Enrolled
Senate Bill 485

Sponsored by COMMITTEE ON BUSINESS, LABOR, AND ECONOMIC DEVELOPMENT (at the request of Senator Gene Derfler and Governor John A. Kitzhaber, M.D., for Associated Oregon Industries and Oregon AFL-CIO)

CHAPTER .....

AN ACT

Relating to employment; creating new provisions; amending ORS 656.005, 656.210, 656.214, 656.252, 656.262, 656.266, 656.268, 656.278, 656.308, 656.313, 656.325, 656.386, 656.605, 656.625 and 656.804; repealing ORS 654.335 and sections 3, 4 and 5, chapter 6, Oregon Laws 1999; and declaring an emergency.

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

SECTION 1. ORS 656.005 is amended to read:

656.005. (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 husband, wife, 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 a guaranty contract insurer.

(5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, an illegitimate child 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. An invalid dependent child 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, an invalid dependent child 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 acci-

dental 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: Father, mother, grandfather, grandmother, stepfather, stepmother, 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 father, mother, husband, wife 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 or physician 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 Board of Medical Examiners for the State of Oregon or 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 period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

(c) "Consulting physician" means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician 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) “Guaranty contract insurer” and “insurer” mean 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 [*or predisposes a worker*] to disability or need for treatment [*and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273.*]**, 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 assistance 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.

SECTION 2. ORS 656.266 is amended to read:

656.266. **(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.

SECTION 3. ORS 656.210 is amended to read:

656.210. (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

[*100*] **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 [*lesser*] **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, within 30 days of receipt of the initial claim, the insurer, self-insured employer or assigned claims agent for a noncomplying employer receives notice that the worker was employed in more than one job with a subject employer at the time of injury and receives 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 a guaranty contract 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.

[*(b)*] **(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.

[*(c)*] **(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 job at the time of injury, the director shall either pay the supplemental benefits directly or shall assign responsibility to process the payment to a paying agent selected by the director.

SECTION 4. ORS 656.804 is amended to read:

656.804. **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.

SECTION 5. ORS 656.605 is amended to read:

656.605. (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) Fines and 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 656.506, 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 of this 2001 Act.

(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.

SECTION 6. ORS 656.214 is amended to read:

656.214. (1) As used in this section:

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

(b) "Permanent partial disability" means the loss of either one arm, one hand, one leg, one foot, loss of hearing in one or both ears, loss of one eye, one or more fingers, or any other injury known in surgery to be permanent partial disability.

(2) When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. The worker shall receive [*$454*] **$511.29** for each degree stated against such disability in subsections (2) to (4) of this section as follows:

(a) For the loss of one arm at or above the elbow joint, 192 degrees, or a proportion thereof for losses less than a complete loss.

(b) For the loss of one forearm at or above the wrist joint, or the loss of one hand, 150 degrees, or a proportion thereof for losses less than a complete loss.

(c) For the loss of one leg, at or above the knee joint, 150 degrees, or a proportion thereof for losses less than a complete loss.

(d) For the loss of one foot, 135 degrees, or a proportion thereof for losses less than a complete loss.

(e) For the loss of a great toe, 18 degrees, or a proportion thereof for losses less than a complete loss; of any other toe, four degrees, or a proportion thereof for losses less than a complete loss.

(f) For partial or complete loss of hearing in one ear, that percentage of 60 degrees which the loss bears to normal monaural hearing.

(g) For partial or complete loss of hearing in both ears, that proportion of 192 degrees 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 disability.

(h) For partial or complete loss of vision of one eye, that proportion of 100 degrees 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 300 degrees 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 disability.

(j) For the loss of a thumb, 48 degrees, or a proportion thereof for losses less than a complete loss.

(k) For the loss of a first finger, 24 degrees, or a proportion thereof for losses less than a complete loss; of a second finger, 22 degrees, or a proportion thereof for losses less than a complete loss; of a third finger, 10 degrees, or a proportion thereof for losses less than a complete loss; of a fourth finger, 6 degrees, or a proportion thereof for losses less than a complete loss.

(3) 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.

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

(5) In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726 (4)(f). The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability.

(6) For injuries for which the disability is determined pursuant to subsection (5) of this section, the worker shall receive an amount equal to:

(a) When the number of degrees stated against the disability is equal to or less than 64, [*$137.80*] **$153.00** times the number of degrees.

(b) When the number of degrees stated against the disability is more than 64 but equal to or less than 160, [*$137.80*] **$153.00** times 64 plus [*$243.80*] **$267.44** times the number of degrees in excess of 64.

(c) When the number of degrees stated against the disability is more than 160, [*$137.80*] **$153.00** times 64 plus [*$243.80*] **$267.44** times 96 plus [*$662.50*] **$709.79** times the number of degrees in excess of 160.

(7) 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.

SECTION 6a. (1) Workers injured between January 1, 2000, and the effective date of this 2001 Act 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.

SECTION 6b. (1) 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 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.

SECTION 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.

