurer or self-insured employer shall also submit a copy of the billing to the worker for whom the service was performed after receipt from the injured worker of a written request for such a copy. [1967 c.626 §§2,5; 1979 c.839 §3; 1981 c.535 §6; 1981 c.874 §17; 1987 c.884 §3; 1995 c.332 §26a; 2001 c.865 §14a; 2003 c.811 §§7,8; 2007 c.365 §4]

656.254 Medical report forms; penalties and other sanctions; procedure for declaring health care practitioner ineligible for workers' compensation reimbursement. (1) The Director of the Department of Consumer and Business Services shall establish medical report forms, in duplicate snap-outs where applicable, to be used by insurers, self-insured employers and physicians, including in such forms information necessary to establish facts required in the determination of the claim.

(2) The director shall establish sanctions for the enforcement of medical reporting requirements. Such sanctions may include, but are not limited to, forfeiture of fees and penalty not to exceed $1,000 for each occurrence.

(3) If the director finds that a health care practitioner has:

(a) Been found, pursuant to ORS 656.327, to have failed to comply with rules adopted pursuant to this chapter regarding the performance of medical services for injured workers or to have provided medical treatment that is excessive, inappropriate or ineffectual, the director may impose a sanction that includes forfeiture of fees and a penalty not to exceed $1,000 for each occurrence. If the failure to comply or perform is repeated and willful, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(b) Had the health care practitioner's license revoked or suspended by the practitioner's professional licensing board for a violation of that profession's ethical standards, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years or the period the practitioner's license is suspended or revoked, whichever period is the longer.

(c) Engaged in any course of conduct demonstrated to be dangerous to the health or safety of a workers' compensation claimant, the director may impose a sanction that includes forfeiture of fees and a penalty not to exceed $1,000 for each occurrence. If the conduct is repeated and willful, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(4) Any declaration that a health care practitioner is ineligible to receive reimbursement under this chapter shall not otherwise interfere with or impair treatment of any person by the health care practitioner.

(5) ORS 656.735 (4) to (6) and 656.740 also apply to orders and penalties assessed under this section. [1967 c.626 §§3,4; 1975 c.556 §40; 1979 c.839 §30; 1981 c.854 §15; 1987 c.233 §1; 1987 c.884 §27; 1995 c.94 §2; 1997 c.249 §200; 2003 c.170 §12; 2005 c.26 §7]

656.256 Considerations for rules regarding certain rural hospitals. Whenever the Workers' Compensation Division of the Department of Consumer and Business Services adopts any rule affecting a type A or B rural hospital, the division shall take into consideration the risk assessment formula set forth in ORS 442.520 (2). [1991 c.947 §19]

656.258 Vocational assistance service payments. The insurer or self-insured employer shall pay a vocational assistance provider for all vocational assistance services, including the cost of an evaluation to determine whether a worker is eligible for vocational assistance, that are performed at the request of the insurer or self-insured employer. Within 60 days after receiving a billing, the insurer or self-insured employer shall pay for all vocational assistance services performed, including those services performed in good faith without knowledge that the worker's eligibility to receive vocational assistance has been terminated or that the worker has withdrawn or is otherwise ineligible for vocational assistance. [1985 c.600 §18]

656.260 Certification procedure for managed health care provider; peer review, quality assurance, service utilization and contract review; confidentiality of certain information; immunity from liability; rules; medical service dispute resolution; penalties. (1) Any health care provider or group of medical service providers may make written application to the Director of the Department of Consumer and Business Services to become certified to provide managed care to injured workers for injuries and diseases compensable under this chapter. However, nothing in this section authorizes an organization that is formed, owned or operated by an insurer or employer other than a health care provider to become certified to provide managed care.

(2) Each application for certification shall be accompanied by a reasonable fee prescribed by the director. A certificate is valid for such period as the director may prescribe unless sooner revoked or suspended.

(3) Application for certification shall be made in such form and manner and shall set forth such information regarding the proposed plan for providing services as the director may prescribe. The information shall include, but not be limited to:

(a) A list of the names of all individuals who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in this state.

(b) A description of the times, places and manner of providing services under the plan.

(c) A description of the times, places and manner of providing other related optional services the applicants wish to provide.

(d) Satisfactory evidence of ability to comply with any financial requirements to insure delivery of service in accordance with the plan which the director may prescribe.

(4) The director shall certify a health care provider or group of medical service providers to provide managed care under a plan if the director finds that the plan:

(a) Proposes to provide medical and health care services required by this chapter in a manner that:

(A) Meets quality, continuity and other treatment standards adopted by the health care provider or group of medical service providers in accordance with processes approved by the director; and

(B) Is timely, effective and convenient for the worker.

(b) Subject to any other provision of law, does not discriminate against or exclude from participation in the plan any category of medical service providers and includes an adequate number of each category of medical service providers to give workers adequate flexibility to choose medical service providers from among those individuals who provide services under the plan. However, nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to the granting of medical staff privileges.

(c) Provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(d) Provides adequate methods of peer review, service utilization review, quality assurance, contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate. A majority of the members of each peer review, quality assurance, service utilization and contract review committee shall be physicians licensed to practice medicine by the Oregon Medical Board. As used in this paragraph:

(A) "Peer review" means evaluation or review of the performance of colleagues by a panel with similar types and degrees of ex-

pertise. Peer review requires participation of at least three physicians prior to final determination.

(B) "Service utilization review" means evaluation and determination of the reasonableness, necessity and appropriateness of a worker's use of medical care resources and the provision of any needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service utilization review" includes prior authorization, concurrent review, retrospective review, discharge planning and case management activities.

(C) "Quality assurance" means activities to safeguard or improve the quality of medical care by assessing the quality of care or service and taking action to improve it.

(D) "Dispute resolution" includes the resolution of disputes arising under peer review, service utilization review and quality assurance activities between insurers, self-insured employers, workers and medical and health care service providers, as required under the certified plan.

(E) "Contract review" means the methods and processes whereby the managed care organization monitors and enforces its contracts with participating providers for matters other than matters enumerated in subparagraphs (A), (B) and (C) of this paragraph.

(e) Provides a program involving cooperative efforts by the workers, the employer and the managed care organizations to promote workplace health and safety consultative and other services and early return to work for injured workers.

(f) Provides a timely and accurate method of reporting to the director necessary information regarding medical and health care service cost and utilization to enable the director to determine the effectiveness of the plan.

(g)(A) Authorizes workers to receive compensable medical treatment from a primary care physician or chiropractic physician who is not a member of the managed care organization, but who maintains the worker's medical records and is a physician with whom the worker has a documented history of treatment, if:

(i) The primary care physician or chiropractic physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require;

(ii) The primary care physician or chiropractic physician agrees to comply with all the rules, terms and conditions regarding services performed by the managed care organization; and

(iii) The treatment is determined to be medically appropriate according to the service utilization review process of the managed care organization.

(B) Nothing in this paragraph is intended to limit the worker's right to change primary care physicians or chiropractic physicians prior to the filing of a workers' compensation claim.

(C) A chiropractic physician authorized to provide compensable medical treatment under this paragraph may provide services and authorize temporary disability compensation as provided in ORS 656.005 (12)(b)(B) and 656.245 (2)(b). However, the managed care organization may authorize chiropractic physicians to provide medical services and authorize temporary disability payments beyond the periods established in ORS 656.005 (12)(b)(B) and ORS 656.245 (2)(b).

(D) As used in this paragraph, "primary care physician" means a physician who is qualified to be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a general practitioner or an internal medicine practitioner.

(h) Provides a written explanation for denial of participation in the managed care organization plan to any licensed health care provider that has been denied participation in the managed care organization plan.

(i) Does not prohibit the injured worker's attending physician from advocating for medical services and temporary disability benefits for the injured worker that are supported by the medical record.

(j) Complies with any other requirement the director determines is necessary to provide quality medical services and health care to injured workers.

(5)(a) Notwithstanding ORS 656.245 (5) and subsection (4)(g) of this section, a managed care organization may deny or terminate the authorization of a primary care physician or chiropractic physician to serve as an attending physician under subsection (4)(g) of this section or of a nurse practitioner to provide medical services as provided in ORS 656.245 (5) if the physician or nurse practitioner, within two years prior to the worker's enrollment in the plan:

(A) Has been terminated from serving as an attending physician or nurse practitioner for a worker enrolled in the plan for failure to meet the requirements of subsection (4)(g) of this section or of ORS 656.245 (5); or

(B) Has failed to satisfy the credentialing standards for participating in the managed care organization.

(b) The director shall adopt by rule reporting standards for managed care organizations to report denials and terminations of the authorization of primary care physicians, chiropractic physicians and nurse practitioners who are not members of the managed care organization to provide compensable medical treatment under ORS 656.245 (5) and subsection (4)(g) of this section. The director shall annually report to the Workers' Compensation Management-Labor Advisory Committee the information reported to the director by managed care organizations under this paragraph.

(6) The director shall refuse to certify or may revoke or suspend the certification of any health care provider or group of medical service providers to provide managed care if the director finds that:

(a) The plan for providing medical or health care services fails to meet the requirements of this section.

(b) Service under the plan is not being provided in accordance with the terms of a certified plan.

(7) Any issue concerning the provision of medical services to injured workers subject to a managed care contract and service utilization review, quality assurance, dispute resolution, contract review and peer review activities as well as authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the director or the director's designated representatives. The decision of the director is subject to review under ORS 656.704. Data generated by or received in connection with these activities, including written reports, notes or records of any such activities, or of any review thereof, shall be confidential, and shall not be disclosed except as considered necessary by the director in the administration of this chapter. The director may report professional misconduct to an appropriate licensing board.

(8) No data generated by service utilization review, quality assurance, dispute resolution or peer review activities and no physician profiles or data used to create physician profiles pursuant to this section or a review thereof shall be used in any action, suit or proceeding except to the extent considered necessary by the director in the administration of this chapter. The confidentiality provisions of this section shall not apply in any action, suit or proceeding arising out of or related to a contract between a managed care organization and a health care provider whose confidentiality is protected by this section.

(9) A person participating in service utilization review, quality assurance, dispute resolution or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

(10) No person who participates in forming consortiums, collectively negotiating fees or otherwise solicits or enters into contracts in a good faith effort to provide medical or health care services according to the provisions of this section shall be examined or subject to administrative or civil liability regarding any such participation except pursuant to the director's active supervision of such activities and the managed care organization. Before engaging in such activities, the person shall provide notice of intent to the director in a form prescribed by the director.

(11) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(12) In consultation with the committees referred to in ORS 656.790 and 656.794, the director shall adopt such rules as may be necessary to carry out the provisions of this section.

(13) As used in this section, ORS 656.245, 656.248 and 656.327, "medical service provider" means a person duly licensed to practice one or more of the healing arts in any country or in any state or territory or possession of the United States.

(14) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care organization contract may designate any medical service provider or category of providers as attending physicians.

(15) If a worker, insurer, self-insured employer, the attending physician or an authorized health care provider is dissatisfied with an action of the managed care organization regarding the provision of medical services pursuant to this chapter, peer review, service utilization review or quality assurance activities, that person or entity must first apply to the director for administrative review of the matter before requesting a hearing. Such application must be made not later than the 60th day after the date the managed care organization has completed and issued its final decision.

(16) Upon a request for administrative review, the director shall create a documentary record sufficient for judicial review. The director shall complete administrative review and issue a proposed order within a reasonable time. The proposed order of the director issued pursuant to this section shall

become final and not subject to further review unless a written request for a hearing is filed with the director within 30 days of the mailing of the order to all parties.

(17) At the contested case hearing, the order may be modified only if it is not supported by substantial evidence in the record or reflects an error of law. No new medical evidence or issues shall be admitted. The dispute may also be remanded to the managed care organization for further evidence taking, correction or other necessary action if the Administrative Law Judge or director determines the record has been improperly, incompletely or otherwise insufficiently developed. Decisions by the director regarding medical disputes are subject to review under ORS 656.704.

(18) Any person who is dissatisfied with an action of a managed care organization other than regarding the provision of medical services pursuant to this chapter, peer review, service utilization review or quality assurance activities may request review under ORS 656.704.

(19) Notwithstanding any other provision of law, original jurisdiction over contract review disputes is with the director. The director may resolve the matter by issuing an order subject to review under ORS 656.704, or the director may determine that the matter in dispute would be best addressed in another forum and so inform the parties.

(20) The director shall conduct such investigations, audits and other administrative oversight in regard to managed care as the director deems necessary to carry out the purposes of this chapter.

(21)(a) Except as otherwise provided in this chapter, only a managed care organization certified by the director may:

(A) Restrict the choice of a health care provider or medical service provider by a worker;

(B) Restrict the access of a worker to any category of medical service providers;

(C) Restrict the ability of a medical service provider to refer a worker to another provider;

(D) Require preauthorization or precertification to determine the necessity of medical services or treatment; or

(E) Restrict treatment provided to a worker by a medical service provider to specific treatment guidelines, protocols or standards.

(b) The provisions of paragraph (a) of this subsection do not apply to:

(A) A medical service provider who refers a worker to another medical service provider;

(B) Use of an on-site medical service facility by the employer to assess the nature or extent of a worker's injury; or

(C) Treatment provided by a medical service provider or transportation of a worker in an emergency or trauma situation.

(c) Except as provided in paragraph (b) of this subsection, if the director finds that a person has violated a provision of paragraph (a) of this subsection, the director may impose a sanction that may include a civil penalty not to exceed $2,000 for each violation.

(d) If violation of paragraph (a) of this subsection is repeated or willful, the director may order the person committing the violation to cease and desist from making any future communications with injured workers or medical service providers or from taking any other actions that directly or indirectly affect the delivery of medical services provided under this chapter.

(e)(A) Penalties imposed under this subsection are subject to ORS 656.735 (4) to (6) and 656.740.

(B) Cease and desist orders issued under this subsection are subject to ORS 656.740. [1990 c.2 §12; 1995 c.332 §27; amendments by 1995 c.332 §27a repealed by 1999 c.6 §1; 1997 c.639 §§1,2; 2005 c.26 §8; 2005 c.364 §1; 2007 c.423 §1; 2011 c.98 §1; 2013 c.179 §2]

Note: See notes under 656.202.

PROCEDURE FOR OBTAINING COMPENSATION

656.262 Processing of claims and payment of compensation; payment by employer; acceptance and denial of claim; penalties and attorney fees; cooperation by worker and attorney in claim investigation; rules. (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.

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

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

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

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

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

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

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

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

(i) The insurer or self-insured employer may unilaterally suspend payment of all compensation to a worker enrolled in a managed care organization if the worker continues to seek care from an attending physician or nurse practitioner authorized to provide compensable medical services under

ORS 656.245 that is not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

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

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

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

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

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

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

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

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

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

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

(c) An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005 (7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the

combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition.

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

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

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

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

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

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

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

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

subsection. The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.

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

(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

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

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

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

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

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

(16) In accordance with ORS 656.283 (3), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (14) of this section. [1965 c.285 §30; 1969 c.399 §1; 1973 c.620 §2; 1975 c.556 §41; 1981 c.535 §7; 1981 c.854 §16; 1981 c.874 §4; 1983 c.809 §1; 1983 c.816 §7; 1985 c.600 §7; 1987 c.884 §19; 1990 c.2 §15; 1995 c.332 §28; 1995 c.641 §4; 1997 c.605 §1; 1997 c.639 §7; 1999 c.313 §5; 2001 c.621 §83; 2001 c.865 §7; 2003 c.667 §1; 2003 c.756 §1; 2003 c.760 §2; 2003

c.811 §§9,10; 2005 c.26 §§9,10; 2005 c.511 §§1,2; 2005 c.588 §§2,3; 2007 c.252 §5; 2007 c.365 §5; 2007 c.518 §§1,2; 2009 c.35 §3; 2009 c.171 §3; 2009 c.526 §1; 2015 c.211 §1; 2015 c.521 §2]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.263 To whom notices sent under ORS 656.262, 656.265, 656.268 to 656.289, 656.295 to 656.325 and 656.382 to 656.388. All notices of proceedings required to be sent under ORS 656.262, 656.265, 656.268 to 656.289, 656.295 to 656.325, 656.382 to 656.388 and this section shall be sent to the employer and the insurer, if any. [1967 c.97 §2; 1975 c.556 §42]

656.264 Compensable injury, denied claim and other reports. (1) Insurers and self-insured employers shall report to the Director of the Department of Consumer and Business Services compensable injuries, denied claims, claims disposition and payments made by them under this chapter.

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

(3) The director may prescribe the interval and the form of such reports and establish sanctions for the enforcement of reporting requirements. [1975 c.556 §39; 1981 c.854 §17; 2003 c.760 §3]

656.265 Notice of accident from worker. (1)(a) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a beneficiary of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice.

(b) Notwithstanding paragraph (a) of this subsection, if an injured worker has not submitted a claim under this chapter but has submitted a claim to a health benefit plan that provides benefits to the worker, and the health benefit plan rejects the claim as being work related, the injured worker may file a claim under this section within 90 days from the date the health benefit plan rejects the claim. If a claim filed under this section is denied, the workers' compensation insurer or self-insured employer shall inform the health benefit plan of the denial and the health benefit plan shall process the claim for payment in accordance with the terms, conditions and benefits of the plan.

(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

(3) Notice shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services and referred to the insurer or self-insured employer.

(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

(a) The employer had knowledge of the injury or death;

(b) The worker died within 180 days after the date of the accident; or

(c) The worker or beneficiaries of the worker establish that the worker had good cause for failure to give notice within 90 days after the accident.

(5) The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death.

(6) The director shall promulgate and prescribe uniform forms to be used by workers in reporting their injuries to their employers. These forms shall be supplied by all employers to injured workers upon request of the injured worker or some other person on behalf of the worker. The failure of the worker to use a specified form shall not, in itself, defeat the claim of the worker if the worker has complied with the requirement that the claim be presented in writing. [1965 c.285 §30a; 1971 c.386 §2; 1981 c.854 §18; 1995 c.332 §29; 2003 c.707 §1; 2015 c.259 §1]

656.266 Burden of proving compensability and nature and extent of disability. (1) The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred.

(2) Notwithstanding subsection (1) of this section, for the purpose of combined condition injury claims under ORS 656.005 (7)(a)(B) only:

(a) Once the worker establishes an otherwise compensable injury, the employer shall bear the burden of proof to establish the otherwise compensable injury is not, or is no longer, the major contributing cause of

the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

(b) Notwithstanding ORS 656.804, paragraph (a) of this subsection does not apply to any occupational disease claim. [1987 c.713 §2; 2001 c.865 §2]

Note: See notes under 656.202.

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

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

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

(3) Notwithstanding subsection (2) of this section, claims for new medical or omitted medical conditions related to an initially accepted claim that have been determined to be compensable and that were initiated after the rights under ORS 656.273 expired shall be processed as requests for relief under the Workers' Compensation Board's own motion jurisdiction pursuant to ORS 656.278 (1)(b). [2001 c.865 §10; 2005 c.188 §1]

Note: See notes under 656.202.

656.268 Claim closure; termination of temporary total disability benefits; reconsideration of closure; medical arbiter to make findings of impairment for reconsideration; credit or offset for fraudulently obtained or overpaid benefits; rules. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when:

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

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

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

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

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

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

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

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

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

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

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

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

(C) Is not with the employer at injury;

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

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

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

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

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

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

(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker, to the worker's attorney if the worker is represented, and to the director. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

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

(B) The worker of:

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

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

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

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

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

(vi) The aggravation rights; and

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

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

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

(A) The decision not to close;

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

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

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

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

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

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

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

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

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

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

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

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

(d) Except as provided in subsection (7) of this section, the reconsideration proceed-

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

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

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

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

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

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

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

(C) The parties agree to the delay; and

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

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

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

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

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

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

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

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

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

(b) If neither party requests a medical arbiter and the director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.

(c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

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

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable

and necessary to establish the worker's impairment.

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

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, there shall be no further opportunity for the worker to attend a medical arbiter examination for this claim closure. The reconsideration record shall be closed, and the director shall issue an order on reconsideration based upon the existing record.

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

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

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

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

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

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

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

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

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

(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

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

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

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

(15) Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied. [1965 c.285 §31; 1973 c.620 §3; 1973 c.634 §2; 1977 c.804 §5; 1977 c.862 §1; 1979 c.839 §4; 1981 c.535 §7a; 1981 c.854 §19; 1981 c.874 §13; 1985 c.425 §1; 1985 c.600 §8; 1987 c.884 §10; 1990 c.2 §16; 1991 c.502 §1; 1995 c.332 §30; 1997 c.111 §1; 1997 c.382 §1; 1999 c.313 §1; 1999 c.1020 §3; 2001 c.349 §1; 2001 c.377 §63; 2001 c.865 §12; 2003 c.429 §1; 2003 c.657 §§7,8; 2003 c.811 §§11,12; 2005 c.221 §§1,2; 2005 c.461 §§3,4; 2005 c.569 §§1,2; 2007 c.241 §§11,12; 2007 c.270 §§4,5; 2007 c.274 §4; 2007 c.365 §6; 2007 c.835 §§2,3; 2011 c.99 §1; 2015 c.144 §1]

Note: See notes under 656.202.

Note: See note under 656.218.

656.270 [1971 c.155 §2; 1977 c.804 §6; 1979 c.839 §5; 1990 c.2 §17; 1999 c.313 §6; repealed by 2009 c.36 §5]

656.271 [1965 c.285 §32; 1969 c.171 §1; repealed by 1973 c.620 §4 (656.273 enacted in lieu of 656.271)]

656.272 [Repealed by 1965 c.285 §95]

656.273 Aggravation for worsened conditions; procedure; limitations; additional compensation. (1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable. A worsened condition is not established by either or both of the following:

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

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

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

(3) A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative and the worker's attending physician. When an insurer or self-insured employer receives a completed aggravation form, the insurer or self-insured employer shall process the claim.

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

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

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

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

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

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

(8) If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. [1973 c.620 §5 (enacted in lieu of 656.271); 1975 c.497 §1; 1977 c.804 §7; 1979 c.839 §6; 1981 c.854 §20; 1987 c.884 §23; 1989 c.171 §76; 1990 c.2 §18; 1995 c.332 §31; 1999 c.313 §2; 2001 c.350 §1; 2005 c.50 §1]

656.274 [Repealed by 1965 c.285 §95]

656.275 [1963 c.20 §2; repealed by 1965 c.285 §95]

656.276 [Repealed by 1965 c.285 §95]

656.277 Request for reclassification of nondisabling claim; nondisabling claim procedure; attorney fees. (1)(a) A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order.

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

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

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

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

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

(c) When otherwise required by the director. [1990 c.2 §48; 1995 c.332 §32; 1999 c.313 §3; 2001 c.350 §2; 2015 c.521 §3]

Note: See first note under 656.012.

Note: 656.277 was added to and made a part of ORS chapter 656 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

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

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

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

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

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

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

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

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

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

(3) An order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS 656.273 is not an order or award, as the case may be, made by the board on its own motion.

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

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

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

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

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

(b) Approving disposition of a claim under ORS 656.236 or 656.289 (4). [Amended by 1955 c.718 §1; 1957 c.559 §1; 1965 c.285 §33; 1981 c.535 §32; 1985 c.212 §6; 1987 c.884 §37; 1990 c.2 §19; 1995 c.332 §33; 2001 c.865 §11; 2005 c.188 §2]

Note: See notes under 656.202.

656.280 [Amended by 1965 c.285 §41b; renumbered 656.325]

656.282 [Amended by 1957 c.455 §1; repealed by 1965 c.285 §95]

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

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

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

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

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

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

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

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

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

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

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

(c) Nothing in paragraph (b) of this subsection alters the obligation of an insurer or self-insured employer to accept or deny a claim for compensation as required under this chapter.

(d) If a hearing has been postponed in accordance with paragraph (b) of this subsection:

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

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

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

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

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

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

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

(6) Except as otherwise provided in this section and rules of procedure established by the board, the Administrative Law Judge is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Neither the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used. Impeachment evidence consisting of medical or vocational reports not used during the course of a hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. Impeachment evidence other than medical or vocational reports that is not presented as evidence at hearing is not subject to disclosure. Evaluation of the worker's disability by the Administrative Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Evidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. If the Administrative Law Judge finds that the claim has been closed prematurely, the Administrative Law Judge shall issue an order rescinding the notice of closure.

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

(8) After a party requests a hearing and before the hearing commences, the board, by rule, may require the requesting party, if represented by an attorney, to notify the Administrative Law Judge in writing that the attorney has conferred with the other party and that settlement has been achieved, subject to board approval, or that settlement cannot be achieved. [1965 c.285 §34; 1979 c.839 §7; 1981 c.535 §33; 1981 c.860 §§1,5; 1985 c.600 §9; 1987 c.884 §11; 1990 c.2 §20; 1995 c.332 §34; 1999 c.313 §7; 2003 c.667 §2; 2005 c.26 §11; 2005 c.624 §1; 2009 c.35 §2]

Note: See notes under 656.202.

656.284 [Amended by 1953 c.671 §2; 1955 c.718 §2; 1959 c.450 §4; repealed by 1965 c.285 §95]

656.285 Protection of witnesses at hearings. ORCP 36 C shall apply to workers' compensation cases, except that the Administrative Law Judge shall make the determinations and orders required of the court in ORCP 36 C, and in addition attorney fees shall not be declared as a matter of course but only in cases of harassment or hardship. [1973 c.652 §1; 1977 c.358 §11; 1979 c.284 §187]

656.287 Use of vocational reports in determining loss of earning capacity at hearing; rules. (1) Where there is an issue regarding loss of earning capacity, reports from vocational consultants employed by governmental agencies, insurers or self-insured employers, or from private vocational consultants, regarding job opportunities, the fitness of claimant to perform certain jobs,

wage levels, or other information relating to claimant's employability shall be admitted into evidence at compensation hearings, provided such information is submitted to claimant 10 days prior to hearing and that upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination.

(2) The Workers' Compensation Board shall establish rules to govern the admissibility of reports from vocational experts, including guidelines to establish the competency of vocational experts. [1973 c.581 §§1,2; 1985 c.600 §10]

656.288 [Amended by 1957 c.288 §1; repealed by 1965 c.285 §95]

656.289 Orders of Administrative Law Judge; review; disposition of claim when compensability disputed; approval of director required for reimbursement of certain expenditures. (1) Upon the conclusion of any hearing, or prior thereto with concurrence of the parties, the Administrative Law Judge shall promptly and not later than 30 days after the hearing determine the matter and make an order in accordance with the Administrative Law Judge's determination.

(2) A copy of the order shall be sent forthwith by mail to the Director of the Department of Consumer and Business Services and to all parties in interest.

(3) The order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests a review by the Workers' Compensation Board under ORS 656.295. When one party requests a review by the board, the other party or parties shall have the remainder of the 30-day period and in no case less than 10 days in which to request board review in the same manner. The 10-day requirement may carry the period of time allowed for requests for board reviews beyond the 30th day. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.295.

(4)(a) Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of an Administrative Law Judge, the board or the court, by agreement make such disposition of the claim as is considered reasonable.

(b) Insurers or self-insured employers who are parties to an approved disputed claim settlement under this subsection shall not be joined as parties in subsequent proceedings under this chapter to determine responsibility for payment for claim conditions for which settlement has been made.

(c) Notwithstanding ORS 656.005 (21), as used in this subsection, "party" does not include a noncomplying employer, except where a noncomplying employer has submitted a disputed claim settlement with a claimant for approval before the claim has been referred to an assigned claims agent by the director. Upon approval of the disputed claim settlement, the Administrative Law Judge, the board or the court shall mail to the director a copy of the disputed claim settlement.

(5) Any claim in which the parties enter into a disposition under subsection (4) of this section shall not be eligible for reimbursement of expenditures from the Workers' Benefit Fund without the prior approval of the director. [1965 c.285 §35; 1969 c.212 §1; 1977 c.804 §9; 1983 c.809 §3; 1990 c.2 §21; 1995 c.332 §35; 1995 c.641 §19]

656.290 [Amended by 1955 c.718 §3; repealed by 1965 c.285 §95]

656.291 Expedited Claim Service; jurisdiction; procedure; representation; rules. (1) The Workers' Compensation Board, by rule, shall establish an Expedited Claim Service to provide for prompt, informal disposition of claims.

(2) The board shall assign to the service those claims:

(a) For which a hearing has been requested when the only matters unresolved do not include compensability of the claim and the amount in controversy is $1,000 or less; or

(b) For which the only matters unresolved are attorney fees or penalties.

(3)(a) The amount in controversy shall be deemed less than $1,000 if the party requesting hearing so indicates, the other party does not disagree and the Administrative Law Judge does not conclude, based on the evidence, that the amount in controversy exceeds $1,000. In a case assigned pursuant to subsection (2)(a) of this section, if the Administrative Law Judge finds that the amount in controversy exceeds $1,000, the Administrative Law Judge shall refer the case for disposition under the ordinary hearing process.

(b) Cases assigned to the Expedited Claim Service pursuant to subsection (2)(a) of this section shall be heard within 30 days of the request for hearing, and an order shall be issued within 10 days of the close of the hearing.

(c) No hearing shall be held in cases assigned to the Expedited Claim Service pursuant to subsection (2)(b) of this section unless the Administrative Law Judge finds that the dispute cannot be decided on stipulated facts.

(4) The board, by rule, shall establish the procedures for disposition of claims by the Expedited Claim Service to insure fair and just treatment of workers in all such proceedings.

(5) Notwithstanding ORS 9.320 or any provision of this chapter, an individual who is not an attorney may represent oneself or other persons who consent to such representation at any proceeding before the Expedited Claim Service.

(6) Any compromises, agreements, admissions, stipulations, statements of fact that are made or other such action taken by the representative is binding on those represented to the same extent as if done by an attorney. A person so represented may not thereafter claim that any such proceeding or meeting was legally defective because the person was not represented by an attorney.

(7) An individual who is not an attorney may not represent a claimant for a fee at any proceeding under this chapter.

(8) As used in this subsection, "attorney" has the meaning for that term provided in ORS 9.005. [1987 c.884 §18]

656.292 [Amended by 1965 c.285 §38; renumbered 656.301]

656.294 [Amended by 1965 c.285 §37; renumbered 656.304]

656.295 Board review of Administrative Law Judge orders; application of standards for evaluation of disability. (1) The request for review by the Workers' Compensation Board of an order of an Administrative Law Judge need only state that the party requests a review of the order.

(2) The requests for review shall be mailed to the board and copies of the request shall be mailed to all parties to the proceeding before the Administrative Law Judge.

(3) When review has been requested, the record of such oral proceedings at the hearings before the Administrative Law Judge as may be necessary for purposes of the review shall be transcribed at the expense of the board. The original transcript shall be certified to be true, accurate and complete by the transcriber. A list of all exhibits received by the Administrative Law Judge shall be furnished to the parties in interest along with a copy of the transcribed record.

(4) Notice of the review shall be given to the parties by mail. The board shall set a date for review as expeditiously as possible. Review shall be scheduled for a date not later than 90 days after receipt by the board of the request for review. Review shall not be postponed except in extraordinary circumstances beyond the control of the requesting party.

(5) The review by the board shall be based upon the record submitted to it under subsection (3) of this section and such oral or written argument as it may receive. Evaluation of the worker's disability by the board shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. If the board finds that the claim has been closed prematurely, the board shall issue an order rescinding the notice of closure. The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. However, if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Administrative Law Judge, it may remand the case to the Administrative Law Judge for further evidence taking, correction or other necessary action.

(6) The board may affirm, reverse, modify or supplement the order of the Administrative Law Judge and make such disposition of the case as it determines to be appropriate. It shall make its decision within 30 days after the review.

(7) The order of the board shall be filed and a copy thereof sent by mail to the director and to the parties.

(8) An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298. [1965 c.285 §35a; 1977 c.804 §10; 1987 c.884 §12; 1990 c.2 §22; 1991 c.293 §1; 1999 c.313 §8]

Note: See notes under 656.202.

656.298 Judicial review of board orders; settlement during pendency of petition for review. (1) Within the time limit specified in ORS 656.295, any party affected by an order of the Workers' Compensation Board, including orders issued pursuant to ORS 656.278, may request judicial review of the order by the Court of Appeals.

(2) The name and style of the proceedings shall be "In the Matter of the Compensation of (name of the worker)."

(3) The judicial review shall be commenced by serving a copy of a petition for judicial review on the board and on the parties who appeared in the review proceedings, and by filing with the clerk of the Court of Appeals the original petition for judicial review with proof of service indorsed thereon. The petition for judicial review shall state:

(a) The name of the person requesting judicial review and of all other parties.

(b) The date of the filing of the order for which judicial review is requested.

(c) A statement that the person is requesting judicial review by the Court of Appeals.

(d) A brief statement of the relief requested and the reasons the relief should be granted.

(4) Within 10 days after service of a petition for judicial review on a party under subsection (3) of this section, such party may also request judicial review in the same manner.

(5) The following requirements of subsection (3) of this section are jurisdictional and may not be waived or extended:

(a) Service of the petition for judicial review on all parties identified in the petition for judicial review as adverse parties or, if the petition for judicial review does not identify adverse parties, on all parties who have appeared in the proceeding before the board, within the time limits imposed by ORS 656.295 (8) and by subsection (4) of this section.

(b) Filing of the original petition for judicial review with the Court of Appeals within the time limits imposed by ORS 656.295 (8) and by subsection (4) of this section.

(6) Within 30 days after service of a petition for judicial review on the board, the board shall forward to the clerk of the Court of Appeals:

(a) The original copy of the transcribed record prepared under ORS 656.295.

(b) All exhibits.

(c) Copies of all decisions and orders entered during the hearing and review proceedings.

(7) The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482 (7) and (8).

(8) Review under this section shall be given precedence on the docket over all other cases, except those given equal status by statute.

(9)(a) If the parties to a petition for judicial review of an order of the board settle all or part of the matter during the pendency of the petition for judicial review, the board has jurisdiction to enter any orders that may be necessary to implement the settlement.

(b) If the settlement disposes of all issues during the pendency of the petition for judicial review, the appellate court may dismiss the petition for judicial review.

(c) If the settlement disposes of part of the issues during the pendency of the petition for judicial review, the appellate court may limit judicial review to the issues not disposed of by the settlement. [1965 c.285 §36; 1977 c.804 §11; 1987 c.884 §12a; 1997 c.389 §1; 2005 c.188 §3; 2007 c.17 §1]

Note: See notes under 656.202.

656.301 [Formerly 656.292; repealed by 1977 c.804 §55]

656.304 When acceptance of compensation precludes hearing. A claimant may accept and cash any check given in payment of any award or compensation without affecting the right to a hearing, except that the right of hearing on any award shall be waived by acceptance of a lump sum award by a claimant where such lump sum award was granted as a result of the claimant's own request under ORS 656.230. This section shall not be construed as a waiver of the necessity of complying with ORS 656.283 to 656.298. [Formerly 656.294; 2007 c.270 §6]

656.307 Determination of issues regarding responsibility for compensation payment; mediation or arbitration procedure; rules. (1)(a) Where there is an issue regarding:

(A) Which of several subject employers is the true employer of a claimant worker;

(B) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(C) Responsibility between two or more employers or their insurers involving payment of compensation for one or more accidental injuries; or

(D) Joint employment by two or more employers,

the Director of the Department of Consumer and Business Services shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262 (4).

(b) At the time of claim closure, all parties to an order issued pursuant to paragraph (a) of this subsection shall have reconsideration and appeal rights.

(2) The director then shall request the Workers' Compensation Board chairperson to appoint an Administrative Law Judge to determine the responsible paying party. The proceedings shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298.

(3) When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. Any monetary adjustment not reimbursed by an insurer or self-insured employer shall be recovered from the Consumer and Business Services Fund. Any stipulation or agreement under subsection (6) of this section shall not obligate the Consumer and Business Services Fund for reimbursement without prior approval of the Director of the Department of Consumer and Business Services.

(4) No self-insured employer or an insurer shall be joined in any proceeding under this section regarding its responsibility for any claim subject to ORS 656.273 unless the issue is entitled to hearing on application of the worker.

(5) The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim.

(6)(a) Notwithstanding subsection (2) of this section, parties to a responsibility proceeding under this section may agree to resolution of the dispute by mediation or arbitration by a private party. Any settlement stipulation, arbitration decision or other resolution of matters in dispute resulting from mediation or arbitration proceedings shall be filed with the Hearings Division and shall be given the same force and effect as an order of an Administrative Law Judge made pursuant to subsection (2) of this section. However, any such settlement stipulation, arbitration decision or other resolution is binding on the parties and is not subject to review by the director, an Administrative Law Judge, the board or any court or other administrative body, unless required pursuant to paragraph (d) of this subsection or subsection (3) of this section.

(b) For purposes of this subsection, mediation is a process of discussion and negotiation, with the mediator playing a central role in seeking a consensus among the parties. Such consensus may be reflected in a final mediation settlement stipulation, signed by all the parties and fully binding upon the parties with the same effect as a final order of an Administrative Law Judge, when the signed mediation settlement stipulation is filed with the Hearings Division of the Workers' Compensation Board.

(c) For purposes of this subsection, arbitration is an agreement to submit the matter to a binding decision by an arbitrator, through a process mutually agreed upon in advance. Once all the parties have agreed in writing to proceed with arbitration, no party may withdraw from the arbitration process except as provided in the written arbitration agreement.

(d) A mediation settlement stipulation may include matters beyond the responsibility issues. If other matters are included, the settlement agreement shall be submitted to the Hearings Division of the Workers' Compensation Board for review and approval, under this chapter, as to such additional matters beyond the responsibility issues.

(e) Any arbitration decision shall be limited to a decision as to responsibility and, where appropriate, the payment of associated costs and attorney fees. The arbitrator's decision shall have the same effect as a final order of an Administrative Law Judge when the signed decision is filed with the Hearings Division.

(f) When the parties have reported to the Hearings Division that they have agreed upon a mediation or arbitration process, the hearing shall be deferred for 90 days to allow the mediation or arbitration process to occur. Once 90 days have passed, the matter shall again be docketed for hearing unless the parties advise the Hearings Division in writing that progress has been made and request an extension of time of up to 90 days, which extension of time shall be granted as a matter of right. Once the second 90 days have passed, the matter shall again be docketed for hearing, and the hearing shall proceed before an Administrative Law Judge as though there had been no mediation or arbitration process, unless the parties present a mediation settlement stipulation or signed arbitration decision before the hearing begins.

(g) All parties must agree in writing to pursue mediation or arbitration and must agree upon the selection of the mediator or arbitrator. The mediator or arbitrator shall not be an employee of any insurer or self-insured employer that is a party to the proceedings. The mediator or arbitrator must be an attorney admitted to practice law in the State of Oregon. The mediator or arbitrator may serve as a mediator or arbitrator, even if the mediator or arbitrator separately re-

presents any insurer or self-insured employer in other proceedings, provided that all parties are advised of such representation and consent in writing that the mediator or arbitrator may so serve despite such other representation. Such written consent supersedes any legal ethics restrictions otherwise provided for in law or regulation.

(h) If the claimant is represented by an attorney, the other parties must arrange for payment of a reasonable attorney fee for the claimant's attorney's services during the mediation or arbitration. Any mediation or arbitration agreement shall specify the terms of the fee arrangement.

(i) If the claimant is not represented by an attorney, the mediation process cannot include any issue other than responsibility. A nonrepresented claimant must be advised in writing of the following before the mediation or arbitration proceeds:

(A) The claimant's right to refuse to participate in mediation or arbitration proceedings and to, instead, proceed to a hearing before an Administrative Law Judge;

(B) The present rate of temporary total disability benefits for each alleged date of injury;

(C) The present rate of permanent partial disability benefits for each alleged date of injury;

(D) The estimated date of expiration of aggravation rights for each alleged date of injury; and

(E) The claimant's right to be represented by counsel of the claimant's choice at no expense to the claimant.

(j) Notwithstanding any other provision of law, any insurer or self-insured employer may be represented by a certified claims examiner rather than by an attorney in any mediation or arbitration hereunder. Any separate insured for the same insurer shall be represented by a separate claims examiner, if the insured has a continuing financial exposure as to the claim; where no continuing financial exposure exists, a single certified claims examiner may represent more than one insured for the same insurer in the mediation or arbitration proceeding.

(k) Any other procedures as to mediation or arbitration shall be subject to agreement among the parties. The Workers' Compensation Board may adopt rules as to the process for deferral and docketing of hearings where mediation or arbitration occurs, the filing of arbitration decisions as orders of the Hearings Division, the filing of mediation settlement stipulations regarding responsibility as orders of the Hearings Division, and review and approval of mediation settlement stipulations that extend beyond the issues of responsibility and associated attorney fees and costs. The Workers' Compensation Board shall not enact rules that restrict the mediation or arbitration process except to the extent provided within this section. [1965 c.285 §39; 1971 c.70 §1; 1979 c.839 §8; 1987 c.713 §5; 1995 c.332 §36; 1997 c.43 §1; 1999 c.313 §9; 1999 c.876 §3; 2003 c.657 §§9,10; 2007 c.274 §5]

656.308 Responsibility for payment of claims; effect of new injury; denial of responsibility; procedure for joining employers and insurers; attorney fees; limitation on filing claims subject to settlement agreement. (1) When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005 (7) shall also be used to determine the occurrence of a new compensable injury or disease under this section.

(2)(a) Any insurer or self-insured employer who disputes responsibility for a claim shall so indicate in or as part of a denial otherwise meeting the requirements of ORS 656.262 issued in the 60 days allowed for processing of the claim. The denial shall advise the worker to file separate, timely claims against other potentially responsible insurers or self-insured employers, including other insurers for the same employer, in order to protect the right to obtain benefits on the claim. The denial may list the names and addresses of other insurers or self-insured employers. Such denials shall be final unless the worker files a timely request for hearing pursuant to ORS 656.319. All such requests for hearing shall be consolidated into one proceeding.

(b) No insurer or self-insured employer, including other insurers for the same employer, shall be joined to any workers' compensation hearing unless the worker has first filed a timely, written claim against that insurer or self-insured employer, or the insurer or self-insured employer has consented to issuance of an order designating a paying agent pursuant to ORS 656.307. An insurer or self-insured employer against whom a claim is filed may contend that responsibility lies with another insurer or self-insured employer, including another insurer for the same employer, regardless of whether the worker has filed a claim against that insurer or self-insured employer.

(c) Upon written notice by an insurer or self-insured employer filed not more than 28 days or less than 14 days before the hearing, the Administrative Law Judge shall dismiss that party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party. The Administrative Law Judge shall decide such motions and inform the parties not less than seven days prior to the hearing, or postpone the hearing.

(d) Notwithstanding ORS 656.382 (2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the attorney for the injured worker for the attorney's appearance and active and meaningful participation in finally prevailing against a responsibility denial. The fee shall not exceed $2,500 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this paragraph shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any.

(3) A worker who is a party to an approved disputed claim settlement agreement under ORS 656.289 (4) may not subsequently file a claim against an insurer or a self-insured employer who is a party to the agreement with regard to claim conditions settled in the agreement even if other insurers or employers disclaim responsibility for those claim conditions. A worker who is a party to an approved claim disposition agreement under ORS 656.236 (1) may not subsequently file a claim against an insurer or a self-insured employer who is a party to the agreement with regard to any matter settled in the agreement even if other insurers or employers disclaim responsibility for those claim conditions, unless the claim in the subsequent proceeding is limited to a claim for medical services for claim conditions settled in the agreement. [1990 c.2 §49; 1995 c.332 §37; 2001 c.865 §8; 2009 c.526 §2]

Note: See notes under 656.202.

656.310 Presumption concerning notice of injury and self-inflicted injuries; reports as evidence. (1) In any proceeding for the enforcement of a claim for compensation under this chapter, there is a rebuttable presumption that:

(a) Sufficient notice of injury was given and timely filed; and

(b) The injury was not occasioned by the willful intention of the injured worker to commit self-injury or suicide.

(2) The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination. This subsection shall also apply to medical or surgical reports from any treating or examining doctor who is not a resident of Oregon, provided that the claimant, self-insured employer or the insurer shall have a reasonable time, but no less than 30 days after receipt of notice that the report will be offered in evidence at a hearing, to cross-examine such doctor by deposition or by written interrogatories to be settled by the Administrative Law Judge. [1965 c.285 §40; 1969 c.447 §1; 1981 c.854 §21]

656.312 [Amended by 1953 c.428 §2; 1965 c.285 §44; renumbered 656.578]

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

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

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

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

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

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

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

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

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

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

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

(c) If the services are settled pursuant to ORS 656.289 (4), the insurer or self-insured employer shall reimburse, out of the settlement proceeds, each medical service provider for billings received by the insurer or self-insured employer on and before the date on which the terms of settlement are agreed as specified in the settlement document that are not otherwise partially or fully reimbursed.

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

(5) As used in this section, "health insurance" has the meaning for that term provided in ORS 731.162. [1965 c.285 §41; 1979 c.673 §1; 1981 c.535 §8; 1981 c.854 §22; 1983 c.809 §2; 1990 c.2 §23; 1993 c.521 §1; 1995 c.332 §38; amendments by 1995 c.332 §38a repealed by 1999 c.6 §1; 1999 c.6 §11; 2001 c.865 §13a; 2005 c.588 §4; 2009 c.35 §4; 2011 c.80 §1; 2015 c.521 §4]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.314 [Amended by 1965 c.285 §45; renumbered 656.580]

656.316 [Amended by 1953 c.428 §2; 1965 c.285 §46; renumbered 656.583]

656.318 [Amended by 1965 c.285 §47; renumbered 656.587]

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

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

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

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

(3) With respect to subsection (2) of this section, lack of mental competency shall apply only to an individual suffering from such mental disorder, mental illness or nervous disorder as is required for commitment or voluntary admission to a treatment facility pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380 and the rules of the Oregon Health Authority.

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

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

(6) A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred.

(7) With respect to objection by a claimant to a notice of closure issued under ORS 656.206, a hearing on the objection shall not be granted unless the request for hearing is filed within 60 days after the notice of closure was mailed to the claimant. [1965 c.285 §41a; 1969 c.206 §1; 1975 c.497 §4; 1983 c.819 §1; 1987 c.884 §14; 1990 c.2 §24; 1995 c.332 §39; 2005 c.461 §6; 2009 c.595 §1041]

Note: See notes under 656.202.

656.320 [Amended by 1953 c.428 §2; 1965 c.285 §48; renumbered 656.591]

656.322 [Amended by 1953 c.428 §2; 1955 c.656 §1; 1959 c.644 §1; 1965 c.285 §49; renumbered 656.593]

656.324 [Amended by 1965 c.285 §50; renumbered 656.595]

656.325 Required medical examination; worker-requested examination; qualified physicians; claimant's duty to reduce disability; suspension or reduction of benefits; cessation or reduction of temporary total disability benefits; rules; penalties. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. No more than three independent medical examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

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

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

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

(B) Impose a monetary penalty against a worker who fails to attend an independent medical examination without prior notification or without justification for not attending the examination. A penalty imposed under this subparagraph may be imposed only on a worker who is not receiving temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may offset any future compensation payable to the worker to recover any penalty imposed under this subparagraph from a claim with the same insurer or self-insured employer. When a penalty is recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment may not exceed 25 percent of the benefit payment without prior authorization from the worker.

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

(d) Notwithstanding ORS 656.262 (6), if the director determines that the location se-

lected for an independent medical examination is unreasonable, the insurer or self-insured employer shall accept or deny the claim within 90 days after the employer has notice or knowledge of the claim.

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

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

(g) A worker who objects to the location of an independent medical examination must request review by the director under paragraph (c)(A) of this subsection within six business days of the date the notice of the independent medical examination was mailed.

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

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

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

(5)(a) Except as provided by ORS 656.268 (4)(c) and (11), an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered.

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

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

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

ORS 656.283. [Formerly 656.280; 1977 c.804 §12; 1977 c.868 §4; 1979 c.839 §29; 1981 c.535 §10; 1981 c.723 §4; 1981 c.854 §23; 1983 c.816 §8; 1985 c.770 §7; 1987 c.884 §43; 1989 c.598 §1; 1990 c.2 §25; 1995 c.332 §40; 2001 c.865 §13; 2003 c.657 §§11,12; 2003 c.811 §§13,14; 2005 c.675 §§1,2; 2007 c.274 §6; 2007 c.365 §7; 2011 c.99 §4]

Note: See notes under 656.202.