SECTION 7. ORS 656.262 is amended to read:

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

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

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

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

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

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

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

(E) Any other details the insurer may require.

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

(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, if the attending physician 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 verification of the worker's inability to work resulting from the claimed injury or disease and the physician 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, 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 verification of the worker's inability to work resulting from the claimed injury or disease, medical services provided by the attending physician are not compensable until the attending physician submits such verification.

(g) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician 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 (5) 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.

(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 not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

(5) Payment of compensation under subsection (4) of this section or payment, in amounts not to exceed $500 per claim, 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.

(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 [*90*] **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 section 14 of this 2001 Act,** pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial 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 659.

(E) Inform the claimant of assistance available to employers 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 section 10 of this 2001 Act**. The insurer or self-insured employer has [*30*] **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 section 10 of this 2001 Act** 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** [*conditions*] **condition claims properly initiated pursuant to section 10 of this 2001 Act** shall be furnished to the claimant by the insurer or self-insured employer within [*90*] **60** days after the insurer or self-insured employer receives written notice of such claims. [*New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time.*] **A worker who fails to comply with the com-**

munication requirements of subsection (6) of this section or section 10 of this 2001 Act 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, 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. 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 described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. The director's action and review thereof shall be subject to ORS 183.310 to 183.550 and such other procedural rules as the director may prescribe.

(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount described in this subsection, the provision for attorney fees provided in this subsection shall apply in the other proceeding.

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

(13) Insurers and self-insured employers shall report every claim for disabling injury to the director within 21 days after the date the employer has notice or knowledge of such injury.

(14) 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. However, 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 [*90*] **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.

SECTION 8. ORS 656.308 is amended to read:

656.308. (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 [*90*] **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 injured worker for the appearance and active and meaningful participation by an

attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances.

(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.

SECTION 9. ORS 656.386 is amended to read:

656.386. (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 [*30*] **60** days; or

(C) A claim for an aggravation **made pursuant to ORS 656.273 (2)** or **for a** new medical condition[,] made pursuant to [*ORS 656.262 (7)(a),*] **section 10 of this 2001 Act,** which the insurer or self-insured employer does not respond to within [*90*] **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) 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.

SECTION 10. (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) 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.

(3) Notwithstanding subsection (2) of this section, claims for new medical or omitted medical conditions related to an initially accepted claim that are initiated after the rights under ORS 656.273 have expired shall be processed as requests for relief under the Workers' Compensation Board's own motion jurisdiction pursuant to ORS 656.278 (1)(b).

SECTION 11. ORS 656.278 is amended to read:

656.278. (1) Except as provided in subsection [*(6)*] **(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 [*either*] **hospitalization or** inpatient or outpatient surgery**,** or other **curative** treatment [*requiring*] **prescribed in lieu of** hospitalization **that is necessary to enable the injured worker to return to work**. In such cases, [*the board may authorize*] 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 worker is actually hospitalized or undergoes outpatient surgery*] **the attending physician authorizes temporary disability compensation for the hospitalization, surgery or other curative treatment** until the worker's condition becomes medically stationary[*, as determined by the board*]; [*or*]

(b) The worker submits and obtains acceptance of a claim for a compensable new medical condition or an omitted medical condition pursuant to section 10 of this 2001 Act 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

[*(b)*] **(c)** The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the [*board may authorize*] 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) The claimant has no right to appeal any order or award made by the board on its own motion, except when the order diminishes or terminates a former award. The employer may appeal from an order which increases the award.

(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.

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

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

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

SECTION 11a. ORS 656.625 is amended to read:

656.625. (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 [*as the board prescribes*] **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.

SECTION 12. ORS 656.268 is amended to read:

656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or 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 impairment;

(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 impairment, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated; or

(c) Without the approval of the attending physician, 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.

(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 and to the employer, if requested by the worker or employer.

(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 advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician 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;

(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; or

(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.

(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 of the Department of Consumer and Business Services. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the worker's attorney if the worker is represented, and to the director. The notice 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;

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within 60 days of the date of the notice of claim closure; of the aggravation rights; and of such 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.

(b) If the worker has returned to work but 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 the decision not to close; of 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 the claim; of the right to be represented by an attorney; and of such other information as the director may require.

(c) If a worker objects to the notice of closure, the worker first must request reconsideration by the director under this section. The request for reconsideration must be made within 60 days of the date of the notice of closure.

(d) 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.

(e) 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 either a scheduled or unscheduled 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 new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, 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 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 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) The reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (7) 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 request for reconsideration pursuant to subsection (5)(c) of this section. The insurer may fully participate in the reconsideration proceeding.

(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) 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 Board of Medical Examiners for the State of Oregon 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 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.

(8) 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.

(9) 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 under the closure shall be suspended, and the worker shall receive temporary disability compensation 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 unscheduled 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.

(10) If the attending physician 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.

(11) 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.

(12) 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 a guaranty contract insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(13)(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.

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

SECTION 13. ORS 656.325 is amended to read:

656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or 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. However, no more than three 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) 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 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 656.268 (7)(d). The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.