656.326 [Amended by 1965 c.285 §51; renumbered 656.597]

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

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

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

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

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

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

(5) The costs of review of medical treatment by the physician or panel of physicians pursuant to this section and costs incurred by the worker in attending any examination required under this section, including child care, transportation, lodging and meals, shall be paid by the insurer or self-insured employer. [1987 c.884 §29; 1990 c.2 §26; 1995 c.332 §41; 2005 c.26 §12]

656.328 List of authorized providers and standards of professional conduct for providers of independent medical examinations; exclusion; complaints; rules. (1) The Director of the Department of Consumer and Business Services shall maintain a list of providers that are authorized to perform independent medical examinations.

(2) A provider on the list maintained by the director under subsection (1) of this section may be excluded from the list by the director after a finding of a violation of standards of professional conduct for conducting independent medical examinations adopted by the appropriate health professional regulatory board. The director shall adopt by rule standards of professional conduct for providers performing independent medical examinations if the appropriate health professional regulatory board has not adopted standards pertaining to independent medical examinations. The rules adopted by the director under this subsection may be consistent with the guidelines of conduct published by the Independent Medical Examination Association in effect on June 4, 2007. The decision of the director to exclude a provider from the list maintained under subsection (1) of this section is subject to review under ORS 656.704.

(3) The director, in consultation with the advisory committee on medical care of the Workers' Compensation Division of the Department of Consumer and Business Services, the Workers' Compensation Management-Labor Advisory Committee and affected interest groups shall develop, and the director shall adopt by rule:

(a) Professional licensing training requirements and educational materials for physicians participating in the workers' compensation system and conducting independent medical examinations required under ORS 656.325 (1); and

(b) A process for investigating and reviewing complaints about independent medical examinations conducted under the requirements of ORS 656.325 (1) that includes, but is not limited to, standards for referring complaints to the appropriate health professional regulatory board and an appeals process for a physician who disagrees with an action taken by the director under subsection (2) of this section. [2005 c.675 §5; 2007 c.300 §1]

656.329 [1987 c.884 §33; repealed by 1995 c.94 §1]

656.330 [1977 c.868 §2; repealed by 1985 c.660 §2 and 1985 c.770 §5]

656.331 Contact, medical examination of worker represented by attorney prohibited without written notice; rules. (1) Notwithstanding any other provision of this chapter, if an injured worker is represented by an attorney and the attorney has given written notice of such representation:

(a) The Director of the Department of Consumer and Business Services, the insurer or self-insured employer shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

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

(2) The director shall adopt rules necessary to carry out the provisions of subsection (1)(b) of this section. [1985 c.706 §8]

656.335 [1981 c.723 §7; 1985 c.600 §3; 1985 c.770 §7a; repealed by 1995 c.332 §68]

656.340 Vocational assistance procedure; eligibility criteria; service providers; resolution of vocational assistance disputes; rules. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be provided to an injured worker who is eligible for assistance in returning to work.

(b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for vocational assistance within five days of:

(A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical or investigation report, notification from the worker, or otherwise; or

(B) The time the worker is medically stationary, if the worker has not returned to or been released for the worker's regular employment or has not returned to other suitable employment with the employer at the time of injury or aggravation and the worker is not receiving vocational assistance.

(c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new information that would change the eligibility determination.

(2) Contact under subsection (1) of this section shall include informing the worker about reemployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job site modification assistance and the provisions of the preferred worker program pursuant to rules adopted by the Director of the Department of Consumer and Business Services.

(3) Within five days after notification that the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has released a worker to return to work, the insurer or self-insured employer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the employer of the worker's reemploy-

ment rights, wage subsidy and the job site modification assistance and the provisions of the preferred worker program.

(4) As soon as possible, and not more than 30 days after the contact required by subsection (1) of this section, the insurer or self-insured employer shall cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance. The insurer or self-insured employer shall notify the worker of the decision regarding the worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the worker is not eligible, the worker may apply to the director for review of the decision as provided in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under standards prescribed by the director, may not be found eligible thereafter unless that eligibility determination is rejected by the director under subsection (16) of this section or the worker's condition worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for such benefits arises from a worsening of the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS 656.273.

(5) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the weekly wage currently being paid for employment which was the worker's regular employment even though the wage available following employment may be less than the wage prescribed by subsection (6) of this section. As used in this subsection and subsection (6) of this section, "regular employment" means the employment the worker held at the time of the injury or the claim for aggravation under ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of the aggravation, the employment the worker held on the last day of work prior to the aggravation.

(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A "substantial handicap to employment" exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) "Suitable employment" means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and

(iii) Employment that produces a weekly wage within 20 percent of that currently being paid for employment that was the worker's regular employment as defined in subsection (5) of this section. The director shall adopt rules providing methods of calculating the weekly wage currently being paid for the worker's regular employment for use in determining eligibility and for providing assistance to eligible workers. If the worker's regular employment was seasonal or temporary, the worker's wage shall be averaged based on a combination of the worker's earned income and any unemployment insurance payments. Only earned income evidenced by verifiable documentation such as federal or state tax returns shall be used in the calculation. Earned income does not include fringe benefits or reimbursement of the worker's employment expenses.

(7) Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training.

(8) An insurer or self-insured employer may utilize its own staff or may engage any other individual certified by the director to perform the vocational evaluation required by subsection (4) of this section.

(9) The director shall adopt rules providing:

(a) Standards for and methods of certifying individuals qualified by education, training and experience to provide vocational assistance to injured workers;

(b) Standards for registration of vocational assistance providers;

(c) Conditions and procedures under which the certification of an individual to provide vocational assistance services or the

registration of a vocational assistance provider may be suspended or revoked for failure to maintain compliance with the certification or registration standards;

(d) Standards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work; and

(e) Procedures, schedules and conditions relating to the payment for services performed by a vocational assistance provider, that are based on payment for specific services performed and not fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for direct worker purchases and for all vocational assistance providers and shall be the same within suitable geographic areas.

(10) Insurers and self-insured employers shall maintain records and make reports to the director of vocational assistance actions at times and in the manner as the director may prescribe. The requirements prescribed shall be for the purpose of assisting the Department of Consumer and Business Services in monitoring compliance with this section to insure that workers receive timely and appropriate vocational assistance. The director shall minimize to the greatest extent possible the number, extent and kinds of reports required. The director shall compile a list of organizations or agencies registered to provide vocational assistance. A current list shall be distributed by the director to all insurers and self-insured employers. The insurer shall send the list to each worker with the notice of eligibility.

(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer shall notify the director and the director shall select a provider. Any change in the choice of vocational assistance provider is subject to the approval of the director.

(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months. The insurer or self-insured employer may voluntarily extend the payment of temporary disability compensation to a maximum of 21 months. The director may order the payment of temporary disability compensation for up to 21 months upon good cause shown by the injured worker. The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months.

(13) As used in this section, "vocational assistance provider" means a public or private organization or agency that provides vocational assistance to injured workers.

(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the same type or extent of assistance.

(b) Training shall not be provided to an eligible worker solely because the worker cannot obtain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage significantly closer to that prescribed in subsection (6) of this section.

(c) Nothing in this section shall be interpreted to expand the availability of training under this section.

(15) A physical capacities evaluation shall be performed in conjunction with vocational assistance or determination of eligibility for such assistance at the request of the insurer or self-insured employer or worker. The request shall be made to the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245. The attending physician or nurse practitioner, within 20 days of the request, shall perform a physical capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer and the worker in writing that the injured worker is incapable of participating in a physical capacities evaluation.

(16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director shall adopt by rule a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter. Application for review must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time.

(c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. The agreement is subject to reconsideration by the director under limitations prescribed by the director, but is not subject to review by any other forum.

(d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order based on a record sufficient to permit review. The order is subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the date the order was issued. At the hearing, the order of the director shall be modified only if it:

(A) Violates a statute or rule;

(B) Exceeds the statutory authority of the agency;

(C) Was made upon unlawful procedure; or

(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(e) For purposes of this subsection, the term "parties" does not include a noncomplying employer. [1981 c.535 §2; 1985 c.600 §11; 1987 c.884 §15; 1990 c.2 §27; 1995 c.332 §42; amendments by 1995 c.332 §42a repealed by 1999 c.6 §1; 2003 c.811 §§15,16; 2007 c.365 §8; 2009 c.35 §1; 2009 c.312 §1; 2013 c.103 §1]

Note: See notes under 656.202.

DISCLOSURE OF WORKER MEDICAL AND VOCATIONAL CLAIM RECORDS

656.360 Confidentiality of worker medical and vocational claim records. Insurers and their assigned claims agents shall maintain the confidentiality of worker medical and vocational claim records. Worker medical and vocational claim records may not be disclosed to persons other than the worker unless the disclosure is:

(1) Made with the consent of the worker or the worker's beneficiary;

(2) Reasonably necessary for the insurer or its assigned claims agent to manage, defend or adjust claims, suits or actions or to perform any other function required by or arising out of ORS chapter 654, 655 or 656 or the insurance contract;

(3) To detect or prevent criminal activity, fraud, material misrepresentation or nondisclosure;

(4) Pursuant to a written agreement that requires the receiving party to maintain the confidentiality of the records; or

(5) Otherwise required or permitted by law. [2001 c.377 §61]

656.362 Liability for disclosure of worker medical and vocational claim records. (1) A cause of action in the nature of defamation, invasion of privacy or negligence may not arise against:

(a) Any insurer or assigned claims agent for disclosing worker medical and vocational claim records in accordance with ORS 656.360; or

(b) Any person for furnishing worker medical and vocational claim records to an insurer or assigned claims agent in accordance with ORS 656.360.

(2) Subsection (1) of this section does not apply to the disclosure or furnishing of false information with malice or willful intent to injure any person. [2001 c.377 §62]

LEGAL REPRESENTATION

656.382 Penalties and attorney fees payable by insurer or employer in processing claim. (1) If an insurer or self-insured employer refuses to pay compensation, costs or attorney fees due under an order of an Administrative Law Judge, the board or the court, or otherwise unreasonably resists the payment of compensation, costs or attorney fees, except as provided in ORS 656.385, the employer or insurer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

(2) If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that all or part of the compensation awarded to a claimant should not be disallowed or reduced, or, through the assistance of an attorney, that an order rescinding a notice of closure should not be reversed or all or part of the compensation awarded by a reconsideration order issued under ORS 656.268 should not be reduced or disallowed, the employer or insurer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal.

(3) If an employer or insurer raises attorney fees, penalties or costs as a separate issue in a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court initiated by the employer or insurer under this section, and the

Administrative Law Judge, board or court finds that the attorney fees, penalties or costs awarded to the claimant should not be disallowed or reduced, the Administrative Law Judge, board or court shall award reasonable additional attorney fees to the attorney for the claimant for efforts in defending the fee, penalty or costs.

(4) If an employer or insurer initiates an appeal to the board or Court of Appeals and the matter is briefed, but the employer or insurer withdraws the appeal prior to a decision by the board or court, resulting in the claimant's prevailing in the matter, the claimant's attorney is entitled to a reasonable attorney fee for efforts in briefing the matter to the board or court.

(5) If upon reaching a decision on a request for hearing initiated by an employer it is found by the Administrative Law Judge that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the Administrative Law Judge may order the employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances. [1965 c.285 §42; 1981 c.854 §24; 1983 c.568 §1; 1987 c.884 §34; 1990 c.2 §28; 1995 c.332 §42b; 2009 c.526 §3; 2015 c.521 §5]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.383 Attorney fees in cases prior to decision or after request for hearing. The claimant's attorney shall be allowed a reasonable assessed attorney fee if:

(1) The claimant's attorney is instrumental in obtaining temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 prior to a decision by an Administrative Law Judge; or

(2) The claimant finally prevails in a dispute over temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 after a request for hearing has been filed. [2015 c.521 §10]

Note: See first note under 656.012.

Note: 656.383 was added to and made a part of ORS chapter 656 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

656.384 [Formerly 656.582; 1977 c.290 §4; 1977 c.804 §13; repealed by 1987 c.250 §1]

656.385 Attorney fees in cases regarding certain medical service or vocational rehabilitation matters; rules; limitation; penalties. (1) In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced, the Director of the Department of Consumer and Business Services, the Administrative Law Judge or the court shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, an Administrative Law Judge or the court, the director, Administrative Law Judge or court shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department or court. The attorney fee assessed under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed $4,000 absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this subsection shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any.

(2) If an insurer or self-insured employer refuses to pay compensation due under, or attorney fees related to, ORS 656.245, 656.247, 656.260, 656.327 or 656.340 pursuant to an order of the director, an Administrative Law Judge or the court or otherwise unreasonably resists the payment of such compensation or attorney fees, the insurer or self-insured employer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (3) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

(3) If a request for a contested case hearing, review on appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an insurer or self-insured employer, and the director, Administrative Law Judge or court finds that all or part of the compensation awarded under ORS 656.245, 656.247, 656.260, 656.327 or 656.340 to a claimant, or attorney fees under this section, should not be disallowed or reduced, the insurer or self-insured employer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the director, Administrative Law Judge or court for legal representation by an attorney for the claimant at the contested case hearing, review on appeal or cross-appeal.

(4) If upon reaching a final contested case decision where such contested case was initiated by an insurer or self-insured em-

ployer it is found that the insurer or self-insured employer initiated the contested case hearing for the purpose of delay or other vexatious reason or without reasonable ground, the director, Administrative Law Judge or court may order the insurer or self-insured employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances.

(5) Penalties and attorney fees awarded pursuant to this section by the director, an Administrative Law Judge or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant. [1995 c.332 §42d; 2003 c.756 §2; 2005 c.26 §13; 2009 c.526 §4; 2015 c.521 §6]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.386 Recovery of attorney fees, expenses and costs in appeal on denied claim; attorney fees in other cases. (1)(a) In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.

(b) For purposes of this section, a "denied claim" is:

(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

(B) A claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262 (6)(d), which the insurer or self-insured employer does not respond to within 60 days;

(C) A claim for an aggravation made pursuant to ORS 656.273 (2) or for a new medical condition made pursuant to ORS 656.267, which the insurer or self-insured employer does not respond to within 60 days; or

(D) A claim for an initial injury or occupational disease to which the insurer or self-insured employer does not respond within 60 days.

(c) A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in timely fashion. Attorney fees provided for in this subsection shall be paid by the insurer or self-insured employer.

(2)(a) If a claimant finally prevails against a denial as provided in subsection (1) of this section, the court, board or Administrative Law Judge may order payment of the claimant's reasonable expenses and costs for records, expert opinions and witness fees.

(b) The court, board or Administrative Law Judge shall determine the reasonableness of witness fees, expenses and costs for the purpose of paragraph (a) of this subsection.

(c) Payments for witness fees, expenses and costs ordered under this subsection shall be made by the insurer or self-insured employer and are in addition to compensation payable to the claimant.

(d) Payments for witness fees, expenses and costs ordered under this subsection may not exceed $1,500 unless the claimant demonstrates extraordinary circumstances justifying payment of a greater amount.

(3) If a claimant requests claim reclassification as provided in ORS 656.277 and the insurer or self-insured employer does not respond within 14 days of the request, or if the claimant, insurer or self-insured employer requests a hearing, review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court and the Director of the Department of Consumer and Business Services, Administrative Law Judge, board or court finally determines that the claim should be classified as disabling, the director, Administrative Law Judge, board or court may assess a reasonable attorney fee.

(4) In disputes involving a claim for costs, if the claimant prevails on the claim for any increase of costs, the Administrative Law Judge, board, Court of Appeals or Supreme Court shall award a reasonable assessed attorney fee to the claimant's attorney.

(5) In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter. [Formerly 656.588; 1977 c.804 §14; 1981 c.854 §25; 1983 c.568 §2; 1990 c.2 §29; 1991 c.312 §1; 1995 c.332 §43; 1997 c.605 §3; 2001 c.865 §9; 2007 c.908 §1; 2009 c.526 §5; 2015 c.521 §7]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.388 Approval of attorney fees required; lien for fees; fee schedule; adjustment; report of legal service costs. (1) No claim or payment for legal services by an attorney representing the worker or for any other services rendered before an Administrative Law Judge or the Workers' Compensation Board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Administrative Law Judge or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law Judge, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307 (5), 656.308 (2), 656.382 or 656.386. No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization.

(2) Any claim for payment to a claimant's attorney by the claimant so approved shall, in the manner and to the extent fixed by the Administrative Law Judge, board or such court, be a lien upon compensation.

(3) If an injured worker signs an attorney fee agreement with an attorney for representation on a claim made pursuant to this chapter and additional compensation is awarded to the worker or a settlement agreement is consummated on the claim after the fee agreement is signed and it is shown that the attorney with whom the fee agreement was signed was instrumental in obtaining the additional compensation or settling the claim, the Administrative Law Judge or the board shall grant the attorney a lien for attorney fees out of the additional compensation awarded or proceeds of the settlement in accordance with rules adopted by the board governing the payment of attorney fees.

(4) The board shall, after consultation with the Board of Governors of the Oregon State Bar, establish a schedule of fees for attorneys representing a worker and representing an insurer or self-insured employer, under this chapter. The Workers' Compensation Board shall review all attorney fee schedules biennially for adjustment.

(5) The board shall, in establishing the schedule of attorney fees awarded under this chapter, consider the contingent nature of the practice of workers' compensation law and the necessity of allowing the broadest access to attorneys by injured workers and shall give consideration to fees earned by attorneys for insurers and self-insured employers.

(6) The board shall approve no claim for legal services by an attorney representing a claimant to be paid by the claimant if fees have been awarded to the claimant or the attorney of the claimant in connection with the same proceeding under ORS 656.268.

(7) Insurers and self-insured employers shall make an annual report to the Director of the Department of Consumer and Business Services reporting attorney salaries and other costs of legal services incurred pursuant to this chapter. The report shall be in such form and shall contain such information as the director prescribes. [Formerly 656.590; 1983 c.568 §3; 1987 c.884 §35; 1990 c.2 §30; 1995 c.332 §44; 2007 c.908 §3; 2015 c.521 §8]

Note: See notes under 656.202.

Note: See first note under 656.012.

656.390 Frivolous appeals, hearing requests or motions; expenses and attorney fee. (1) Notwithstanding ORS 656.236, if either party requests a hearing before the Hearings Division, requests review of an Administrative Law Judge's decision before the Workers' Compensation Board, appeals for review of the claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the Administrative Law Judge, board or court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the Administrative Law Judge, board or court may impose an appropriate sanction upon the attorney who filed the request for hearing, request for review, appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the request for hearing, request for review, appeal or motion, including a reasonable attorney fee.

(2) As used in this section, "frivolous" means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing. [1987 c.884 §31; 1995 c.332 §45]

656.401 [1965 c.285 §74; 1967 c.359 §699; repealed by 1975 c.556 §25 (656.403 enacted in lieu of 656.401)]

656.402 [Renumbered 656.712]

SELF-INSURED AND CARRIER-INSURED EMPLOYERS; INSURERS

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

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

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

(4) When a self-insured employer is a worker leasing company required to be licensed pursuant to ORS 656.850 and 656.855, the company also shall comply with the worker leasing company regulatory provisions of ORS chapters 656 and 737 and with such rules as may be adopted pursuant to ORS 656.726 and 731.244 for the supervision and regulation of worker leasing companies. [1975 c.556 §26 (enacted in lieu of 656.401); 1981 c.854 §26; 1993 c.628 §7]

656.404 [Repealed by 1959 c.449 §5]

656.405 [1965 c.285 §75(1); 1967 c.359 §700; repealed by 1975 c.556 §54]

656.406 [Renumbered 656.714]

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

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

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

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

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

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

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

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

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

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

ment otherwise prescribed by or pursuant to law.

(ii) That is dedicated to and may be expended only for the payment of compensation and amounts due the director by the city, county or qualified self-insured employer group under this chapter.

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

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

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

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

(4) As used in this section, "qualified self-insured employer group" means a self-insured employer group that is a municipal corporation or a public corporation, as those terms are defined in ORS 297.405. [1975 c.556 §27; 1979 c.839 §28; 1981 c.854 §27; 1985 c.212 §7; 1989 c.966 §67; 1991 c.648 §1; 1993 c.18 §140; 2003 c.170 §2; 2007 c.241 §13; 2013 c.471 §1; 2014 c.48 §3]

656.408 [Renumbered 656.716]

656.409 [1965 c.285 §75(2),(3); repealed by 1975 c.556 §54]

656.410 [Amended by 1965 c.285 §54; renumbered 656.726]

656.411 [1975 c.556 §28; 1979 c.348 §1; repealed by 1981 c.854 §1]

656.412 [Amended by 1965 c.285 §52; renumbered 656.732]

656.413 [1965 c.285 §76(1),(2); repealed by 1975 c.556 §54]

656.414 [Renumbered 656.718]

656.415 [1975 c.556 §30; repealed by 1981 c.854 §1]

656.416 [Amended by 1965 c.285 §53; renumbered 656.722]

656.417 [1965 c.285 §76 (3),(8); 1967 c.341 §6; repealed by 1975 c.556 §54]

656.418 [Repealed by 1965 c.285 §95]

656.419 Workers' compensation insurance contracts. (1) A workers' compensation insurance policy issued by an insurer under this section shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer, arising during the period the policy is in effect, for prompt payment of all compensation for compensable injuries that may become due under this chapter to subject workers and their beneficiaries.

(2)(a) The insurer issuing the workers' compensation insurance policy shall file proof of coverage with the Director of the Department of Consumer and Business Services within 30 days after workers' compensation coverage of the employer is effective. The filing shall be in the form and manner and shall include any information that the director may prescribe by rule.

(b) An insurer shall file the proof of coverage required under this section for each new or renewed policy issued by the insurer.

(3) Workers' compensation coverage is effective when the application of the subject employer for coverage together with any required fees or premium are received and accepted by an authorized representative of an insurer or on the date specified in writing by the employer and the insurer.

(4) Coverage of an employer under a workers' compensation insurance policy continues until:

(a) The expiration of the term of the policy;

(b) The coverage is canceled prior to the expiration date of the policy as provided by ORS 656.423 or 656.427;

(c) Another insurer files proof of coverage on behalf of the employer; or

(d) The employer becomes self-insured under ORS 656.430. [1975 c.556 §29; 1977 c.405 §7; 1981 c.854 §28; 1987 c.237 §1; 1995 c.93 §35; 1995 c.332 §46; 2003 c.170 §3; 2007 c.241 §1]

656.420 [Renumbered 656.758]

656.421 [1965 c.285 §76(4),(5),(6),(7); repealed by 1975 c.556 §54]

656.422 [Amended by 1959 c.450 §5; repealed by 1965 c.285 §95]

656.423 Cancellation of coverage by employer; notice required. (1) An insured employer may cancel coverage with the insurer by giving the insurer at least 30 days'

written notice, unless a shorter period is permitted by subsection (3) of this section.

(2) Cancellation of coverage is effective at 12 midnight 30 days after the date the cancellation notice is received by an authorized representative of the insurer, unless a later date is specified.

(3) An employer may cancel coverage effective less than 30 days after written notice is received by an authorized representative of the insurer by providing other coverage, by becoming a self-insured employer or by agreement of the employer and the insurer. A cancellation under this subsection is effective immediately upon the effective date of the other coverage, on the effective date of certification as a self-insured employer or on a date agreed upon in writing by the employer and insurer.

(4) The insurer shall file a notice of cancellation with the Director of the Department of Consumer and Business Services within 10 calendar days after the effective date of the cancellation or the date on which the insurer receives the notice required under subsection (1) of this section, whichever is later. The notice required under this subsection shall be in the form and manner and shall contain any information that the director may prescribe by rule. [1975 c.556 §31; 1981 c.854 §29; 2003 c.170 §4; 2007 c.241 §2]

656.424 [Renumbered 656.734]

656.425 [1965 c.285 §76a; repealed by 1975 c.556 §54]

656.426 [Amended by 1965 c.285 §68b; renumbered 656.702]

656.427 Termination of workers' compensation insurance contract or surety bond liability by insurer. (1) An insurer that issues a workers' compensation insurance policy or surety bond to an employer under this chapter may cancel the policy or surety bond prior to the expiration date of the policy or surety bond by giving the employer and the Director of the Department of Consumer and Business Services notice of cancellation in accordance with rules adopted by the director. Notice required under this section must be provided to the director within 10 calendar days after the effective date of the cancellation provided in the notice given to the employer.

(2) An insurer may cancel a workers' compensation insurance policy or surety bond under this section as follows:

(a) If the cancellation of a workers' compensation insurance policy is for reasons other than those set forth in paragraphs (b) and (c) of this subsection, it is effective at 12 midnight not less than 45 days after the date the notice is mailed to the employer.

(b) If the cancellation of a workers' compensation insurance policy is based on the insurer's decision not to offer insurance to employers within a specific premium category, it is effective not sooner than 90 days after the date the notice is mailed to the employer.

(c) If the cancellation of a workers' compensation insurance policy is based on nonpayment of premium, the cancellation is effective not sooner than 10 days after the date the notice is mailed to the employer.

(d) The cancellation of a surety bond is effective at 12 midnight not less than 30 days after the date the notice is received by the director.

(3) An insurer may nonrenew a workers' compensation insurance policy by providing notice in the manner provided for in subsection (2) of this section.

(4) Notice to the employer under this section shall be given by mail, addressed to the employer at the last-known address of the employer. If the employer is a partnership, notice may be given to any of the partners. If the employer is a limited liability company, notice may be given to any manager, or in a member managed limited liability company, to any of the members. If the employer is a corporation, notice may be given to any agent or officer of the corporation under whom legal process may be served.

(5) Cancellation of a workers' compensation insurance policy or surety bond shall in no way limit liability that was incurred under the policy or surety bond prior to the effective date of the cancellation.

(6) If, before the effective date of a cancellation under this section, the employer gives notice to the insurer that it has not obtained coverage from another insurer and intends to become insured under the assigned risk plan established under ORS 656.730, the insurer shall ensure that continuing coverage is provided to the employer under the plan without further application by the employer, transferring the risk to the plan as of the effective date of cancellation. If the insurer is a servicing carrier under the plan, it shall continue to provide coverage for the employer as a servicing carrier, at least until another servicing carrier is provided for the employer in the normal course of administering the plan. If the insurer is not a servicing carrier, it shall apply to the plan for coverage on the employer's behalf. Nothing in this section is intended to limit the authority of administrators of the plan to require the employer to provide deposits or to make payments consistent with plan requirements. However, the rules of the plan shall allow any deposit requirements imposed by the plan to be deferred for as long as one year.

(7) The cancellation of a workers' compensation insurance policy under this section is effective on the earliest of:

(a) The expiration of the term of the policy;

(b) The effective date of a cancellation under subsection (2) of this section; or

(c) The effective date of a policy for which another insurer makes a proof of coverage filing on behalf of the employer. [1975 c.556 §32; 1981 c.854 §30; 1981 c.874 §5; 1981 c.876 §6; 1985 c.212 §8; 1990 c.1 §1; 1995 c.93 §36; 1995 c.332 §46a; 2003 c.170 §5; 2007 c.241 §3; 2007 c.656 §§1,2,3]

656.428 [Amended by 1957 c.440 §3; repealed by 1965 c.285 §95]

656.429 [1965 c.285 §77; repealed by 1975 c.556 §54]

656.430 Certification of self-insured employer; employer groups; insurance policy requirements; revocation of certification; rules. (1) Upon determining that an employer has qualified as a self-insured employer under ORS 656.407, the Director of the Department of Consumer and Business Services shall issue a certificate to that effect to the employer.

(2) Coverage of a self-insured employer is effective on the date of certification unless a later date is specified in the certificate.

(3) Two or more entities shall not be included in the certification of one employer unless in each entity the same person, or group of persons, or corporation owns a majority interest. If an entity owns a majority interest in another entity which in turn owns the majority interest in another entity, all entities so related may be combined regardless of the number of entities in succession. If more than one entity is included in the certification of one employer, each entity included is jointly and severally liable for any compensation and other amounts due the Department of Consumer and Business Services under this chapter by any entity included in the certification.

(4) In the term "majority interest," as used in this section, "majority" means more than 50 percent.

(5) If an entity other than a partnership:

(a) Has issued voting stock, "majority interest" means a majority of the issued voting stock;

(b) Has not issued voting stock, "majority interest" means a majority of the members; or

(c) Has not issued voting stock and has no members, "majority interest" means a majority of the board of directors or comparable governing body.

(6) If the entity is a partnership, majority interest shall be determined in accordance with the participation of each general partner in the profits of the partnership.

(7)(a) Notwithstanding any other provision of this section, the director may certify five or more subject employers as a self-insured employer group, which shall be considered an employer for purposes of this chapter, if:

(A) The director finds that the employers as a group meet the requirements of ORS 656.407 (1)(b) and (2);

(B) The director determines that the employers as a group meet the insurance coverage retention and combined net worth requirements adopted by the director by rule;

(C) The director finds that the grouping is likely to improve accident prevention and claims handling for the employer;

(D) Each employer executes and files with the designated entity a written agreement, in such form as the director may prescribe, in which:

(i) The employer agrees to be jointly and severally liable for the payment of any compensation and other amounts due to the Department of Consumer and Business Services under this chapter incurred by a member of the group; or

(ii) The employer, if a city, county, special district described and listed in ORS 198.010 or 198.180, translator district formed under ORS 354.605 to 354.715, weed control district organized under ORS 569.350 to 569.445, intergovernmental agency created under ORS 225.050, school district as defined in ORS 255.005 (9), public housing authority created under ORS chapter 456 or regional council of governments created under ORS chapter 190, agrees to be individually liable for the payment of any compensation and other amounts due to the department under this chapter incurred by the employer during the period of group self-insurance;

(E) The director finds that the employer group is organized as a corporation or cooperative pursuant to ORS chapter 60, 62 or 65, is an intergovernmental entity created under ORS 190.003 to 190.130 and the bylaws require the governing group to obtain fidelity bonds;

(F) The director finds that the employer group has designated an entity responsible for:

(i) Centralized claims processing in accordance with paragraph (b) of this subsection; and

(ii) Payroll records, safety requirements, recording and submitting assessments and contributions and making such other reports as the director may require; and

(G) The employer has presented a method approved by the director to notify the department of:

(i) The commencement or termination of membership by employers in the group, and the effect thereof on the net worth of the employers in the group; and

(ii) Whether an employer who terminates membership in the group continues to be a subject employer; and

(b) Except for employer groups composed of cities, counties, special districts created under ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456 and regional councils of governments created under ORS chapter 190, a group administrator may not be a group member or a member of the board of the group.

(8) A self-insured employer must have excess insurance coverage appropriate for the employer's potential liability under this chapter with an insurer authorized to do business in this state. A self-insured employer certified prior to November 1, 1981, must have excess insurance coverage appropriate for the employer's potential liability under this chapter either with an insurer authorized to do business in this state or with any other insurer from whom such insurance can be obtained pursuant to ORS 744.305 to 744.405 (1985 Replacement Part). Evidence of such coverage must be submitted at the time application is made for self-insured certification in the form of an insurance binder providing the appropriate coverage effective the date of certification. The policy providing such coverage must be filed with the director not later than 30 days after the date the coverage is effective. Any changes in the insurer or the coverage must be filed with the department not later than 30 days after the effective date of the change. With respect to such coverage:

(a) The policy must include a provision, approved by the director, for reimbursement to the department of all expenses paid by the department on behalf of the employer pursuant to ORS 656.614 (1) and 656.443 in the same manner as if the department were the insured employer, subject to the policy limitations on amounts and limits of liability to the insured employer; and

(b) The period of coverage must be continuous and remain in effect until the certification is revoked or canceled.

(9) Notwithstanding ORS 656.440, the director may revoke the certification of any self-insured employer after giving 30 days' written notice if the employer:

(a) Fails to comply with subsection (8) of this section;

(b) In the case of an employer described in subsection (7) of this section, fails to comply with that subsection; or

(c) Fails to comply with rules adopted by the director as required by subsection (11) of this section.

(10) A self-insured employer must have an occupational safety and health loss control program as required by ORS 654.097.

(11) The director, by rule shall:

(a) Prescribe methods for determining and approving net worth.

(b) Prescribe the types and approve the retention and limitation levels of excess insurance policies.

(c) Establish reporting requirements.

(d) Prescribe information to be submitted in applications for self-insured employer certifications.

(e) Prescribe the form and manner of reporting commencement or termination in a self-insured employer group.

(f) Prescribe the form, amount and manner for establishing and operating a common claims fund.

(g) Prescribe such other requirements as the director considers necessary so that employers certified as self-insured employers will meet the financial responsibilities under this chapter.

(12) For the purpose of certification as a self-insured employer group, cities, counties, special districts created under ORS 198.010, intergovernmental agencies created under ORS 225.050, school districts as defined in ORS 255.005, public housing authorities created under ORS chapter 456 and regional councils of governments created under ORS chapter 190 shall be considered by the director to be of the same industry.

(13) Notwithstanding subsection (8) of this section, a public utility with assets of more than $500 million may obtain excess insurance coverage from an eligible surplus lines insurer. As used in this subsection, "public utility" has the meaning given that term in ORS 757.005. [1975 c.556 §33; 1979 c.845 §1; 1981 c.535 §38; 1983 c.816 §9; 1985 c.739 §6; 1987 c.94 §107; 1987 c.800 §1; 1987 c.884 §58; 1989 c.602 §1; 1993 c.817 §2; 1999 c.280 §1; 2003 c.170 §6; 2005 c.189 §1; 2014 c.48 §4]

656.431 [1965 c.285 §78; 1973 c.620 §6; repealed by 1975 c.556 §54]

656.432 [1977 c.659 §2; 1979 c.815 §8; repealed by 1981 c.854 §1]

656.434 Certification effective until canceled or revoked; revocation of certificate. (1) A certification issued under ORS 656.430 remains in effect until:

(a) Revoked by the Director of the Department of Consumer and Business Services as provided by this section and ORS 656.440; or

(b) Canceled by the employer with the approval of the director.

(2) The director may revoke the certification of a self-insured employer if:

(a) The employer fails to comply with ORS 656.407 or 656.430 or is in default as described in ORS 656.443; or

(b) The employer commits any violation for which a civil penalty could be assessed under ORS 656.745.

(3) When the certification of a self-insured employer is revoked, or when an employer terminates in a self-insured employer group, that employer must immediately comply with ORS 656.017 (1). If the employer fails to so comply, notwithstanding ORS 656.052 (3), the director immediately may file suit in the circuit court of the county in which the employer resides or employs workers. Upon filing of such a suit, the court shall set a date for hearing and shall cause notice thereof to be served on the employer. The hearing shall be not less than five nor more than 15 days from the date of service of the notice. Upon commencement of the suit, the circuit court shall enjoin the employer from further employing workers until the employer complies with ORS 656.017 (1). [1975 c.556 §34; 1979 c.845 §2; 1981 c.535 §39; 2014 c.48 §5]

656.440 Notice of certificate revocation; appeal; effective date. (1) Before revocation of certification under ORS 656.434 becomes effective, the Director of the Department of Consumer and Business Services shall give the employer notice that the certification will be revoked stating the grounds for the revocation. The notice shall be served on the employer in the manner provided by ORS 656.427 (4). The revocation shall become effective within 10 days after receipt of such notice by the employer unless within such period of time the employer corrects the grounds for the revocation or appeals in writing to the director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge.

(2) If the employer appeals, the Hearings Division of the Workers' Compensation Board under ORS 656.283 shall set a date for a hearing, which date shall be within 30 days after receiving the appeal request, and shall give the employer at least five days' notice of the time and place of the hearing. A record of the hearing shall be kept but it need not be transcribed unless requested by the employer. The cost of transcription shall be charged to the employer. Within 10 days after the hearing, the Administrative Law Judge shall either affirm or disaffirm the revocation and give the employer written notice thereof by registered or certified mail.

(3) If revocation is affirmed on review by the Administrative Law Judge, the revocation is effective five days after the employer receives notice of the affirmance unless within such period of time the employer corrects the grounds for the revocation or petitions for judicial review of the affirmance pursuant to ORS 183.480 to 183.497.

(4) If the revocation is affirmed following judicial review, the revocation is effective five days after entry of the final judgment of affirmance, unless within such period the employer corrects the grounds for the revocation. [1975 c.556 §35; 1977 c.804 §15; 2003 c.576 §530; 2005 c.26 §14; 2007 c.241 §30]

656.441 Advancement of funds from Workers' Benefit Fund for compensation due workers insured by certain decertified self-insured employer groups. (1) Notwithstanding ORS 656.605, if a self-insured employer group is decertified no later than September 15, 2014, the Director of the Department of Consumer and Business Services may advance funds from the Workers' Benefit Fund to injured workers who have not received payment of compensation due after the common claims fund and securities deposited with the director are exhausted.

(2) Expenditures authorized under this section may exceed the amount of surety bonds and any other security on deposit with the director for the decertified self-insured employer group. [2014 c.48 §1]

656.442 [1967 c.341 §7; repealed by 1975 c.556 §54]

656.443 Procedure upon default by employer or self-insured employer group. (1) If an employer or self-insured employer group defaults in payment of compensation or other payments due to the Director of the Department of Consumer and Business Services under this chapter, the director may, on notice to the employer or self-insured employer group and any insurer providing workers' compensation insurance coverage, a surety bond or other security to the employer or self-insured employer group, use money or interest and dividends on securities, sell securities or institute legal proceedings on any insurance policy, surety bond or other security for which a notice of coverage has been filed with the director to the extent necessary to make such payments.

(2) Prior to any default by the employer or self-insured employer group, the employer or group is entitled to all interest and dividends on securities on deposit and to exer-

cise all voting rights, stock options and other similar incidents of ownership of the securities.

(3) If for any reason the certification of a self-insured employer or self-insured employer group is canceled or terminated, the surety bond or other security deposited with the director shall remain on deposit or in effect, as the case may be, for a period of at least 62 months after the employer ceases to be a self-insured employer. The surety bond or other security shall be maintained in an amount necessary to secure the outstanding and contingent liability arising from the accidental injuries secured by the surety bond or other security, and to assure the payment of claims for aggravation and claims arising under ORS 656.278 based on those accidental injuries. At the expiration of the 62-month period, or of another period the director may consider proper, the director may accept in lieu of the surety bond or other security deposited with the director a policy of paid-up insurance in a form approved by the director.

(4) If a self-insured employer group is in default, is decertified by the director or cancels its certification under ORS 656.434, the director may:

(a) Order members of the group to pay an assessment for the continuing claim liabilities as specified in ORS 656.430 (7)(a)(D)(i); and

(b) Determine the claims processing agent that shall process claims of the group. The claims processing agent may be the assigned claims agent selected under ORS 656.054.

(5) Member assessments collected under subsection (4) of this section shall be deposited in the Consumer and Business Services Fund created in ORS 705.145.

(6) Failure to pay an assessment ordered under subsection (4) of this section subjects members of the self-insured employer group to civil penalties as provided in ORS 656.745. [1975 c.556 §36; 1981 c.854 §31; 1987 c.373 §32; 2007 c.241 §14; 2014 c.48 §6]

656.444 [1967 c.341 §9; repealed by 1975 c.556 §54]

656.445 Advancement of funds from Workers' Benefit Fund for compensation due workers insured by insurer in default; limitations; rules. (1) If an insurer defaults in payment of compensation due an injured worker, the Director of the Department of Consumer and Business Services may advance funds from the Workers' Benefit Fund to injured workers who have not received payment of compensation due from the insurer in default.

(2) The maximum expenditures that may be made under this section may not exceed the amount of securities on deposit for the insurer pursuant to ORS 731.628.

(3) The director shall adopt rules to regulate, manage and disburse moneys in the Workers' Benefit Fund for the purposes of subsection (1) of this section. The rules shall include but not be limited to eligibility criteria, procedures for distributing funds, accounting procedures and a maximum expenditure limitation on payments made under subsection (1) of this section from the fund. [2001 c.974 §6]

656.446 [1967 c.341 §10; repealed by 1975 c.556 §54]

656.447 Sanctions against insurer for failure to comply with contracts, orders or rules. (1) The Director of the Department of Consumer and Business Services may suspend or revoke the authorization of an insurer to issue workers' compensation insurance policies if the director, after notice to the company and giving the company an opportunity to be heard and present evidence, finds that:

(a) The company has failed to comply with its obligations under any such policy; or

(b) The company has failed to comply with the orders of the director or the provisions of this chapter or any rule promulgated pursuant thereto.

(2) A suspension or revocation shall not affect the liability of any such company on any workers' compensation insurance policy in force prior to the suspension or revocation. [1975 c.556 §37; 1977 c.430 §2; 1987 c.373 §33; 2007 c.241 §15]

656.451 [1975 c.585 §6; 1981 c.854 §32; 1987 c.373 §34; 1987 c.884 §59; 1989 c.654 §1; 1991 c.640 §1; renumbered 654.097]

656.452 [Amended by 1965 c.285 §54a; renumbered 656.632]

656.454 [Renumbered 656.634]

656.455 Self-insured employers required to keep records of compensation claims; location and inspection; expenses of audits and inspections; rules. (1) Every self-insured employer shall maintain a place of business in this state where the employer shall keep complete records of all claims for compensation made to the employer under this chapter or a self-insured employer may, under the conditions prescribed by ORS 731.475 (3), keep such records in this state at places operated by service companies. The records shall be retained in, and may be removed from, this state or disposed of, in accordance with the rules of the Director of the Department of Consumer and Business Services adopted pursuant to ORS 731.475. Such records shall be available to the director for examination and audit at all reasonable times upon notice by the director to the employer.

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

(3) Notwithstanding subsection (1) of this section, a self-insured employer may not have at any one time more than three locations where claims are processed or records are maintained. [1975 c.585 §8; 1989 c.630 §2]

656.456 [Amended by 1955 c.323 §2; 1957 c.63 §1; 1959 c.178 §1; 1961 c.697 §1; 1965 c.285 §62; renumbered 656.636]

656.458 [Repealed by 1965 c.285 §95]

656.460 [Amended by 1953 c.674 §13; 1959 c.517 §3; 1963 c.323 §1; 1965 c.285 §64; renumbered 656.638]

656.462 [Amended by 1953 c.674 §13; repealed by 1965 c.285 §95]

656.464 [Amended by 1953 c.674 §13; 1957 c.574 §5; 1959 c.449 §2; 1965 c.285 §66b; renumbered 656.642]

656.466 [Amended by 1953 c.674 §13; 1959 c.449 §3; 1965 c.285 §67g; renumbered 656.644]

656.468 [Amended by 1953 c.674 §13; 1965 c.285 §66; renumbered 656.640]

656.470 [Repealed by 1953 c.674 §13]

656.472 [Amended by 1953 c.674 §13; 1957 c.574 §6; 1959 c.449 §4; 1965 c.285 §68a; renumbered 656.602]

656.474 [Amended by 1953 c.674 §13; 1965 c.285 §68c; renumbered 656.604]

CHARGES AGAINST EMPLOYERS AND WORKERS

656.502 "Fiscal year" defined. As used in ORS 656.502 to 656.526, "fiscal year" means the period of time commencing on July 1 and ending on the succeeding June 30.

656.504 Rates, charges, fees and reports by employers insured by State Accident Insurance Fund Corporation. (1) Every employer insured by the State Accident Insurance Fund Corporation shall pay to the State Accident Insurance Fund Corporation on or before the 15th day of each month, for insurance coverage, a percentage of the employer's total payroll for the preceding calendar month of subject workers according to and at the rates promulgated by the State Accident Insurance Fund Corporation under ORS 656.508 and shall forward to the State Accident Insurance Fund Corporation on or before the 15th day of each month a signed statement showing the employer's total payroll for the preceding calendar month, the kind of work performed, the number of workers and the number of days worked. The State Accident Insurance Fund Corporation may establish other reporting periods and payment-due dates and in lieu of payment based upon a percentage of total payroll may promulgate rates to be paid by employers insured with the State Accident Insurance Fund Corporation utilizing a certain number of cents for each work-hour worked by workers in such employer's employ. Each such employer shall also pay an annual fee, deposit and minimum premium in such amount and at such time as the State Accident Insurance Fund Corporation shall prescribe, to the Industrial Accident Fund for each calendar year. Each such employer may be required to pay a registration fee in such amount and at such time as the State Accident Insurance Fund Corporation shall prescribe. The State Accident Insurance Fund Corporation may vary the amount of these fees and minimum premium by employer groupings, accept them in lieu of the other premiums which are based on the employer's payroll, and may adjust the period of application from a calendar year to a fiscal year.

(2) The State Accident Insurance Fund Corporation may provide for a short rate premium applicable to employers who cancel their coverage with the State Accident Insurance Fund Corporation prior to the expiration of the coverage period using a standard short rate table. [Amended by 1957 c.441 §3; 1959 c.450 §6; 1965 c.285 §69; 1967 c.341 §8; 1979 c.348 §2; 1981 c.535 §11; 1981 c.854 §33]

656.505 Estimate of payroll when employer fails to file payroll report; demand for and recovery of premiums and assessments. (1) In every case where an employer fails or refuses to file any report of payroll required by ORS 656.504 and fails or refuses to pay the premiums and assessments due on such unreported payroll the State Accident Insurance Fund Corporation shall have authority to estimate such payroll and make a demand for premiums and assessments due thereon.

(2) If the report required and the premiums and assessments due thereon are not made within 30 days from the mailing of such demand the employer shall be in default as provided in ORS 656.560, and the corporation may have and recover judgment or file liens for such estimated premiums and assessments or the actual premium and assessment, whichever is greater. [1953 c.679 §2; 1979 c.348 §3; 1981 c.854 §34]

656.506 Assessments for programs; setting assessment amount; determination by director of benefit level. (1) As used in this section:

(a) "Employee" means a subject worker as defined in ORS 656.005 (28).

(b) "Employer" means a subject employer as defined in ORS 656.005 (27).

(2) Every employer shall retain from the moneys earned by all employees an amount determined by the Director of the Department of Consumer and Business Services for each hour or part of an hour the employee is employed and pay the money retained in the manner and at such intervals as the Director of the Department of Consumer and Business Services shall direct.

(3) In addition to all moneys retained under subsection (2) of this section, the director shall assess each employer an amount equal to that assessed pursuant to subsection (2) of this section. The assessment shall be paid in such manner and at such intervals as the director may direct.

(4) Moneys collected pursuant to subsections (2) and (3) of this section, and any accrued cash balances, shall be deposited by the Department of Consumer and Business Services into the Workers' Benefit Fund. Subject to the limitations in subsections (2) and (3) of this section, the amount of the hourly assessments provided in subsections (2) and (3) of this section annually may be adjusted to meet the needs of the Workers' Benefit Fund for the expenditures of the department in carrying out its functions and duties pursuant to subsection (7) of this section and ORS 656.445, 656.622, 656.625, 656.628 and 656.630. Factors to be considered in making such adjustment of the assessments shall include, but not be limited to, the cash balance as determined by the director and estimated expenditures and revenues of the Workers' Benefit Fund.

(5) It is the intent of the Legislative Assembly that the department set rates for the collection of assessments pursuant to subsections (2) and (3) of this section in a manner so that at the end of the period for which the rates shall be effective, the cash balance shall be an amount of not less than six months of projected expenditures from the Workers' Benefit Fund in regard to its functions and duties under subsection (7) of this section and ORS 656.445, 656.622, 656.625, 656.628 and 656.630, in a manner that minimizes the volatility of the rates assessed. The department may set the assessment rate at a higher level if the department determines that a higher rate is necessary to avoid unintentional program or benefit reductions in the time period immediately following the period for which the rate is being set.

(6) Every employer required to pay the assessments referred to in this section shall make and file a report of employee hours worked and amounts due under this section upon a combined report form prescribed by the Department of Revenue. The report shall be filed with the Department of Revenue:

(a) At the times and in the manner prescribed in ORS 316.168 and 316.171; or

(b) Annually as required or allowed pursuant to ORS 316.197 or 657.571.