[*(b)*] **(c)** 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 subsection, "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 section shall be made in the manner prescribed by the director.

(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 unscheduled permanent total or unscheduled 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 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) Notwithstanding ORS 656.268:*]

(5)(a) **Except as provided by ORS 656.268 (4)(c) and (10),** 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, 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 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 approves employment in a modified job whether or not such a job is available.

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

SECTION 13a. ORS 656.313 is amended to read:

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

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

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

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

(D) Vocational benefits for services for vocational evaluation and help in directly obtaining employment as provided by ORS 656.340 (7) and for services related to the development of plans for return to work, as provided by ORS 656.340 (9). No plan for return to work may be implemented until the vocational order on appeal has become final.

(b) If ultimately found payable under a final order, benefits withheld under this subsection 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 section 14 of this 2001 Act,** 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 section 14 of this 2001 Act:**

(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.

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

SECTION 14. (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 if the expenses are for:

(a) Diagnostic services required to identify appropriate treatment or to prevent disability;

(b) Medication required to alleviate pain; or

(c) Services required to stabilize the worker's claimed condition and to prevent further disability.

(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 a contested case hearing before the director pursuant to ORS 183.310 to 183.550 within 60 days of the date of the director's order. At the contested case hearing, the administrative order 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 is accepted, the insurer or self-insured employer shall make payment for such medical services subject to the limitations and conditions of this chapter.

(b) If the claim in which medical services are provided under subsection (1) of this section is denied and a health benefit plan provides benefits to the worker, the health benefit plan shall be the first payer of the expenses for medical services according to the terms, conditions and benefits of the plan. Except as provided by subsection (2) of this section, after payment by the health benefit plan, the workers' compensation insurer or self-insured employer shall pay any balance remaining for such services subject to the limitations and conditions of this chapter.

(c) As used in this subsection, "health benefit plan" has the meaning given that term in ORS 743.730.

(5) An insurer or self-insured employer may recover expenses for medical services paid under subsection (1) of this section as an overpayment as provided by ORS 656.268 (13)(a).

SECTION 14a. ORS 656.252 is amended to read:

656.252. (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 to make the insurer or self-insured employer a first report of injury within [*a specified time*] **72 hours** after the first service rendered.

(b) Requiring attending physicians to submit follow-up reports within specified time limits or upon the request of an interested party.

(c) Requiring examining physicians 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 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.

[*(a)*] **(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 physician 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 shall forward such reports.

[*(b)*] **(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 notify the insurer or employer of the worker's release to return to work without notifying the worker at the same time.

[*(c)*] **(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, the newly selected attending physician 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 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.

SECTION 15. (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.

SECTION 15a. To assist the Legislative Assembly in developing a constitutionally adequate system of exclusive remedies for workplace injuries, the Workers′ Compensation Management-Labor Advisory Committee shall recommend to the Seventy-second Legislative Assembly an exclusive, no-fault, expeditious alternative remedy to civil litigation for injured workers who have established that their injuries were work-related but whose claims have been denied because the workers have failed to establish that work-related incidents were the major contributing cause of their injuries.

SECTION 15b. (1) The Department of Consumer and Business Services shall collect data and report to the Seventy-second Legislative Assembly on civil negligence claims filed for a work-related injury that has been determined to be not compensable under this chapter because the injured worker has failed to establish that a work-related incident was the major contributing cause of the worker′s injury. This information shall include the number of claims filed, verdicts rendered, settlements reached and the average cost of such claims, including litigation costs.

(2) Insurers and self-insured employers shall assist the department in gathering such data.

SECTION 16. Section 17 of this 2001 Act is added to and made a part of ORS 654.305 to 654.335.

SECTION 17. The provisions of ORS 18.470 to 18.490 apply to an action under ORS 654.305 to 654.335.

SECTION 18. Section 17 of this 2001 Act applies only to actions under ORS 654.305 to 654.335 that are filed on or after January 1, 2002.

SECTION 19. ORS 654.335 is repealed.

SECTION 19a. Section 17 of this 2001 Act and the repeal of ORS 654.335 by section 19 of this 2001 Act become operative on January 1, 2002.

SECTION 20. Sections 6a, 6b, 6c, 10, 14, 15 and 15b of this 2001 Act are added to and made a part of ORS chapter 656.

SECTION 21. Section 10 of this 2001 Act and the amendments to ORS 656.278 and 656.625 by sections 11 and 11a of this 2001 Act become operative on January 1, 2002.

SECTION 22. (1) Section 14 of this 2001 Act 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 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.

SECTION 23. Sections 3 (amending ORS 656.012), 4 (amending ORS 656.018) and 5, chapter 6, Oregon Laws 1999, are repealed.

SECTION 24. This 2001 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2001 Act takes effect on its passage.

Passed by Senate March 22, 2001

Repassed by Senate July 5, 2001

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Secretary of Senate

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President of Senate

Passed by House July 4, 2001

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Speaker of House

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2001

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Secretary of State