(7) There is established a Retroactive Program for the purpose of providing increased benefits to claimants or beneficiaries eligible to receive compensation under the benefit schedules of ORS 656.204, 656.206, 656.208 and 656.210 which are lower than currently being paid for like injuries. However, benefits payable under ORS 656.210 shall not be increased by the Retroactive Program for claimants whose injury occurred on or after April 1, 1974. Notwithstanding the formulas for computing benefits provided in ORS 656.204, 656.206, 656.208 and 656.210, the increased benefits payable under this subsection shall be in such amount as the director considers appropriate. The director annually shall compute the amount which may be available during the succeeding year for payment of such increased benefits and determine the level of benefits to be paid during such year. If, during such year, it is determined by the director that there are insufficient funds to increase benefits to the level fixed by the director, the director may reduce the level of benefits payable under this subsection. The increase in benefits to workers shall be payable in the first instance by the insurer or self-insured employer subject to reimbursement from the Workers' Benefit Fund by the director. If the insurer is a member of the Oregon Insurance Guaranty Association and becomes insolvent and the Oregon Insurance Guaranty Association assumes the insurer's obligations to pay covered claims of subject workers, including Retroactive Program benefits, such benefits shall be payable in the first instance by the Oregon Insurance Guaranty Association, subject to reimbursement from the Workers' Benefit Fund by the director. [Amended by 1955 c.323 §1; 1965 c.285 §70; 1971 c.768 §1; 1973 c.55 §1; 1974 c.41 §8; 1977 c.143 §2; 1979 c.845 §5; 1983 c.391 §1; 1985 c.739 §1; 1990 c.2 §31; 1993 c.760 §1; 1995 c.332 §63; 1995 c.527 §1; 1995 c.641 §20; 1999 c.118 §1; 2001 c.591 §1; 2001 c.974 §7; 2014 c.48 §7]

Note: See notes under 656.202.

Note: Section 9, chapter 48, Oregon Laws 2014, provides:

Sec. 9. No later than January 1, 2019, the Workers' Compensation Management-Labor Advisory Committee established under ORS 656.790 shall study the effects of the amendments to ORS 656.506 by section 7 of this 2014 Act and report to the Legislative Assembly the findings of the committee about the advisability of the continuation of the changes resulting from those amendments. [2014 c.48 §9]

656.507 [1953 c.679 §1; 1959 c.450 §7; repealed by 1965 c.285 §95]

656.508 Authority to fix premium rates for employers. (1) The State Accident Insurance Fund Corporation shall classify occupations or industries with respect to their degree of hazard and fix premium rates upon each of the occupations or industries sufficient to provide adequate funds to carry out the purposes of this chapter and the duties of the State Accident Insurance Fund Corporation.

(2) The State Accident Insurance Fund Corporation may annually, and at such other times as it deems necessary, readjust, increase or decrease the premium rates of employers insured with the State Accident Insurance Fund Corporation. Any such readjustment, increase or decrease shall be made and become effective on such dates as the State Accident Insurance Fund Corporation may determine. The State Accident Insurance Fund Corporation shall notify the employer of the rate.

(3) The State Accident Insurance Fund Corporation may establish a uniform system of rate modification conforming to recognized insurance principles including schedule rating and experience rating, premium discount and retrospective rating. [Amended by 1957 c.41 §1; 1957 c.386 §1; 1963 c.587 §1; 1965 c.285 §71; 1977 c.405 §8; 1981 c.854 §35]

656.509 [1973 c.614 §6; 1974 c.41 §9; repealed by 1974 c.41 §9]

656.510 [Amended by 1957 c.440 §4; 1963 c.214 §1; 1965 c.546 §1; repealed by 1965 c.285 §95 and 1965 c.546 §4]

656.512 [Amended by 1957 c.440 §5; repealed by 1965 c.285 §95]

656.514 [Amended by 1965 c.546 §2; repealed by 1965 c.285 §95 and 1965 c.546 §4]

656.516 [Amended by 1953 c.674 §13; 1957 c.453 §3; 1959 c.517 §4; 1963 c.323 §2; 1965 c.546 §3; repealed by 1965 c.285 §95 and 1965 c.546 §4]

656.518 [Amended by 1957 c.440 §6; repealed by 1965 c.285 §95]

656.520 [Amended by 1957 c.574 §7; repealed by 1965 c.285 §95]

656.522 [Amended by 1965 c.285 §71a; repealed by 1981 c.854 §1 and 1981 c.876 §1]

656.524 [Amended by 1979 c.562 §29; repealed by 1981 c.854 §1 and 1981 c.876 §1]

656.526 Distribution of dividends from surplus in Industrial Accident Fund. (1) Periodically, the State Accident Insurance Fund Corporation shall determine the total liability existing against the Industrial Accident Fund.

(2) If, after the determination required by subsection (1) of this section, the State Accident Insurance Fund Corporation finds the Industrial Accident Fund, aside from the reserves deemed actuarially necessary according to recognized insurance principles, contains a surplus, the State Accident Insurance Fund Corporation in its discretion may, after providing for any payments to the state, taxes or other dispositions of surplus provided by law, declare a dividend to be paid to, or credited to the accounts of, employers who were insured by the State Accident Insurance Fund Corporation during all or part of the period for which the dividend is declared. Any dividend so declared shall give due consideration to the solvency of the Industrial Accident Fund, not be unfairly discriminatory and not be promised in advance of such declaration.

(3) An employer in default when the dividend is declared shall not be eligible to receive payment or the credit provided by subsection (2) of this section. [Amended by 1953 c.674 §13; 1955 c.323 §3; 1957 c.574 §8; 1965 c.285 §72; 1967 c.252 §1; 1969 c.589 §1; 1971 c.385 §3; 1971 c.725 §1; 1981 c.854 §36; 1982 s.s.3 c.2 §3; 1999 c.424 §1]

656.530 [1969 c.536 §2; 1971 c.768 §2; 1975 c.556 §43; 1981 c.535 §23; 1990 c.2 §32; 1991 c.93 §10; 1995 c.641 §7; repealed by 1999 c.273 §1]

656.532 [1987 c.884 §40; repealed by 1993 c.760 §4]

656.535 [1973 c.669 §2; repealed by 1973 c.669 §4]

656.536 Premium charges for coverage of reforestation cooperative workers based on prevailing wage; manner of determining prevailing wage. (1) The premiums charged by an insurer for coverage under this chapter for members of a workers' cooperative engaged primarily in reforestation work and all computations for benefits payable to such individuals under this chapter shall be based on the prevailing rate of wage paid to individuals performing the same work in the same locality as members of the workers' cooperative.

(2) Each time a cooperative contracts for services, the cooperative shall determine the prevailing rate of wage of each job category involved in performance of the contract. The determination of the prevailing rate of wage shall be filed with the insurer and used during the term of the contract. If a dispute arises between the workers' cooperative and the insurer concerning the propriety of the prevailing rate of wage determination by the workers' cooperative, the Director of the Department of Consumer and Business Services shall determine the appropriate prevailing rate of wage.

(3) The determination of the prevailing rate of wage shall be based on the best evidence available concerning wages paid to employees who do not have an ownership interest in the contracting enterprise performing the same work under similar conditions in the same locality as the cooperative. If no such work is being performed in the same locality at the time the workers' cooperative engages in a contract for services, the best evidence available from the latest such contract for services for the same work under similar conditions in the nearest locality

shall be used by the workers' cooperative to determine the prevailing rate of wage.

(4) Notwithstanding any other provision of this section, in no case shall the prevailing rate of wage used for the purpose of this section be less than the rate of wage specified in the contract for services as the minimum wage to be paid for services performed under the contract. If no such minimum wage requirement is specified in the contract for services, the most recent such contract for services for the same work under similar conditions in the nearest locality which specifies minimum wages shall be used to determine the prevailing rate of wage.

(5) As used in this section:

(a) "Prevailing rate of wage" means the average wage paid to employees who do not have an ownership interest in the contracting enterprise performing the same work under similar conditions in the same locality as the cooperative.

(b) "Workers' cooperative" means an enterprise:

(A) Formed pursuant to ORS chapter 62.

(B) The membership of which is limited to individuals who maintain and operate the enterprise.

(C) The members of which each have equal voting power in the control of the enterprise.

(D) The profits of which are distributed to each member on the basis of the quantity or value of the services performed by that individual as a member of the cooperative.

(E) Which makes no dividend or financial or monetary return or any other payment based on capital investment except as provided in subparagraph (D) of this paragraph or at a strictly limited rate of interest agreed upon at the time the capital is invested.

(F) Receives not less than 80 percent of its gross income from engaging in reforestation work and related activity, including but not limited to tree planting, brush clearing, precommercial thinning, trail building, trail maintenance, fire fighting, timber stand examinations, cone picking, tubing, conifer release and roadside brush clearing. [1981 c.279 §2]

656.538 [1983 c.816 §11; 1987 c.373 §§35,35a; 1987 c.884 §21; 1990 c.2 §33; repealed by 1993 c.760 §4]

ENFORCEMENT OF PREMIUM PAYMENTS

656.552 Deposit of cash, bond or letter of credit to secure payment of employer's premiums. (1) If the State Accident Insurance Fund Corporation finds it necessary for the protection of the Industrial Accident Fund, it may require any employer insured with the State Accident Insurance Fund Corporation, except political subdivisions of the state, to deposit and keep on deposit with the State Accident Insurance Fund Corporation a sum equal to the premiums due the State Accident Insurance Fund Corporation upon the estimated payroll of the employer for a period of not to exceed six months.

(2) The State Accident Insurance Fund Corporation may, in its discretion and in lieu of such deposit, accept a bond, letter of credit or similar instrument to secure payment of premiums to become due the Industrial Accident Fund. The deposit or posting of the bond, letter of credit or similar instrument shall not relieve the employer from making premium payments to the Industrial Accident Fund based on the actual payroll of the employer, as provided by ORS 656.504.

(3) If an employer ceases to be insured by the State Accident Insurance Fund Corporation, the State Accident Insurance Fund Corporation shall, upon receipt of all payments due the Industrial Accident Fund, refund to the employer all deposits remaining to the employer's credit and shall cancel any bond, letter of credit or similar instrument given under this section. [Amended by 1959 c.450 §8; 1965 c.285 §81; 1981 c.854 §37; 2009 c.145 §1]

656.554 Injunction against employer failing to comply with deposit requirements. (1) If an employer fails to comply with ORS 656.552, the circuit court of the county in which the employer resides or in which the employer employs workers shall, upon the commencement of a suit by the State Accident Insurance Fund Corporation for that purpose, enjoin the employer from further employing workers under this chapter until the employer has complied with ORS 656.552.

(2) Upon filing of a suit for such purpose by the State Accident Insurance Fund Corporation, the court shall set a day for hearing and shall cause notice thereof to be served upon the employer. The hearing shall be not less than five nor more than 15 days from the service of the notice.

656.556 Liability of person letting a contract for amounts due from contractor. If any person lets a contract and the person to whom the contract was let, while performing the contract, engages as an employer subject to this chapter at the plant of the person letting the contract, upon premises owned, leased or controlled by such person or upon premises where such person is conducting business, the person letting the contract shall be liable to the Industrial Accident Fund for the payment of all premiums, fees and assessments which may be due such fund on account of the performance of the

contract or any subcontract thereunder. [Amended by 1965 c.285 §73; 1981 c.854 §38]

656.558 [Amended by 1965 c.285 §66a; renumbered 656.646]

656.560 Default in payment of premiums, fees, assessments or deposit; remedies. (1) When any payment of premiums, fees and assessments required by this chapter to be made by an employer insured with the State Accident Insurance Fund Corporation on the account of the employer or on account of workers employed by that employer becomes due, interest at the rate of one percent per month or fraction thereof shall be added to the amount of such payment commencing with the first day of the month following the date upon which such payment became due.

(2) If any employer insured with the State Accident Insurance Fund Corporation fails to make and maintain the deposit provided in ORS 656.552 or fails to make payment of premiums, fees and assessments required within 30 days after a written demand by the State Accident Insurance Fund Corporation, such employer is in default and is also subject to a penalty of 10 percent of the amount then due. The written demand shall be mailed to the employer at the last-known address of the employer by registered or certified mail. A copy of the demand shall at the same time be sent to the Director of the Department of Consumer and Business Services.

(3) The amount at any time due, together with interest thereon, and penalty for nonpayment thereof, may be collected by the State Accident Insurance Fund Corporation in the same action.

(4) Every employer in default, as provided in this section, upon receipt of notice thereof, shall display such notice of default by posting it in a place accessible to the workers in such manner as to inform the workers of such default. [Amended by 1965 c.285 §73a; 1969 c.248 §1; 1971 c.73 §1; 1975 c.556 §44; 1981 c.854 §39]

656.562 Moneys due Industrial Accident Fund as preferred claims; moneys due department as taxes due state. (1) All premiums, fees, assessments, interest charges, penalties or amounts due the Industrial Accident Fund from any employer under this chapter and all judgments recovered by the State Accident Insurance Fund Corporation against any employer under this chapter shall be deemed preferred to all general claims in all bankruptcy proceedings, trustee proceedings, proceedings for the administration of estates and receiverships involving the employer liable therefor or the property of such employer.

(2) All assessments, interest charges, penalties or amounts due the Department of Consumer and Business Services shall be considered taxes due the State of Oregon. [Amended by 1979 c.839 §11; 1981 c.854 §40]

656.564 Lien for amounts due from employer on real property, improvements and equipment on or with which labor is performed by workers of employer. (1) A lien hereby is created in favor of the insurer upon all real property within this state and any structure or improvement thereon and upon any mine, lode, deposit, mining claim, or any road, tramway, trail, flume, ditch, pipeline, building, or other structure or equipment on or pertaining thereto, upon which labor is performed by the workers of any employer subject to this chapter in a sum equal to the amount at any time due from such employer to the insurer on account of labor performed thereon by the workers of such employer, together with interest and penalty.

(2) The insurer shall also have a lien on all lumber, sawlogs, spars, piles, ties or other timber, and upon all other manufactured articles of whatsoever kind or nature, and upon all machinery, tools and equipment of the employer used in connection with the employment on which contributions, premiums or assessments are due, in a sum equal to the amount at any time due from any employer subject to this chapter on account of labor performed by the workers of such employer, together with interest and penalty.

(3) In order to avail itself of the lien created by this section, the insurer shall, within 60 days after the employer is in default, as provided in ORS 656.560, file with the county clerk of the county within which such property is then situated a statement in writing describing the property upon which a lien is claimed and stating the amount of the lien claimed by the insurer. If a lien is claimed on real property not then owned by the employer, the statement must be filed within 60 days from the completion of the work.

(4) The insurer shall, within six months from the filing of the statement, commence a suit to cause such lien to be foreclosed in the manner provided by law for the foreclosure of other liens on real or personal property.

(5) The lien created by this section shall be prior to all other liens and encumbrances, except labor liens and liens for taxes and other amounts due the State of Oregon. [Amended by 1979 c.815 §6; 1981 c.535 §40]

656.566 Lien on property of employer for amounts due. (1) If any employer liable for the payment of premiums, fees and assessments to the Industrial Accident Fund is

placed in default as provided by ORS 656.560, the amount due the fund, including interest and penalty, is a lien in favor of the State Accident Insurance Fund Corporation upon all property, whether real or personal, belonging to such employer.

(2) The lien attaches upon the filing of a notice of claim of lien with the county clerk of the county in which the property is located. The notice of lien claim shall contain a true statement of the demand, after deducting all just credits and offsets, and the default of such employer. The county clerk shall record the claim of lien in the County Clerk Lien Record and shall receive the fee provided in ORS 205.320.

(3) The employer against whose property the lien has been filed may cause the property to be released by filing with the county clerk of the county wherein the lien is recorded a bond in a sum double the amount claimed in the lien, executed by a surety company licensed to do business in Oregon or by two freeholders of this state, having the qualifications of bail upon arrest, to be approved by the circuit judge of the district in which the lien is filed, or in the event of absence from the county in which the lien is filed, then by the county judge of said county, running to the State Accident Insurance Fund Corporation and conditioned for the payment of all damages, costs, charges and disbursements that may be recovered by the State Accident Insurance Fund Corporation against the employer or that may be found to be a lien upon or against the property of such employer. The clerk shall record evidence that the bond is substituted in lieu of the property of the employer and that the lien on the property is forever released and discharged. If the State Accident Insurance Fund Corporation establishes the validity of its lien by a suit to foreclose the lien, it shall be entitled to judgment against the sureties upon the bond.

(4) The lien created by this section may be foreclosed by a suit in the circuit court in the manner provided by law for the foreclosure of other liens on real or personal property. Unless a suit is instituted by the State Accident Insurance Fund Corporation to foreclose such lien within two years from the date of filing, the lien shall expire.

(5) The lien created by this section is prior to all liens and encumbrances recorded subsequent to the filing of notice of claim of lien, except taxes and labor liens. [Amended by 1981 c.854 §41; 2001 c.577 §5; 2003 c.576 §531]

RECOVERY AGAINST THIRD PERSONS AND NONCOMPLYING EMPLOYERS

656.576 "Paying agency" defined. As used in ORS 656.578 to 656.595, "paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. [1965 c.285 §44a; 1981 c.854 §42]

656.578 Workers' election whether to sue third person or noncomplying employer for damages. If a worker of a noncomplying employer receives a compensable injury in the course of employment, or if a worker receives a compensable injury due to the negligence or wrong of a third person (other than those exempt from liability under ORS 656.018), entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from such employer or third person. If a worker leaves beneficiaries who are minors, the right of election shall be exercised by their surviving parent, if any; otherwise, such election shall be exercised by the guardian. [Formerly 656.312]

656.580 Payment of compensation notwithstanding cause of action for damages; lien on cause of action for compensation paid. (1) The worker or beneficiaries of the worker, as the case may be, shall be paid the benefits provided by this chapter in the same manner and to the same extent as if no right of action existed against the employer or third party, until damages are recovered from such employer or third party.

(2) The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages. [Formerly 656.314]

656.582 [Renumbered 656.384]

656.583 Paying agency may compel election and prompt action. (1) The paying agency may require the worker or other beneficiaries or the legal representative of a deceased worker to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker, beneficiaries or legal representative.

(2) Unless such election is made within 60 days from the receipt or service of such demand and unless, after making such election, an action against such third person is instituted within such time as is granted by the paying agency, the worker, beneficiaries or legal representative is deemed to have assigned the cause of action to the paying agency. The paying agency shall allow the worker, the beneficiaries or legal representative of the worker at least 90 days

from the making of such election to institute such action. In any case where an insurer of a third person is also the insurer of the employer, notice of this fact must be given in writing by the insurer to the injured worker and to the Director of the Department of Consumer and Business Services within 10 days after the occurrence of any accident which may result in the assertion of the claim against the third person by the injured worker. [Formerly 656.316; 1981 c.854 §43]

656.584 [Amended by 1965 c.285 §68d; renumbered 656.624]

656.586 [Renumbered 656.720]

656.587 Paying agency must join in any compromise. Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Workers' Compensation Board. [Formerly 656.318; 1990 c.2 §34]

656.588 [Amended by 1957 c.558 §1; 1965 c.285 §42a; renumbered 656.386]

656.590 [Amended by 1965 c.285 §42b; renumbered 656.388]

656.591 Election not to bring action operates as assignment of cause of action. (1) An election made pursuant to ORS 656.578 not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker, the beneficiaries or legal representative of the deceased worker, against the employer or third person, and the paying agency may bring action against such employer or third person in the name of the injured worker or other beneficiaries.

(2) Any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical, surgical or hospital service, together with the present worth of the monthly payments of compensation to which such worker or other beneficiaries may be entitled under this chapter, shall be paid such worker or other beneficiaries. [Formerly 656.320]

656.593 Procedure when worker elects to bring action; release of liability and lien of paying agency in certain cases. (1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section. When the proceeds are paid in a series of payments, each payment shall be distributed proportionately to each recipient according to the formula provided in this section, unless otherwise agreed by the parties. The total proceeds shall be distributed as follows:

(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the Workers' Compensation Board for such actions.

(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. Such other costs include expenditures of the Department of Consumer and Business Services from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency. Such other costs also include assessments for the Workers' Benefit Fund, and include any compensation which may become payable under ORS 656.273 or 656.278.

(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

(2) The amount retained by the worker or the beneficiaries of the worker shall be in addition to the compensation or other benefits to which such worker or beneficiaries are entitled under this chapter.

(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to

what may be a just and proper distribution shall be resolved by the board.

(4) As used in this section, "paying agency" includes the Department of Consumer and Business Services with respect to its expenditures from the Workers' Benefit Fund in reimbursement of the costs of another paying agency for vocational assistance and the costs of claims of noncomplying employers.

(5) The department shall be repaid for its expenditures from the proceeds recovered by the paying agency in an amount proportional to the amount of the department's reimbursement of the paying agency's costs. All moneys received by the department under this section shall be deposited in the same fund from which the paying agency's costs originally had been reimbursed.

(6) Prior to and instead of the distribution of proceeds as described in subsection (1) of this section, when the worker or the beneficiaries of the worker are entitled to receive payment pursuant to a judgment or a settlement in the third party action in the amount of $1 million or more, the worker or the beneficiaries of the worker may elect to release the paying agency from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of its reasonably expected future expenditures for workers' compensation and other costs of the worker's claim, if all of the following conditions are met as part of the claim release:

(a) The worker or the beneficiaries of the worker are represented by an attorney.

(b) The release of the claim is presented in writing and is filed with the Workers' Compensation Board, with a copy served on the paying agency, including the Department of Consumer and Business Services with respect to its expenditures from the Workers' Benefit Fund, the Consumer and Business Services Fund and the Self-Insured Employer Adjustment Reserve.

(c) The claim release specifies that the worker or the beneficiaries of the worker understand that the claim release means that no further benefits of any nature whatsoever shall be paid to the worker or the beneficiaries of the worker.

(d) The release of the claim is accompanied by a settlement stipulation with the paying agency, outlining terms of reimbursement to the paying agency, covering its incurred expenditures for compensation, first aid or other medical, surgical or hospital service and for expenditures from the Workers' Benefit Fund, the Consumer and Business Services Fund and the Self-Insured Employer Adjustment Reserve, to the date the release becomes final or the order of the board becomes final. If the payment of such incurred expenditures is in dispute, the release of the claim shall be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the board for resolution of the dispute by order of the board under procedures allowing for board resolution under ORS 656.587, in which case the release of the claim shall not be final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying agent.

(e) If a service, item or benefit has been provided but a bill for that service, item or benefit has not been received by the paying agency before the release or order becomes final, the reimbursement payment shall cover the bill pursuant to the following process:

(A) The paying agency may maintain a contingency fund in an amount reasonably sufficient to cover reimbursement for the billing.

(B) If a dispute arises as to reimbursement for any bill first received by the paying agency not later than 180 days after the date the release or order became final, the dispute shall be resolved by order of the board.

(C) Any amount remaining in the contingency fund after the 180-day period shall be paid to the worker or the beneficiaries of the worker.

(D) Any billing for a service, item or benefit that is first received by the paying agency more than 180 days after the date the release or order became final is unenforceable by the person who issued the bill.

(f) The settlement or judgment proceeds are available for payment or actually have been paid out and are available in a trust fund or similar account, or are available through a legally enforceable structured settlement agreement if sufficient funds are available to make payment to the paying agency.

(g) The agreed-upon payment to the paying agency, or the payment to the paying agency ordered by the board, is made within 30 days of the filing of the withdrawal of the claim with the board or within 30 days after the board has entered a final order resolving any dispute with the paying agency.

(7) When a release of further liability on a claim, as provided in subsection (6) of this section, has been filed, and when payment to the paying agency has been made, the effect of the release is that the worker or beneficiaries of the worker shall have no further right to seek benefits pursuant to the original claim, or any independent workers'

compensation claim regarding the same circumstances, and the claim shall not be reasserted, refiled or reestablished through any legal proceeding. [Formerly 656.322; 1977 c.804 §16; 1979 c.839 §12; 1981 c.540 §1; 1985 c.600 §12; 1987 c.373 §35b; 1993 c.445 §1; 1995 c.332 §47; 1995 c.641 §8; 1997 c.639 §4]

Note: See notes under 656.202.

656.595 Precedence of cause of action; compensation paid or payable not to be an issue. (1) Any action brought against a third party or employer, as provided in this chapter, shall have precedence over all other civil cases.

(2) In any third party action brought pursuant to this chapter, the fact that the injured worker or the beneficiaries of the injured worker are entitled to or have received benefits under this chapter shall not be pleaded or admissible in evidence.

(3) A challenge of the right to bring such third party action shall be made by supplemental pleadings only and such challenge shall be determined by the court as a matter of law. [Formerly 656.324]

656.596 Damage recovery as offset against compensation; recovery procedure; notice to paying agent. (1) If no workers' compensation claim has been filed or accepted at the time a worker or the beneficiaries of a worker recover damages from a third person or noncomplying employer pursuant to ORS 656.576 to 656.596, the amount of the damages shall constitute an offset against compensation due the worker or beneficiaries of the worker for the injuries for which the recovery is made to the extent of any lien that would have been authorized by ORS 656.576 to 656.596 if a workers' compensation claim had been filed and accepted at the time of recovery of damages.

(2) The offset created by subsection (1) of this section shall be recoverable from compensation payable to the worker, the worker's beneficiaries and the worker's attorney. No compensation payments shall be made to the worker, the worker's beneficiaries or the worker's attorney until the offset has been fully recovered.

(3) The worker or the beneficiaries of the worker shall notify the paying agency or potential paying agency of the amount of any damages recovered from a third person or noncomplying employer at the time of recovery or when the worker or the beneficiaries of a worker file a workers' compensation claim that is subject to ORS 656.576 to 656.596. [1993 c.644 §2; 1995 c.332 §48]

656.597 [Formerly 656.326; repealed by 1971 c.70 §2]

FUNDS; SOURCE; INVESTMENT; DISBURSEMENT

(General Provisions)

656.602 Disbursement procedures. All disbursements for administrative expenses from the Industrial Accident Fund, except as provided by ORS 656.642, shall be made only upon warrants drawn by the Oregon Department of Administrative Services upon vouchers duly approved by the State Accident Insurance Fund Corporation. [Formerly 656.472; 1977 c.804 §17; 1983 c.740 §243; 1985 c.212 §9; 1987 c.373 §36]

656.604 [Formerly 656.474; repealed by 1987 c.373 §85]

656.605 Workers' Benefit Fund; uses and limitations. (1) The Workers' Benefit Fund is created in the State Treasury, separate and distinct from the General Fund. Moneys in the fund shall be invested in the same manner as other state moneys and investment earnings shall be credited to the fund. The fund shall consist of the following:

(a) Moneys received pursuant to ORS 656.506.

(b) Moneys recovered under ORS 656.054.

(c) Penalties recovered under ORS 656.735.

(d) All moneys received by the Director of the Department of Consumer and Business Services pursuant to law or from any other source for purposes for which the fund may be expended.

(2) Moneys in the Workers' Benefit Fund may be expended for the following purposes:

(a) Expenses of programs under ORS 656.445, 656.506, 656.622, 656.625, 656.628 and 656.630.

(b) Proceedings against noncomplying employers pursuant to ORS 656.054 and 656.735.

(c) Expenses of vocational assistance on claims, the cost of which was imposed pursuant to section 15, chapter 600, Oregon Laws 1985.

(d) Payment of supplemental temporary disability benefits for workers employed in more than one job at the time of injury and reimbursement of the costs of administering payments resulting from elections by insurers and self-insured employers as provided by ORS 656.210 (5).

(e) Payments made to injured workers pursuant to section 6a, chapter 865, Oregon Laws 2001.

(f) Expenses of the Bureau of Labor and Industries for enforcing ORS 659A.040, 659A.043, 659A.046, 659A.049 and 659A.052, subject to an agreement between the Director of the Department of Consumer and

Business Services and the Commissioner of the Bureau of Labor and Industries. The agreement must include, but is not limited to, the amount of funds to be transferred to the bureau for enforcing ORS 659A.040, 659A.043, 659A.046, 659A.049 and 659A.052 and the information relating to the enforcement of ORS 659A.040, 659A.043, 659A.046, 659A.049 and 659A.052 that the bureau must report to the director.

(g) Reimbursement to the insurer or self-insured employer for the amount of permanent total disability benefits paid after the date of the notice of closure that was upheld pursuant to ORS 656.206.

(h) Reimbursement of vocational benefit expenses as provided in ORS 656.313.

(3) Subject to the following provisions, all moneys in the fund are appropriated continuously to the Director of the Department of Consumer and Business Services to carry out the activities for which the fund may be expended:

(a) Moneys received pursuant to ORS 656.054 and 656.735 and transfers made pursuant to ORS 705.148 may be expended only to carry out the provisions of ORS 656.054 and 656.735 and section 15, chapter 600, Oregon Laws 1985.

(b) Moneys received pursuant to ORS 656.506 and the transfers of unexpended and unobligated moneys in the Retroactive Reserve, Reemployment Assistance Reserve, Reopened Claims Reserve and Handicapped Workers Reserve referred to in ORS 656.506, 656.622, 656.625 and 656.628 (All 1993 Edition) may be expended only to carry out the programs referred to in ORS 656.506, 656.622, 656.625, 656.628 and 656.630.

(4) Notwithstanding any other provision of this chapter, if the director determines at any time that there are insufficient moneys in the Workers' Benefit Fund to pay the expenses of programs for which expenditure of the fund is authorized, the director may reduce the level of benefits payable accordingly. [1995 c.641 §15; 1999 c.273 §3; 2001 c.865 §5; 2001 c.974 §8; 2002 s.s.2 c.4 §4; 2005 c.461 §5; 2005 c.588 §5; 2011 c.597 §267]

Note: See notes under 656.202.

656.612 Assessments for department activities; amount; collection procedure. (1) The Director of the Department of Consumer and Business Services shall impose and collect assessments from all insurers, self-insured employers and self-insured employer groups in an amount sufficient to pay the expenses of the Department of Consumer and Business Services under this chapter and ORS chapter 654 and under the Insurance Code. The assessments shall be paid in the manner and at intervals as the director may direct and when collected shall be deposited in the Consumer and Business Services Fund. The receipts in the account are continuously appropriated to the department for the purpose described in this subsection.

(2) The assessments shall be levied against the insurers' direct earned premium and the direct earned premium self-insured employers and self-insured employer groups would have paid had they been insured employers.

(3) The director may impose and collect an additional assessment from self-insured employer groups in an amount sufficient to pay the additional expenses involved in administering the group self-insured program.

(4) The director may establish a minimum assessment applicable to all insurers, self-insured employers and self-insured employer groups and shall establish the time, manner and method of imposing and collecting assessments subject to applicable budgeting and fiscal laws.

(5) The assessments required under this section shall be developed pursuant to ORS 183.310 to 183.410 and in such a manner that will reasonably and substantially accomplish the objective of subsection (2) of this section at the least possible administrative cost to everyone.

(6) Assessments developed by the department under this section shall be reported to the Joint Committee on Ways and Means or, during the interim between sessions of the Legislative Assembly, to the Emergency Board or to the Joint Interim Committee on Ways and Means. [1965 c.285 §69a; 1973 c.353 §2; 1975 c.556 §45; 1977 c.804 §18; 1979 c.839 §13; 1981 c.535 §41; 1981 c.854 §44; 1985 c.506 §1; 1987 c.373 §37; 1987 c.884 §22; 1989 c.413 §21; 1990 c.2 §35; 1999 c.409 §1; 2012 c.107 §17]

656.614 Self-Insured Employer Adjustment Reserve; Self-Insured Employer Group Adjustment Reserve. (1) The Self-Insured Employer Adjustment Reserve and the Self-Insured Employer Group Adjustment Reserve shall be established within the Consumer and Business Services Fund. These reserves shall be used to pay the claims of workers of self-insured employers or of employers that are members of a self-insured employer group when the Director of the Department of Consumer and Business Services finds that the worker cannot obtain payment from the employer or self-insured employer group responsible for payment of the claim because of insolvency, default or decertification of the employer, the self-insured employer group or the excess insurer of the employer or group, and exhaustion of the excess insurance and security deposited to secure such payment.

(2) If at any time the director finds that the amount of moneys in the reserves is not sufficient to carry out the purposes stated in subsection (1) of this section, the director may impose and collect from self-insured employers and self-insured employer groups assessments sufficient to raise the amount of moneys in the reserves to the point where it can carry out such purposes. If at any time the director finds that there is a surplus in the reserves beyond an amount that can reasonably be anticipated as sufficient to carry out the purposes stated in subsection (1) of this section, the director may transfer the surplus to the Consumer and Business Services Fund and reduce the total amount of assessment by the amount so transferred.

(3) Notwithstanding the provisions of this section, the director may impose a differential assessment between the two employers adjustment reserves in order to collect sufficient moneys in the reserves as provided in subsection (2) of this section.

(4) Assessments imposed under this section shall be paid to the director in the manner and at such times as the director may direct.

(5) Assessments paid by self-insured employer groups shall be deposited in the Consumer and Business Services Fund in separate accounts for public employers that are members of a self-insured employer group and for private employers that are members of a self-insured employer group. Moneys deposited in each account may be used only to pay claims expenses of employees of each category of self-insured employer group.

(6) Notwithstanding subsection (1) of this section, the director may use the reserves to assure timely payment of compensation pending payment from the excess insurance or security deposit. The director shall recover these costs from the excess insurance or the security deposit, up to their limits. [1965 c.285 §67a; 1975 c.556 §46; 1979 c.845 §3; 1981 c.535 §42; 1983 c.816 §12; 2014 c.48 §8]

656.616 [Formerly 344.810; repealed by 1985 c.600 §15]

656.618 [1965 c.285 §67e; 1977 c.804 §19; repealed by 1987 c.373 §85]

656.620 [1965 c.285 §67f; 1977 c.804 §20; 1979 c.839 §14; repealed by 1987 c.373 §85]

656.622 Reemployment Assistance Program; claim data not to be used for insurance rating; rules. (1) There is established a Reemployment Assistance Program for the benefit of employers and workers and for the purpose of:

(a) Giving employers and workers the benefits provided in this section.

(b) Providing reimbursement of reasonable program administration costs of self-insured employers and of insurers of employers who participate in any program funded through the Reemployment Assistance Program.

(2) In order to preclude or reduce nondisabling claims from becoming disabling claims, preclude on-the-job injuries from recurring, reduce disability by returning injured workers to work sooner and to help injured workers remain employed, the Director of the Department of Consumer and Business Services may provide assistance to employers from the Reemployment Assistance Program in such manner and amount as the director considers appropriate. Assistance may include, but need not be limited to, modification of work sites. For purposes of this subsection, work site modification may include engineering design work and occupational health consulting services. Factors to be considered by the director in determining the extent of assistance must include but need not be limited to the employer's record of returning injured workers to the workplace and the cost-effectiveness of modifications. Assistance may be provided in the form of grants and matching contributions from employers for funds.

(3) In order to encourage the employment of individuals who have incurred compensable injuries that result in disability which may be a substantial obstacle to employment, the director may provide, to eligible injured workers and to employers who employ them, assistance from the Workers' Benefit Fund in such manner and amount as the director considers appropriate.

(4)(a) In addition to such assistance as the director may provide under this section, the director shall provide reimbursement to self-insured employers or to the insurers of employers who hire preferred workers for the claim costs incurred for injuries to those workers during the first three years from the date of hire, as follows:

(A) The claim costs of injuries incurred by those workers.

(B) Reasonable claims administration costs.

(b) A worker may not waive eligibility for preferred worker status in the claim by agreement pursuant to ORS 656.236.

(5)(a) In addition to such assistance as the Director of the Department of Consumer and Business Services may provide under subsection (3) of this section, the director shall provide to participating self-insured employers and the insurers of participating employers reimbursement of reasonable program administration costs.

(b) As used in this subsection, "participating employer" or "participating self-

insured employer" means an employer participating in any program funded through the Reemployment Assistance Program.

(6) Notwithstanding any other provision of law, determinations by the director regarding assistance pursuant to this section are not subject to review by any court or other administrative body.

(7) The Reemployment Assistance Program shall be funded with moneys collected as provided in ORS 656.506.

(8) Any assistance from the Reemployment Assistance Program shall be to the extent of the moneys available in the Workers' Benefit Fund, for the purpose of the program as determined by the director.

(9) The director may make such rules as may be required to establish, regulate, manage and disburse moneys in the Workers' Benefit Fund in accordance with the intent of this section. Such rules shall include, but are not limited to, the eligibility criteria to receive assistance under this section and the issuance of identity cards to preferred workers to assist employers in the administration of the program.

(10) If claim cost reimbursement is requested under subsection (4) of this section, claims costs incurred as a result of an injury sustained by a preferred worker during the three years after that worker is hired shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services. Neither insurance premiums nor premium assessments under this chapter are payable for preferred workers during the first three years from the date of hire.

(11) Any moneys from the Workers' Benefit Fund reimbursed to an agency for costs incurred in reemploying injured state workers in the manner described in ORS 659A.052 or in providing wage subsidies for the reemployment of injured state workers shall be outside the biennial expenditure limitation imposed on the agency by the Legislative Assembly and shall be available for expenditure by the agency as a continuous appropriation.

(12) As used in this section, "preferred worker" means a worker who, because of a permanent disability resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment, whether or not an order has been issued awarding permanent disability. [1965 c.285 §68; 1969 c.536 §3; 1971 c.768 §3; 1977 c.557 §2; 1981 c.854 §60; 1983 c.391 §4; 1983 c.816 §13; 1985 c.600 §13; 1985 c.770 §2; 1987 c.884 §20; 1990 c.2 §36; 1991 c.93 §11; 1991 c.496 §1; 1991 c.694 §1; 1993 c.760 §3; 1995 c.332 §49; 1995 c.641 §21; 1999 c.273 §4; 2005 c.588 §1; 2007 c.241 §16; 2009 c.36 §§3,4]

Note: See notes under 656.202.

656.624 [Formerly 656.584; 1983 c.740 §244; repealed by 1987 c.250 §1]

656.625 Reopened Claims Program; rules. (1) There is established a Reopened Claims Program for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the Workers' Compensation Board or voluntary claim reopening pursuant to ORS 656.278 after January 1, 1988.

(2) Notwithstanding any other provision of law, any reimbursement from the Workers' Benefit Fund for the purposes of the Reopened Claims Program shall be in such amounts payable to an injured worker pursuant to ORS 656.278 and only to the extent that moneys are available in the fund as determined by the Director of the Department of Consumer and Business Services.

(3) The director, by rule, shall prescribe the form and manner of requesting reimbursement under this section, the amount payable and such other matters as may be necessary for the administration of this section. [1987 c.884 §39; 1995 c.332 §49a; 1995 c.641 §22; 2001 c.865 §11a]

Note: See notes under 656.202.

656.628 Workers with Disabilities Program; use of funds; conditions and limitations; rules. (1) There is established a Workers with Disabilities Program for the benefit of complying employers and their workers. The purpose of the program is to encourage the employment or reemployment of workers with disabilities.

(2) As used in this section, "worker with a disability" means a worker who has or is subject to any permanent physical or mental impairment, whether congenital or due to an injury or disease, including periodic impairment of consciousness or muscular control of such character that the impairment would prevent the worker from obtaining or retaining employment.

(3) Any employer of a worker who claims or has received compensation under this chapter, or whose dependents have claimed or received such compensation, may file an application with the Director of the Department of Consumer and Business Services requesting the director to make the determinations referred to in subsection (4) of this section.

(4) When the director receives a request referred to in subsection (3) of this section, the director shall determine:

(a) Whether the injured worker was a worker with a disability and whether the injury, disease or death sustained by the worker would not have been sustained except for the disability; or

(b) Whether the injured worker was a worker with a disability and whether the injury, disease or death sustained by the worker would have been sustained without regard to the disability but that:

(A) Any resulting disability was substantially greater by reason of the disability; or

(B) The disability contributed substantially to the worker's death; and

(C) Whether the injury, disease or death of the worker would not have occurred except for the act or omission of a worker with a disability employed by the same employer and that the act or omission of the worker with a disability would not have occurred except for the impairment of the worker with a disability.

(5) If the director determines that any of the conditions described in subsection (4) of this section exist, the director may reimburse the paying agency for compensation amounts in excess of $1,000 per claimant for all subsequent injuries throughout the claimant's working career, paid as the result of the condition.

(6) The reimbursement paid from the Workers' Benefit Fund may not be included in any data used for rate making or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services.

(7) Notwithstanding any other provision of law:

(a) Any reimbursement to employers under the Workers with Disabilities Program shall be in such amounts as the director prescribes and only to the extent of moneys available in the Workers' Benefit Fund as determined by the director.

(b) Determinations made by the director regarding reimbursement from the Workers' Benefit Fund for the purposes of this section are not subject to review by any court or administrative body.

(c) After a determination has been made by the director that an employer will receive reimbursement from the Workers' Benefit Fund, any settlement of the claim by the parties is void unless made with the written approval of the director.

(8) The director by rule shall prescribe the form and manner of requesting determinations under this section, the amount of reimbursement payable and such other matters as may be necessary for the administration of this section. [1981 c.535 §14; 1995 c.332 §49b; 1995 c.641 §23; 2007 c.70 §286; 2007 c.241 §17]

656.630 Oregon Institute of Occupational Health Sciences funding; report of activities. (1) There is transferred to and continuously appropriated to the Oregon Institute of Occupational Health Sciences of the Oregon Health and Science University, the following amounts from the following sources:

(a) The amount of revenue equivalent to one-sixteenth of one cent of the money deductible from workers' wages pursuant to ORS 656.506 (2).

(b) An amount equal to the amount raised by paragraph (a) of this subsection from those assessments made pursuant to ORS 656.612 (2).

(2) The moneys referred to in subsection (1) of this section may only be used for paying the expenses of the Oregon Institute of Occupational Health Sciences. If the Director of the Department of Consumer and Business Services determines adequate funds are available and the director reduces or suspends for a period of time the assessments made pursuant to ORS 656.506 (2) and 656.612 (2), the reduction or suspension of the assessments does not terminate the transfers to the Oregon Institute of Occupational Health Sciences authorized in subsection (1) of this section.

(3) Annually, the Oregon Institute of Occupational Health Sciences shall file a report with the Oregon Health and Science University, with a copy to the Director of the Department of Consumer and Business Services, describing the activities in sufficient detail for which moneys received under this section during the year have been obligated or expended. [1993 c.760 §6; 1995 c.162 §85; 1995 c.641 §11a; 2013 c.111 §4]

(Industrial Accident Fund and Reserves)

656.632 Industrial Accident Fund. (1) The Industrial Accident Fund is continued. This fund shall be held by the State Treasurer and by the State Treasurer deposited in such banks as are authorized to receive deposits of general funds of the state.

(2) All moneys received by the State Accident Insurance Fund Corporation under this chapter, shall be paid forthwith to the State Treasurer and shall become a part of the Industrial Accident Fund. However, any assessments collected for the Director of the Department of Consumer and Business Services under this chapter and deposited in the Industrial Accident Fund may thereafter be

transferred to the director and deposited in the Consumer and Business Services Fund.

(3) All payments authorized to be made by the State Accident Insurance Fund Corporation by this chapter, including all salaries, clerk hire and all other expenses, shall be made from the Industrial Accident Fund. [Formerly 656.452; 1975 c.556 §47; 2003 c.781 §§9,13]

656.634 Trust fund status of Industrial Accident Fund. (1) The Industrial Accident Fund is a trust fund exclusively for the uses and purposes declared in this chapter, except that this provision shall not be deemed to amend or impair the force or effect of any law of this state specifically authorizing the investment of moneys from the fund.

(2) Subject to the right of the State of Oregon to direct legislatively the disposition of any surplus in excess of reserves and surplus deemed actuarially necessary according to recognized insurance principles, and necessary in addition thereto to assure continued fiscal soundness of the State Accident Insurance Fund Corporation both for current operations and for future capital needs, the State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund. [Formerly 656.454; 1967 c.335 §55; 1982 s.s.3 c.2 §4]

656.635 Reserve accounts in Industrial Accident Fund. (1) The State Accident Insurance Fund Corporation may set aside, out of interest and other income received through investment of the Industrial Accident Fund, such part of the income as the State Accident Insurance Fund Corporation considers necessary, which moneys so segregated shall remain in the fund and constitute one or more reserve accounts. Such reserve accounts shall be maintained and used by the State Accident Insurance Fund Corporation to offset gains and losses of invested capital.

(2) The State Accident Insurance Fund Corporation may provide for amortizing gains and losses of invested capital in such instances as the State Accident Insurance Fund Corporation determines that amortization is preferable to a reserve account provided for in subsection (1) of this section. [1967 c.335 §57]

656.636 Reserves in Industrial Accident Fund for awards for permanent disability or death. For every case where the State Accident Insurance Fund Corporation must pay an award or benefits for death or permanent total disability or permanent partial disability, the State Accident Insurance Fund Corporation forthwith shall set aside in the Industrial Accident Fund in a reserve account the amount required to equal, together with the anticipated interest increment, the present worth of the installments payable on account of that injury. The number of installments shall be computed in case of permanent total disability or death according to the ages of the beneficiaries, and according to the actuarial practices in the insurance field as recommended by the Director of the Department of Consumer and Business Services and, in the case of permanent partial disability, according to the schedule in ORS 656.214 and 656.216. [Formerly 656.456; 1971 c.768 §4; 1973 c.614 §7; 1974 c.41 §10; 1977 c.200 §1; 1977 c.804 §21; 1979 c.839 §15; 1979 c.845 §4; 1981 c.854 §45; 1983 c.391 §2; 1985 c.739 §2]

656.637 [1979 c.334 §2; 1983 c.391 §3; repealed by 1985 c.739 §3]

656.638 [Formerly 656.460; 1969 c.536 §4; 1971 c.768 §5; 1977 c.804 §22; repealed by 1981 c.854 §1]

656.640 Creation of reserves. The State Accident Insurance Fund Corporation may set aside such other reserves within the Industrial Accident Fund as are deemed necessary. [Formerly 656.468; 1981 c.854 §46]

(Other Funds)

656.642 Emergency Fund. (1) There is created a revolving fund known as the Emergency Fund, which shall be deposited and maintained with the State Treasurer in the sum of $200,000.

(2) The Emergency Fund shall be disbursed by checks or orders issued by the State Accident Insurance Fund Corporation and drawn upon the State Treasurer:

(a) To pay compensation benefits.

(b) To refund to employers amounts paid to the Industrial Accident Fund in excess of the amounts required by this chapter.

(c) To distribute any surplus to employers as required by ORS 656.526.

(d) To distribute any moneys recovered from an employer or third party in which the State Accident Insurance Fund Corporation has no equity.

(e) To pay administrative expenses. [Formerly 656.464; 1971 c.357 §1; 1983 c.740 §245]

656.644 Petty cash funds. The State Accident Insurance Fund Corporation may, at its discretion, establish and maintain petty cash funds, not exceeding a total of $20,000 for the purpose of making change, refunding fees and premiums and assessments paid in error, the advance of traveling expense to employees and claimants, and paying miscellaneous legal fees and other petty incidental expenses in the administration of the Workers' Compensation Law. [Formerly 656.466; 1981 c.854 §47]

656.646 [Formerly 656.558; repealed by 1981 c.876 §1]

656.648 [1974 c.41 §12; repealed by 1981 c.854 §1 and 1981 c.876 §1]

ADMINISTRATION

(General Provisions)

656.702 Disclosure of records of corporation, department and insurers. (1)(a) The records of the State Accident Insurance Fund Corporation are subject to ORS 192.410 to 192.505.

(b) Notwithstanding ORS 192.502, the State Accident Insurance Fund Corporation shall make the accident experience records of the corporation available to a bona fide rating organization to assist in making workers' compensation rates. Costs involved in making the records available shall be borne by the rating organization. Accident experience records of carrier-insured employers shall also be available on the same terms to assist in making such rates.

(2) Disclosure of workers' compensation claim records of the Department of Consumer and Business Services is governed by ORS 192.502 (20). [Formerly 656.426; 1973 c.794 §33a; 1975 c.556 §48; 1987 c.884 §47; 1993 c.817 §3; 1997 c.825 §3; 2007 c.152 §5; 2009 c.57 §1]

656.704 Actions and orders regarding matters concerning claim and matters other than matters concerning claim; authority of director and board; administrative and judicial review; rules. (1) Actions and orders of the Director of the Department of Consumer and Business Services regarding matters concerning a claim under this chapter, and administrative and judicial review of those matters, are subject to the procedural provisions of this chapter and such procedural rules as the Workers' Compensation Board may prescribe.

(2)(a) A party dissatisfied with an action or order regarding a matter other than a matter concerning a claim under this chapter may request a hearing on the matter in writing to the director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge. Review of an order issued by the Administrative Law Judge shall be by the director and the director shall issue a final order that is subject to judicial review as provided by ORS 183.480 to 183.497.

(b) The director shall prescribe the classes of orders issued under this subsection by Administrative Law Judges and other personnel that are final, appealable orders and those orders that are preliminary orders subject to revision by the director.

(3)(a) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, subject to paragraph (b) of this subsection, such matters do not include any disputes arising under ORS 656.245, 656.247, 656.248, 656.260 or 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide.

(b) The respective authority of the board and the director to resolve medical service disputes shall be determined according to the following principles:

(A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim.

(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245 (1)(c), is not a matter concerning a claim.

(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.

(c) Notwithstanding ORS 656.283 (3), if parties to a hearing scheduled before an Administrative Law Judge are involved in a dispute regarding both matters concerning a claim and matters not concerning a claim, the Administrative Law Judge may defer any action on the matter concerning a claim until the director has completed an administrative review of the matters other than those concerning a claim. The director shall mail a copy of the administrative order to the parties and to the Administrative Law Judge. A party may request a hearing on the order of the director. At the request of a party or by the own motion of the Administrative Law Judge, the hearings on the separate matters may be consolidated. The Administrative Law Judge shall issue an order for those matters concerning a claim and a separate order for matters other than those concerning a claim.

(4) Hearings under ORS 656.740 shall be conducted by an Administrative Law Judge from the board's Hearings Division.

(5) If a request for hearing or administrative review is filed with either the director or the board and it is determined that the request should have been filed with the other, the dispute shall be transferred. Filing a request will be timely filed if the original filing was completed within the prescribed time. [1965 c.285 §54b; 1977 c.804 §23; 1979 c.839 §16; 1981 c.874 §11; 1985 c.770 §8; 1987 c.373 §38a; 1990 c.2 §37; 1995 c.332 §50; 1999 c.849 §§121a,121c,121e; 1999 c.876 §4; 1999 c.926 §2; 2003 c.75 §48; 2005 c.26 §15; 2009 c.35 §5]

656.708 Hearings Division; duties. The Hearings Division is continued within the Workers' Compensation Board. The division has the responsibility for providing an impartial forum for deciding all cases, disputes and controversies arising under ORS 654.001 to 654.295, 654.412 to 654.423 and 654.750 to 654.780, all cases, disputes and controversies regarding matters concerning a claim under this chapter, and for conducting such other hearings and proceedings as may be prescribed by law. [1977 c.804 §25; 1979 c.839 §17; 1987 c.373 §39]

656.709 Ombudsman for injured workers; ombudsman for small business; duties. (1)(a) The Director of the Department of Consumer and Business Services, with the concurrence of the Governor, shall appoint an ombudsman for injured workers. The ombudsman is under the supervision and control of the director and, with the concurrence of the Governor, the director may terminate the ombudsman.

(b) The ombudsman for injured workers shall:

(A) Act as an advocate for injured workers by accepting, investigating and attempting to resolve complaints concerning matters related to workers' compensation;

(B) Provide information to injured workers to enable them to protect their rights in the workers' compensation system; and

(C) Report to the Governor in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and for protecting workers' rights in the workers' compensation system.

(2)(a) The Director of the Department of Consumer and Business Services, with the concurrence of the Governor, shall appoint an ombudsman for small business. The ombudsman is under the supervision and control of the director and, with the concurrence of the Governor, the director may terminate the ombudsman.

(b) The ombudsman for small business shall:

(A) Provide information and assistance to small businesses with regard to workers' compensation insurance and claims processing matters; and

(B) Report to the Governor in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman services and for providing information and assistance to small businesses with regard to workers' compensation insurance and claims processing matters. [1987 c.884 §60b; 1990 c.2 §38; 2003 c.591 §16]

656.710 [1977 c.699 §2; 1979 c.839 §18; repealed by 1981 c.535 §26]

656.712 Workers' Compensation Board; members; qualifications; chairperson; confirmation; term; vacancies. (1) The Workers' Compensation Board, composed of five members appointed by the Governor, is created within the Department of Consumer and Business Services. Not more than three members shall belong to one political party and inasmuch as the duties to be performed by the members vitally concern the employers, the employees, as well as the whole people, of the state, persons shall be appointed as members who fairly represent the interests of all concerned. All board members shall impartially apply the law in each case and shall not represent any special interest. However, at least two members shall be selected from among persons with background and understanding as to the concerns of employers and at least two members of the board shall be selected from among persons with background and understanding as to the concerns of employees. One member shall represent the interests of the public and shall serve as the board chairperson.

(2) A member of the board shall be appointed for a term of four years from the date of appointment and qualification. Each member shall hold office until a successor is appointed and qualified. However, all board members serve at the pleasure of the Governor and may be removed in accordance with the provisions of ORS 656.714.

(3) Any vacancy on the board shall be filled by appointment by the Governor.

(4) All appointments of members of the board by the Governor are subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. [Formerly 656.402; 1973 c.792 §28; 1977 c.109 §3; 1977 c.804 §26; 1981 c.535 §43; 1987 c.373 §40; 1993 c.462 §1; 1995 c.332 §64; 1999 c.876 §5]

656.714 Removal of board member. (1) The Governor may at any time remove any member of the Workers' Compensation Board for inefficiency, neglect of duty or malfea-

sance in office. Before such removal the Governor shall give the member a copy of the charges against the member and shall fix the time when the member can be heard in defense, which shall not be less than 10 days thereafter. Such hearing shall be open to the public.

(2) If the member is removed, the Governor shall file in the office of the Secretary of State a complete statement of all charges made against such member and the findings thereon, with a record of the proceedings.

(3) The power of removal is absolute and there is no right of review in any court whatsoever. [Formerly 656.406; 1989 c.1094 §3]

656.716 Board members not to engage in political or business activity that interferes with duties as board member; oath and bond required. (1) No member of the Workers' Compensation Board shall hold any other office or position of profit or pursue any other business or vocation or serve on or under any committee of any political party, but shall devote the entire time to the duties of the office of the member.

(2) Before entering on the duties of office, each member shall take and subscribe to an oath or affirmation:

(a) That the member will support the Constitutions of the United States and of this state and faithfully and honestly discharge the duties of the office.

(b) That the member does not hold any other office or position of profit that will interfere with the ability of the member to fully perform the duties of the member's position with the board.

(c) That the member is not pursuing and will not pursue, while a member, any other calling or vocation that will interfere with the ability of the member to fully perform the duties of the member's position with the board.

(d) That the member does not hold and while a member will not hold a position under any political party.

(3) The oath or affirmation shall be filed in the office of the Secretary of State.

(4) Each of the members of the board shall also, before entering upon the duties of office, execute a bond payable to the State of Oregon, in the penal sum of $10,000, with sureties to be approved by the Governor, conditioned for the faithful discharge of the duties of office. The bond, when so executed and approved, shall be filed in the office of the Secretary of State. [Formerly 656.408; 1977 c.804 §27; 1987 c.373 §41; 1999 c.1020 §4]

656.718 Chairperson; quorum; panels. (1) The board chairperson shall supervise and manage the Workers' Compensation Board and the Hearings Division. The chairperson serves at the pleasure of the Governor and may be removed in accordance with the provisions of ORS 656.714.

(2) A majority of the board's members shall constitute a quorum to transact the board's business. No vacancy shall impair the right of the remaining members to exercise all the powers of the board.

(3)(a) In exercise of authority to decide individual cases, members of the board may sit together or in panels.

(b) When sitting en banc, the concurrence of a majority of the members participating is necessary for a decision.

(c) A panel must consist of two members with different backgrounds and understanding. One of the members of a panel may be the board member that represents the interests of the public if either a member with background and understanding as to the concerns of employers or a member with background and understanding as to the concerns of employees is unavailable. If the members of a panel cannot agree on a decision in an individual case, the case shall be decided by a panel of three members, two of whom have different backgrounds and understanding and one who represents the interests of the public.

(d) A board member may not review any case in which the member acted as an Administrative Law Judge in the case. [Formerly 656.414; 1967 c.2 §4; 1993 c.462 §2; 1999 c.876 §6; 2003 c.365 §1]

656.720 Prosecution and defense of actions by Attorney General and district attorneys. Upon request of the Director of the Department of Consumer and Business Services the Attorney General or, under direction of the Attorney General, the district attorney of any county, shall institute or prosecute actions or proceedings for the enforcement of this chapter, when such actions or proceedings are within the county in which such district attorney was elected, and shall defend in like manner all suits, actions and proceedings brought against the Department of Consumer and Business Services or its employees in their official capacity. [Formerly 656.586; 1971 c.418 §18; 1977 c.804 §28]

656.722 Authority to employ subordinates. The Workers' Compensation Board chairperson may employ and terminate the employment of such assistants, experts, field personnel and clerks as may be required in the administration of ORS chapter 654 and this chapter and other duties assigned to the board or the board chairperson by statute.

[Formerly 656.416; 1977 c.804 §29; 1981 c.860 §§2,6; 1987 c.373 §42; 1999 c.876 §7]

656.724 Administrative Law Judges; appointment; qualifications; term; performance survey; removal procedure. (1) The Workers' Compensation Board chairperson, after consultation with the board, shall employ Administrative Law Judges to hold such hearings as may be prescribed by law. An Administrative Law Judge must be a member in good standing of the Oregon State Bar, or the bar of the highest court of record in any other state or currently admitted to practice before the federal courts in the District of Columbia. Administrative Law Judges shall qualify in the same manner as members of the board under ORS 656.716 (2). The board chairperson, after consultation with the board, may appoint Administrative Law Judges to serve for a probationary period of 18 months or less prior to regular employment.

(2) Administrative Law Judges are in the unclassified service under ORS chapter 240, and the board shall fix their salaries in accordance with ORS 240.245.

(3)(a) The board chairperson, after consultation with the board, shall establish criteria whereby each Administrative Law Judge shall receive an annual performance evaluation. Such criteria shall include, but not be limited to, work quality and productivity.

(b) The employment of each Administrative Law Judge shall be subject to formal review by the board chairperson every four years. Complaints and comments filed with the board chairperson regarding the official conduct, competence or fitness of an Administrative Law Judge, as well as the board's records, shall be reviewed by the board chairperson. Not less than 90 days prior to the expiration of the probationary period, or within 180 days but not less than 90 days prior to each four-year review, the board chairperson shall solicit comments from attorneys practicing in the field of workers' compensation. These comments and all complaints and other records filed with the board chairperson regarding the official conduct, competence or fitness of an Administrative Law Judge shall be reviewed by the board. The board chairperson shall conduct an annual survey of all attorneys regularly participating in workers' compensation cases, in such manner as to allow the attorneys to remain anonymous while rating the Administrative Law Judges as to knowledge of workers' compensation law, judicial temperament, capability to handle hearings, diligence, efficiency and other similar factors. The results of the survey shall be published by the board chairperson, listing each Administrative Law Judge by name.

(c) Notwithstanding ORS 240.240 and in accordance with ORS 240.555 and 240.560, an Administrative Law Judge may be removed at any time, for official misconduct, incompetence, inefficiency, indolence, malfeasance or other unfitness to render effective service.

(4) Administrative Law Judges have the same powers granted to board members or assistants under ORS 656.726 (2)(a), (b), (c) and (d).

(5) A presiding Administrative Law Judge shall be appointed by the board chairperson and shall serve as presiding Administrative Law Judge at the pleasure of the board chairperson. The presiding Administrative Law Judge shall perform such administrative duties as the board chairperson may delegate. The board chairperson may designate another Administrative Law Judge to serve as acting presiding Administrative Law Judge during any period when the presiding Administrative Law Judge is absent or disabled.

(6) Notwithstanding subsections (1) to (5) of this section, the board chairperson, after consultation with the board, may employ any member of the Oregon State Bar to serve as an Administrative Law Judge on a temporary basis, not to exceed one year, when the board chairperson determines that such employment is necessary in the conduct of the business of the Hearings Division. Criteria and procedures for selecting and employing such Administrative Law Judges shall be identical to those established for regularly employed Administrative Law Judges.

(7) It is the declared purpose of this section to foster and protect the Administrative Law Judges' ability to provide full, fair and speedy hearings and decisions. [1965 c.285 §53a; 1965 c.564 §6; 1967 c.180 §1; 1971 c.695 §9; 1973 c.774 §1; 1979 c.677 §1; 1979 c.839 §19; 1981 c.535 §44; 1985 c.212 §11; 1987 c.884 §13; 1989 c.1094 §4; 1990 c.2 §39; 1995 c.332 §51; 1999 c.876 §8]

656.725 Duties and status of Administrative Law Judges. (1) Individuals holding the position of Administrative Law Judge created by the amendments to ORS 656.724 by section 51, chapter 332, Oregon Laws 1995, have the authority to perform only those duties, functions and powers provided in ORS chapters 654, 655 and 656, and such other duties, functions and powers as may be prescribed by the Workers' Compensation Board pursuant to ORS 656.726.

(2) Administrative Law Judges are not judges for the purposes of any provision of the Oregon Constitution and are not judges for the purposes of judges' retirement under ORS chapters 238 and 238A. [1995 c.332 §53; 2003 c.733 §80]

656.726 Duties and powers to carry out workers' compensation and occupational safety laws; rules. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter and to require the electronic transmission and filing of proof of coverage required under ORS 656.419, 656.423 and 656.427. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS 656.704. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. Permanent impairment is expressed as a percentage of the whole person. The impairment value may not exceed 100 percent of the whole person.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment as modified by the factors of age, education and adaptability to perform a given job.

(D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall, in the order on reconsideration, determine the extent of permanent disability that addresses the worker's impairment.

(E) Notwithstanding any other provision of this section, only impairment benefits shall be awarded under ORS 656.214 if the worker has been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has returned to regular work at the job held at the time of injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.412 to 654.423, 654.750 to 654.780 and this chapter.

(5)(a) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(b) Notwithstanding any other provision of this chapter, the board may adopt rules to allow for the electronic transmission of filings, reports, notices and other documents required to be filed under the board's authority.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity. [Formerly 656.410; 1977 c.804 §30; 1979 c.677 §2; 1979 c.839 §20; 1981 c.535 §45; 1981 c.723 §5; 1981 c.854 §49a; 1981 c.876 §9; 1985 c.600 §16; 1985 c.706 §4; 1985 c.770 §4; 1987 c.884 §2; 1990 c.2 §40; 1995 c.332 §55; amendments by 1995 c.332 §55a repealed by 1999 c.6 §1; 1999 c.313 §10; 1999 c.876 §9; 2003 c.170 §7; 2003 c.171 §1; 2003 c.657 §§3,4; 2003 c.811 §§17,18; 2005 c.26 §§16,17; 2005 c.653 §§1,2a; 2007 c.241 §§4,5; 2007 c.270 §§7,8; 2007 c.274 §2; 2013 c.162 §1]

Note: See notes under 656.202.

656.727 Rules for administration of benefit offset. In carrying out the provisions of ORS 656.209, the Department of Consumer and Business Services shall promulgate rules that include, but are not limited to:

(1) Requiring injured workers to make application for federal Social Security disability benefits.

(2) Requiring injured workers to file with the appropriate agency that administers the federal Social Security program a release authorizing the federal agency to make disclosure to the department of such information regarding the injured worker as will enable the department to carry out the provisions of ORS 656.209.

(3) A procedure for ordering reduction of benefits or such other sanctions as the department considers appropriate to insure that injured workers comply with rules promulgated pursuant to this section. [1977 c.430 §7; 1979 c.117 §4]

656.728 [Subsection (1) formerly 344.820; subsection (2) formerly 344.830; 1973 c.634 §3; 1977 c.862 §2; 1981 c.854 §50; 1981 c.874 §6; 1981 c.535 §12; repealed by 1985 c.600 §2]

656.729 [1981 c.723 §2; repealed by 1985 c.770 §5]

656.730 Assigned risk plan. (1) The Director of the Department of Consumer and Business Services shall promulgate a plan for

the equitable apportionment among the State Accident Insurance Fund Corporation and all members of workers' compensation rating organizations in the state coverage required by ORS 656.017 for subject employers whose coverage the fund, or any members of such rating organizations, object to providing. The plan shall include provisions authorized pursuant to ORS 737.265 (2), except that:

(a) Regardless of the rating plans adopted by any rating organization, the plan shall provide a rating structure with differing rate tiers for insureds too small to qualify for experience rating and for insureds large enough to be experience rated; and

(b) The plan shall seek and be entitled to receive approval for all classification exceptions approved by the director for any insurer.

(2) If any insurer issuing workers' compensation insurance policies under this chapter refuses to accept its equitable apportionment under such plan, the director shall revoke the insurer's authority to issue workers' compensation insurance policies. [1965 c.285 §94a; 1979 c.673 §2; 1990 c.1 §2; 2007 c.241 §18]

656.732 Power to compel obedience to subpoenas and punish for misconduct. The circuit court for any county, or the judge of such court, on application of the Director of the Department of Consumer and Business Services, the Workers' Compensation Board, or any of the board members, their Administrative Law Judges or assistants, shall compel obedience to subpoenas issued and served pursuant to ORS 656.726 and shall punish disobedience of any such subpoena or any refusal to testify at any authorized session or hearing or to answer any lawful inquiry of the director or any of the board members, Administrative Law Judges or assistants, in the same manner as a refusal to testify in the circuit court or the disobedience of the requirements of a subpoena issued from the court is punished. [Formerly 656.412; 1979 c.839 §21]

656.734 [Formerly 656.424; repealed by 1973 c.833 §48]

656.735 Civil penalty for noncomplying employers; amount; liability of partners and of corporate and limited liability company officers; effect of final order; penalty as preferred claim; disposition of moneys collected. (1) The Director of the Department of Consumer and Business Services shall assess any person who violates ORS 656.052 (1) a civil penalty of not more than $1,000 or twice the premium that would have been due for the period of noncompliance, whichever is the greater.

(2) The director shall assess any person who continues to violate ORS 656.052 (1), after an order issued pursuant to ORS 656.052 (2) has become final, a civil penalty, in addition to any penalty assessed under subsection (1) of this section, of not more than $250 for each day such violation continues.

(3)(a) When a noncomplying employer is a corporation, such corporation and the officers and directors thereof shall be jointly and severally liable for any civil penalties assessed under this section and any claim costs incurred under ORS 656.054.

(b) When a noncomplying employer is a limited liability company, the company and its members and managers shall be jointly and severally liable for any civil penalties assessed by the director under this section and any claim costs incurred under ORS 656.054. As used in this paragraph, "limited liability company," "manager" and "member" have the meanings for those terms provided in ORS 63.001.

(c) When a noncomplying employer is a limited liability partnership or foreign limited liability partnership, the partnership and its limited liability partners shall be jointly and severally liable for any civil penalties assessed by the director under this section and any claim costs incurred under ORS 656.054. As used in this paragraph, "limited liability partnership" and "foreign limited liability partnership" have the meanings for those terms provided in ORS 67.005.

(d) When a noncomplying employer is a partnership, the partnership and its partners shall be jointly and severally liable for any civil penalties assessed by the director under this section and any claim costs incurred under ORS 656.054. As used in this paragraph, "partnership" has the meaning for that term provided in ORS 67.005.

(4) When an order assessing a civil penalty becomes final by operation of law or on appeal, unless the amount of penalty is paid within 10 days after the order becomes final, it constitutes a judgment and may be recorded with the county clerk in any county of this state. The clerk shall thereupon record the name of the person incurring the penalty and the amount of the penalty in the County Clerk Lien Record. The penalty provided in the order so recorded shall become a lien upon the title to any interest in property owned by the person against whom the order is entered, and execution may be issued upon the order in the same manner as execution upon a judgment of a court of record.

(5) Civil penalties, and judgments entered thereon, due to the director under this section from any person shall be deemed preferred to all general claims in all bankruptcy proceedings, trustee proceedings, and proceedings for the administration of estates

and receiverships involving the person liable therefor or the property of such person.

(6) All moneys collected under this section shall be paid into the Workers' Benefit Fund. [1973 c.447 §4; 1977 c.73 §1; 1983 c.696 §23; 1995 c.332 §65; 1995 c.641 §12; 1995 c.689 §37; 1997 c.775 §91; 2003 c.170 §8]

656.740 Review of proposed order declaring noncomplying employer or nonsubjectivity determination; review of proposed assessment or civil penalty; insurer as party; hearing. (1) A person may contest a proposed order of the Director of the Department of Consumer and Business Services declaring that person to be a noncomplying employer, or a proposed assessment of civil penalty, by filing with the Department of Consumer and Business Services, within 60 days after the mailing of the order, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment. An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect.

(2) A person may contest a nonsubjectivity determination of the director by filing a written request for hearing with the department within 60 days after the mailing of the determination.

(3) When any insurance carrier, including the State Accident Insurance Fund Corporation, is alleged by an employer to have contracted to provide the employer with workers' compensation coverage for the period in question, the Workers' Compensation Board shall join such insurance carrier as a necessary party to any hearing relating to such employer's alleged noncompliance or to any hearing relating to a nonsubjectivity determination and shall serve the carrier, at least 30 days prior to such hearing, with notice thereof.

(4) A hearing relating to a nonsubjectivity determination, to a proposed order declaring a person to be a noncomplying employer, or to a proposed assessment of civil penalty under ORS 656.735, shall be held by an Administrative Law Judge of the board's Hearings Division. However, a hearing shall not be granted unless a request for hearing is filed within the period specified in subsection (1) or (2) of this section, and if a request for hearing is not so filed, the nonsubjectivity determination, order or penalty, as proposed, shall be a final order of the department and shall not be subject to review by any agency or court.

(5) Notwithstanding ORS 183.315 (1), the issuance of nonsubjectivity determinations, orders declaring a person to be a noncomplying employer or the assessment of civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS chapter 183, except that:

(a) The order of an Administrative Law Judge in a contested case shall be deemed to be a final order of the director.

(b) The director shall have the same right to judicial review of the order of an Administrative Law Judge as any person who is adversely affected or aggrieved by such final order.

(c) When a nonsubjectivity determination or an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim.

(6)(a) If a person against whom an order is issued pursuant to this section prevails at hearing or on appeal, the person is entitled to reasonable attorney fees to be paid by the director from the Workers' Benefit Fund.

(b) If a person against whom an order is issued is found to be a noncomplying employer by the director, but the person proves coverage pursuant to subsection (3) of this section and the insurer failed to file timely proof of coverage as required by ORS 656.419 or improperly canceled the person's coverage, the employer is entitled to reasonable attorney fees paid by the insurer.

(c) If a worker prevails at hearing or on appeal from a nonsubjectivity determination, the worker is entitled to reasonable attorney fees to be paid by the director from the Workers' Benefit Fund and reimbursed by the employer. [1973 c.447 §5; 1975 c.341 §1; 1975 c.759 §19; 1977 c.804 §31; 1979 c.839 §22; 1983 c.816 §14; 1987 c.234 §3; 1995 c.332 §65a; 1995 c.641 §13; 1999 c.246 §1; 1999 c.1020 §2; 2003 c.170 §9; 2007 c.241 §19]

656.745 Civil penalty for inducing failure to report claims; failure to pay assessments; failure to comply with statutes, rules or orders; amount; procedure. (1) The Director of the Department of Consumer and Business Services shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due.

(2) The director may assess a civil penalty against an employer, insurer, managed care organization or service company that:

(a) Fails to pay assessments or other payments due to the director under this chapter and is in default; or

(b) Fails to comply with statutes, rules or orders of the director regarding reports or other requirements necessary to carry out the purposes of this chapter.

(3) Except as specified in ORS 656.780, the director may assess a penalty against a service company only for claims processing performance deficiencies revealed in annual audits associated with claims processing performance. The director may assess only one penalty for each separate violation by an employer, insurer or service company for deficiencies revealed in annual audits associated with claims processing performance.

(4) A civil penalty shall be not more than $2,000 for each violation or $10,000 in the aggregate for all violations within any three-month period. Each violation, or each day a violation continues, shall be considered a separate violation.

(5) ORS 656.735 (4) to (6) and 656.740 also apply to orders and penalties assessed under this section. [1975 c.556 §38; 1979 c.839 §31; 1987 c.233 §2; 1987 c.884 §46; 2003 c.170 §13; 2005 c.221 §3; 2007 c.270 §9; 2015 c.194 §1]

656.750 Civil penalty for failure to maintain records of compensation claims; amount; disposition of funds. (1) The Director of the Department of Consumer and Business Services shall assess against a self-insured employer who fails to comply with ORS 656.455, a civil penalty of $250 a day for each day such failure continues.

(2) ORS 656.735 (4) to (6) and 656.740 also apply to orders and penalties assessed under this section. [1975 c.585 §9; 1983 c.696 §24; 1987 c.233 §3; 1987 c.884 §60; 1991 c.640 §3; 2003 c.170 §14]

(State Accident Insurance Fund Corporation)

656.751 State Accident Insurance Fund Corporation created; board; members' qualifications; terms; compensation; expenses; function; report. (1) The State Accident Insurance Fund Corporation is created as an independent public corporation. The corporation shall be governed by a board of five directors appointed by the Governor. Two members shall be chosen to represent the public. Of the remaining three members, a board member must be insured by the State Accident Insurance Fund Corporation at the time of appointment and for one year prior to appointment, or an employee of such an employer. Members of the board are subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution.

(2) No member of the board of directors shall have any pecuniary interest, other than an incidental interest which is disclosed and made a matter of public record at the time of appointment to the board, in any corporation or other business entity doing business in the workers' compensation insurance industry.

(3) The term of office of a member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the board of directors is entitled to compensation and expenses as provided in ORS 292.495.

(5) The board of directors shall select one of its members as chairperson and another as vice chairperson, for such terms and with such duties and powers as the board of directors considers necessary for performance of the functions of those offices. A majority of the members of the board of directors constitutes a quorum for the transaction of business.

(6) The board of directors shall meet at least once every three months at a time and place determined by the board of directors. The board of directors shall meet at such other times and places specified by the call of the chairperson or of a majority of the members of the board of directors.

(7) It is the function of the board of directors to establish the policies for the operation of the State Accident Insurance Fund Corporation, consistent with all applicable provisions of law.

(8) The board shall file with the Legislative Assembly and the Governor, not later than April 15 of each year, a report covering the activities and operations of the State Accident Insurance Fund Corporation for the preceding year. [1979 c.829 §2; 1981 c.854 §51]

656.752 State Accident Insurance Fund Corporation; purpose and functions. (1) The State Accident Insurance Fund Corporation is created for the purpose of transacting workers' compensation insurance and reinsurance business. The State Accident Insurance Fund Corporation also may insure an Oregon employer against any liability such employer may have on account of bodily injury to a worker of the employer arising out of and in the course of employment as fully as any private insurance carrier.

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

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

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

(c) To receive and handle and process the claims of workers and beneficiaries of workers injured in the employ of insured employers insured with the State Accident Insurance Fund Corporation; and

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

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

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

(5) The State Accident Insurance Fund Corporation in its own name, may acquire, lease, rent, own and manage real property. It may construct, equip and furnish buildings or other structures as are necessary to accommodate its needs. It may purchase, rent, lease or otherwise acquire for its use all supplies, materials, equipment and services necessary to carry out its functions. It may sell or otherwise dispose of any property acquired under this subsection.

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

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

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

(9) The State Accident Insurance Fund Corporation may contract with the Oregon Department of Administrative Services to provide claim management services for claims filed under ORS 655.505 to 655.555 by inmates of institutions of the Department of Corrections. [1965 c.285 §55; 1965 c.564 §7; 1967 c.253 §1; 1969 c.247 §2; 1971 c.262 §1; 1977 c.659 §3; 1979 c.815 §10; 1979 c.829 §5a; 1981 c.854 §52; 1981 c.876 §7; 1990 c.1 §3; 2007 c.326 §1]

656.753 State Accident Insurance Fund Corporation exempt from certain financial administration laws; contracts with state agencies for services. (1) Except as otherwise provided by law, the provisions of ORS 279.835 to 279.855 and 283.085 to 283.092 and ORS chapters 240, 276, 279A, 279B, 279C, 282, 283, 291, 292 and 293 do not apply to the State Accident Insurance Fund Corporation.

(2) In carrying out the duties, functions and powers imposed by law upon the State Accident Insurance Fund Corporation, the board of directors or the manager of the State Accident Insurance Fund Corporation may contract with any state agency for the performance of such duties, functions and powers as the corporation considers appropriate.

(3) Notwithstanding subsection (1) or (2) of this section, ORS 293.240 except for appeals pursuant to ORS 737.318, ORS 293.260, 293.262 and 293.505 (2) shall apply to the directors, manager, assistants and accounts of the State Accident Insurance Fund Corporation and any subsidiary corporation formed or acquired by the State Accident Insurance Fund Corporation.

(4) Notwithstanding subsection (1) or (2) of this section, ORS 243.305, 279A.100 and 659A.012 apply to the directors, manager and employees of the State Accident Insurance Fund Corporation. [1979 c.829 §4; 1981 c.876 §8; subsection (3) enacted as 1983 c.412 §2; subsection (4) enacted as 1983 c.808 §4; 1987 c.884 §5; 2003 c.794 §310; 2012 c.107 §67]

656.754 Manager; appointment; functions. (1) The State Accident Insurance Fund Corporation is under the direct supervision of a manager appointed by the board of directors of the State Accident Insurance Fund Corporation. The manager serves at the pleasure of the board of directors. The manager shall qualify in the manner provided for board members in ORS 656.716 except that no bond shall be required.

(2) The manager has such powers as are necessary to carry out the functions of the State Accident Insurance Fund Corporation, subject to policy direction by the board of directors.

(3) The manager may employ, terminate and supervise the employment of such assistants, experts, field personnel and clerks as

may be required in the administration of the State Accident Insurance Fund Corporation. [1965 c.285 §56; 1973 c.792 §29; 1979 c.829 §6]

656.756 [1965 c.285 §56a; repealed by 1967 c.7 §40]

656.758 Inspection of books, records and payrolls; statement of employment data; civil penalty for misrepresentation; failure to submit books for inspection and refusal to keep correct payroll. (1) The books, records and payrolls of any employer pertinent to the administration of this chapter shall always be open to inspection by the State Accident Insurance Fund Corporation or its agent for the purpose of ascertaining the correctness of the payroll, the persons employed, and such other information as may be necessary in the administration of said statutes.

(2) Every employer subject to this chapter shall keep a true and accurate record of the number of workers and the wages paid by the employer, the occupations at which and the number of days or parts of days any of the workers are employed, and shall furnish to the State Accident Insurance Fund Corporation, upon request, a sworn statement of the same.

(3) Any employer who willfully misrepresents to the State Accident Insurance Fund Corporation the amount of the payroll upon which the amount of premium is based shall be liable to the State Accident Insurance Fund Corporation in a sum equal to 10 times the amount of the difference between the amount of such premium computed according to the representation thereof by such employer and the amount for which the employer is liable under this chapter according to a correct computation of the payroll. Such liability shall be enforced in a civil action in the name of the State Accident Insurance Fund Corporation and any amount so collected shall become a part of the Industrial Accident Fund.

(4) Failure on the part of the employer to submit such books, records and payrolls for inspection to any member of the State Accident Insurance Fund Corporation or any of its representatives presenting written authority from the State Accident Insurance Fund Corporation, or a refusal on the part of an employer to keep a payroll in accordance with this section, when demanded by the State Accident Insurance Fund Corporation, subjects the offending employer to a penalty of $100 for each offense, to be collected by a civil action in the name of the State Accident Insurance Fund Corporation and paid into the Industrial Accident Fund. [Amended by 1981 c.854 §53]

656.760 [1983 c.412 §3; renumbered 656.776 in 2001]

656.772 Annual audit of State Accident Insurance Fund Corporation by Secretary of State; scope of review; report of audit. (1)(a) The Secretary of State shall conduct an annual audit of the State Accident Insurance Fund Corporation and the Industrial Accident Fund pursuant to ORS 297.210. As part of this audit, the Secretary of State shall contract with a firm qualified to perform an independent actuarial review.

(b) The firm conducting the review required by paragraph (a) of this subsection shall be familiar with the accounting standards applicable to the reserves under review, shall meet all appropriate standards of practice established by the Casualty Actuarial Society, shall employ a staff that includes no fewer than three people who have attained fellowship in the Casualty Actuarial Society and shall maintain limits of errors and omission insurance as prescribed by the Secretary of State.

(c) The Secretary of State shall determine the scope of the review required by paragraph (a) of this subsection, which shall include, but is not limited to:

(A) A review of the sources and uses of the moneys in the Industrial Accident Fund;

(B) A reconciliation of changes in actuarial assumptions and reserve values from the prior year;

(C) An examination of the development of claim reserve inadequacies or redundancies over time;

(D) An assessment of the future financial viability of the Industrial Accident Fund; and

(E) An evaluation of losses and loss adjustment expense reserves discounted by a rate determined by the Director of the Department of Consumer and Business Services that is consistent with discount rates generally applied by insurers authorized to underwrite workers' compensation insurance in Oregon.

(d) The State Accident Insurance Fund Corporation shall cooperate with the actuarial firm in all respects and shall permit the firm full access to all information the firm deems necessary for a true and complete review. Information provided to the actuarial firm conducting the annual review is subject to the same limitations on public inspections as required for the records of the State Accident Insurance Fund Corporation.

(e) The audit required by paragraph (a) of this subsection shall be conducted using both generally accepted accounting princi-

ples and the statutory accounting principles published by the National Association of Insurance Commissioners.

(f) The cost of the audit required by paragraph (a) of this subsection shall be paid by the State Accident Insurance Fund Corporation.

(2) The Secretary of State shall issue an annual report to the Governor, the President of the Senate and the Speaker of the House of Representatives on the results of the audit and review. The audit and the report of the review performed by the independent actuarial firm shall be available for public inspection, in accordance with the Secretary of State's established rules and procedures governing public disclosure of audit documents. [2001 c.724 §1]

Note: 656.772 and 656.774 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 656 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

656.774 Annual report by State Accident Insurance Fund Corporation to Secretary of State; contents. The board of directors of the State Accident Insurance Fund Corporation shall report to the Secretary of State by March 15 of each year:

(1) The total amount of assets in the Industrial Accident Fund as of December 31 of the prior year;

(2) The reserves and surplus that are actuarially necessary according to recognized insurance principles as described in ORS 656.634 (2) and statutory accounting principles published by the National Association of Insurance Commissioners, excluding any allowance for undeclared dividends;

(3) Any funds in addition to those described in subsection (2) of this section; and

(4) The total amount of investment gain generated by the Industrial Accident Fund during the prior year ending on December 31. [2001 c.724 §2]

Note: See note under 656.772.

656.776 Notice to Secretary of State regarding action on audit report. Not later than the 90th day after the Secretary of State completes and delivers to the appropriate authority an audit under ORS 297.210, the State Accident Insurance Fund Corporation or any subsidiary corporation formed or acquired by the State Accident Insurance Fund Corporation shall notify the Secretary of State in writing of the measures taken and proposed to be taken, if any, to respond to the recommendations of the audit report. The Secretary of State may extend the 90-day period for good cause. [Formerly 656.760]

(Claims Examiner Certification)

656.780 Certification and training of claims examiners; records of certification and training of examiners; department inspection of records; penalties; rules. (1) The Director of the Department of Consumer and Business Services shall:

(a) Adopt by rule standards for certification of workers' compensation claims examiners that shall be administered by workers' compensation insurers, self-insured employers and service companies; and

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

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

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

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

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

(3) Insurers, self-insured employers and service companies may employ only certified workers' compensation claims examiners to process workers' compensation claims. The director may impose a civil penalty against any insurer, self-insured employer or service company that violates this subsection. [1990 c.2 §52; 1999 c.418 §1; 2005 c.675 §3; 2015 c.194 §2]

Note: See notes under 656.202.

Note: Section 14 (1), chapter 781, Oregon Laws 2003, provides:

Sec. 14. Funds for repayment of certain reinsurance claims. (1) The State Accident Insurance Fund Corporation shall continue paying reinsurance claims incurred or made prior to January 1, 2012, from the Rural Medical Liability Reinsurance Fund until the State Accident Insurance Fund Corporation has extinguished its liabilities for reinsurance issued under section 1, chapter 781, Oregon Laws 2003, by payment of

claims or by purchase of reinsurance. Purchase of reinsurance under this subsection shall be subject to approval by the Director of the Department of Consumer and Business Services. [2003 c.781 §14(1); 2007 c.574 §4(1)]

(Advisory Committees)

656.790 Workers' Compensation Management-Labor Advisory Committee; membership; duties; expenses. (1) The Governor shall appoint a Workers' Compensation Management-Labor Advisory Committee composed of 10 appointed members. Five members from organized labor shall represent subject workers and five members shall represent subject employers. In addition to the appointed members, the Director of the Department of Consumer and Business Services shall serve ex officio as a member of the committee. The appointment of members of the committee is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(2) The director may recommend areas of the law which the director desires to have studied or the committee may study such aspects of the law as the committee shall determine require their consideration. The committee shall biennially review the standards for evaluation of permanent disability adopted under ORS 656.726 and shall recommend to the director factors to be included or such other modification of application of the standards as the committee considers appropriate. The committee shall biennially review and make recommendations about permanent partial disability benefits. The committee shall advise the director regarding any proposed changes in the operation of programs funded by the Workers' Benefit Fund. The committee shall report its findings to the director for such action as the director deems appropriate.

(3) The committee shall report to the Legislative Assembly such findings and recommendations as the committee considers appropriate, including a report on the following matters:

(a) Decisions of the Supreme Court and Court of Appeals that have significant impact on the workers' compensation system.

(b) Adequacy of workers' compensation benefits.

(c) Medical and legal system costs.

(d) Adequacy of assessments for reserve programs and administrative costs.

(e) The operation of programs funded by the Workers' Benefit Fund.

(4) The members of the committee shall be appointed for a term of two years and shall serve without compensation, but shall be entitled to travel expenses. The committee may hire, subject to approval of the director, such experts as it may require to discharge its duties. All expenses of the committee shall be paid out of the Consumer and Business Services Fund. [1969 c.448 §2; 1975 c.556 §49; 1977 c.804 §32; 1990 c.2 §41; 1995 c.332 §55b; 1995 c.641 §25; 2007 c.274 §7]

Note: See notes under 656.202.

656.792 [1965 c.285 §29; 1969 c.314 §69; repealed by 1969 c.448 §3]

656.794 Advisory committee on medical care; rules. There shall be created an advisory committee on medical care. This committee shall consist of members appointed by and serving at the pleasure of the Director of the Department of Consumer and Business Services to advise the director on matters relating to the provision of medical care to workers. The director by rule shall determine the composition of the committee. Membership of the committee shall include representatives of the types of health care providers that are most representative of health care providers providing medical care services to injured workers. The committee shall also include one representative of insurers, one representative of employers, one representative of workers, one representative of managed care organizations and other persons as the director may determine are necessary to carry out the purpose of the committee. Members of the committee shall be paid travel and other necessary expenses for service as a member. Such payments shall be made from the Consumer and Business Services Fund. [1965 c.285 §27; 1981 c.535 §46; 1981 c.854 §54; 1987 c.884 §26; 1999 c.879 §1]

INFORMATIONAL MATERIALS ABOUT WORKERS' COMPENSATION SYSTEM

656.795 Informational materials for nurse practitioners. The Director of the Department of Consumer and Business Services shall develop and make available to nurse practitioners informational materials about the workers' compensation system, including, but not limited to, the management of indemnity claims, standards for authorization of temporary disability benefits, return to work responsibilities and programs, and general workers' compensation rules and procedures for medical service providers. [2003 c.811 §29]

Note: 656.795 to 656.798 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 656 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

656.796 [1981 c.535 §50; repealed by 1997 c.82 §11]

656.797 Certification by nurse practitioner of review of required materials. On or after October 1, 2004, a nurse practitioner licensed under ORS 678.375 to 678.390, prior to providing compensable medical services or authorizing temporary disability benefits un-

der ORS 656.245, must certify in a form acceptable to the Director of the Department of Consumer and Business Services that the nurse practitioner has reviewed the materials developed under ORS 656.795. [2003 c.811 §30]

Note: See note under 656.795.

656.798 Duty of insurer, self-insured employer and self-insured employer group to provide information to director. Every workers' compensation insurer, self-insured employer and self-insured employer group shall provide to the Director of the Department of Consumer and Business Services all information requested by the director for the purpose of assessing the impact of ORS 656.795 and 656.797 and the amendments to ORS 656.005, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340, 656.726, 657.170, 659A.043, 659A.046, 659A.049 and 659A.063 by sections 1, 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, 25 and 27, chapter 811, Oregon Laws 2003. [2003 c.811 §31]

Note: See note under 656.795.

656.799 Informational materials for other health care professionals; certification of review of materials. (1) The Director of the Department of Consumer and Business Services shall develop and make available to medical service providers informational materials about the workers' compensation system including, but not limited to, the management of indemnity claims, standards for the authorization of temporary disability benefits, return to work responsibilities and programs, and workers' compensation rules and procedures for medical service providers.

(2) Prior to providing compensable medical services or authorizing temporary disability benefits under ORS 656.245, a medical service provider must certify, in a form acceptable to the director, that the medical service provider has reviewed the materials developed under this section.

(3) As used in this section, "medical service provider" means a:

(a) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;

(b) Physician assistant licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory or possession of the United States; or

(c) Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States. [2007 c.252 §7; 2009 c.43 §8; 2011 c.117 §2]

OCCUPATIONAL DISEASE LAW

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

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

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

(C) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death.

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

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

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

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

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

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

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

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

(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every

working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Notwithstanding ORS 656.027 (6), any city providing a disability and retirement system by ordinance or charter for firefighters and police officers not subject to this chapter shall apply the presumptions established under subsection (5) of this section when processing claims for firefighters covered by the system. [Amended by 1959 c.351 §1; 1961 c.583 §1; 1973 c.543 §1; 1977 c.734 §1; 1983 c.236 §1; 1987 c.713 §4; 1990 c.2 §43; 1995 c.332 §56; 2009 c.24 §1]

656.804 Occupational disease as an injury under Workers' Compensation Law. Subject to ORS 656.005 (24) and 656.266 (2), an occupational disease, as defined in ORS 656.802, is considered an injury for employees of employers who have come under this chapter, except as otherwise provided in ORS

656.802 to 656.807. [Amended by 1965 c.285 §87; 1973 c.543 §2; 2001 c.865 §4]

Note: See notes under 656.202.

656.806 [Repealed by 2005 c.221 §4]

656.807 Time for filing of claims for occupational disease; procedure. (1) All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease.

(2) If the occupational disease results in death, a claim may be filed within one year from the date that the worker's beneficiary first discovered, or in the exercise of reasonable care should have discovered, that the cause of the worker's death was due to an occupational disease.

(3) The procedure for processing occupational disease claims shall be the same as provided for accidental injuries under this chapter. [Amended by 1953 c.440 §2; 1959 c.351 §2; 1965 c.285 §87a; 1973 c.543 §3; 1981 c.535 §47; 1981 c.854 §55; 1985 c.212 §10; 1987 c.713 §6]

656.808 [Amended by 1957 c.559 §2; 1965 c.285 §88; repealed by 1973 c.543 §4]

656.810 [Amended by 1959 c.351 §3; 1965 c.285 §89; repealed by 1973 c.543 §4]

656.812 [Amended by 1959 c.351 §4; repealed by 1973 c.543 §4]

656.814 [Amended by 1965 c.285 §90; repealed by 1973 c.543 §4]

656.816 [Amended by 1959 c.351 §5; 1965 c.285 §91; repealed by 1973 c.543 §4]

656.818 [Amended by 1959 c.351 §6; 1965 c.285 §92; repealed by 1973 c.543 §4]

656.820 [Repealed by 1973 c.543 §4]

656.822 [Amended by 1965 c.285 §92a; repealed by 1973 c.543 §4]

656.824 [Repealed by 1981 c.854 §1]

WORKER LEASING COMPANIES

656.850 License; compliance with workers' compensation and safety laws. (1) As used in this section and ORS 656.018, 656.403, 656.855 and 737.270:

(a) "Worker leasing company" means a person who provides workers, by contract and for a fee, to work for a client but does not include a person who provides workers to a client on a temporary basis.

(b) "Temporary basis" means providing workers to a client for special situations such as to cover employee absences, employee leaves, professional skill shortages, seasonal workloads and special assignments and projects with the expectation that the position or positions will be terminated upon completion of the special situation. Workers also are provided on a temporary basis if they are provided as probationary new hires with a reasonable expectation of transitioning to permanent employment with the client and the client uses a preestablished probationary period in its overall employment selection program.

(c) "Temporary service provider" means a person who provides workers, by contract and for a fee, to a client on a temporary basis.

(2) No person shall perform services as a worker leasing company in this state without first having obtained a license therefor from the Director of the Department of Consumer and Business Services. No person required by this section to obtain a license shall fail to comply with this section or ORS 656.855, or any rule adopted pursuant thereto.

(3) When a worker leasing company provides workers to a client, the worker leasing company shall satisfy the requirements of ORS 656.017 and 656.407 and provide workers' compensation coverage for those workers and any subject workers employed by the client unless during the term of the lease arrangement the client has proof of coverage on file with the director that extends coverage to subject workers employed by the client and any workers leased by the client. If the client allows the coverage to expire and continues to employ subject workers or has leased workers, the client shall be considered a noncomplying employer unless the worker leasing company has complied with subsection (5) of this section.

(4) When a worker leasing company provides workers for a client, the worker leasing company shall assure that the client provides adequate training, supervision and instruction for those workers to meet the requirements of ORS chapter 654.

(5) When a worker leasing company provides subject workers to work for a client and also provides workers' compensation coverage for those workers, the worker leasing company shall notify the director in writing. The notification shall be given in such manner as the director may prescribe. A worker leasing company may terminate its obligation to provide workers' compensation coverage for workers provided to a client by giving to the client and the director written notice of the termination. A notice of termination shall state the effective date and hour of the termination, but the termination shall be effective not less than 30 days after the notice is received by the director. Notice to the client under this section shall be given

by mail, addressed to the client at the client's last-known address. If the client is a partnership, notice may be given to any of the partners. If the client is a corporation, notice may be given to any agent or officer of the corporation upon whom legal process may be served. [1993 c.628 §2; 1997 c.491 §4; 2007 c.241 §20]

656.855 Licensing system for worker leasing companies; rules; fees; dedication of moneys received. (1) In accordance with any applicable provision of ORS chapter 183, the Director of the Department of Consumer and Business Services, by rule, shall establish a licensing system for worker leasing companies. Such system shall include, but not be limited to:

(a) Prescribing the form and content of and the times and procedures for submitting applications for license issuance or renewal.

(b) Prescribing the term of the license and the fee for original issuance and renewal of the license. The fees shall be set in an amount necessary to support the administration of this section and ORS 656.850.

(c) Prescribing those violations of this section or of ORS 656.850 for which the director may refuse to issue or renew or may suspend or revoke a license.

(d) Prescribing the form and contents of records a licensee is required to maintain and specifying the times, places and manner of audit by the director of those records.

(2) All moneys received by the director pursuant to this section shall be credited to the Consumer and Business Services Fund and are appropriated continuously to the director to carry out the provisions of this section and ORS 656.850. [1993 c.628 §3]

PENALTIES

656.990 Penalties. (1) Any person who knowingly makes any false statement or representation to the Workers' Compensation Board or its employees, the Workers' Compensation Board chairperson, the Director of the Department of Consumer and Business Services or employees of the director, the insurer or self-insured employer for the purpose of obtaining any benefit or payment under this chapter, either for self or any other person, or who knowingly misrepresents to the board, the board chairperson, the director or the corporation or any of their representatives the amount of a payroll, or who knowingly submits a false payroll report to the board, the board chairperson, the director or the corporation, commits a Class A misdemeanor.

(2) Violation of ORS 656.052 is a Class D violation. Each day during which an employer engages in any subject occupation in violation of ORS 656.052 constitutes a separate offense.

(3) Violation of ORS 656.056 is a Class D violation.

(4) The individual refusing to keep the payroll in accordance with ORS 656.726 or 656.758 when demanded by the director or corporation commits a Class C misdemeanor.

(5) Failure on the part of an employer to send the signed payroll statement required by ORS 656.504 within 30 days after receipt of notice by the director or corporation is a Class A misdemeanor.

(6) Violation of ORS 656.560 (4) is a Class D violation. [Amended by 1959 c.450 §9; 1965 c.285 §93; 1977 c.804 §33; 1981 c.535 §48; 1981 c.854 §56; 1985 c.770 §9; 1990 c.2 §44; 1999 c.876 §10; 1999 c.1051 §216; 2011 c.597 §268]