

**Enrolled**  
**House Bill 2091**

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Pre-session filed (at the request of Governor Theodore R. Kulongoski for Office of Regulatory Streamlining)

CHAPTER .....

AN ACT

Relating to review of certain decisions in workers' compensation claims; creating new provisions; and amending ORS 183.635, 656.054, 656.170, 656.245, 656.247, 656.248, 656.254, 656.260, 656.262, 656.283, 656.327, 656.385, 656.440, 656.704 and 656.726.

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

**SECTION 1.** ORS 656.054 is amended to read:

656.054. (1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The Director of the Department of Consumer and Business Services shall refer the claim for such an injury to an assigned claims agent within 60 days of the date the director has notice of the claim. At the time of referral of the claim, the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. A claim for compensation made by such a worker shall be processed by the assigned claims agent in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first installment of compensation is to be paid, pursuant to ORS 656.262 (4), shall not begin to run until the director has referred the claim to the assigned claims agent. At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim. If an order becomes final holding the claim to be compensable, the employer is liable for all costs imposed by this chapter, including reasonable attorney fees to be paid to the worker's attorney for services rendered in connection with the employer's objection to the claim.

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

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

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

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

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

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

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

(4) The State Accident Insurance Fund Corporation and any assigned claims agent may [appeal] **request review under ORS 656.704** of any disapproval of reimbursement made by the director under this section [pursuant to ORS chapter 183 and such procedural rules as the director may prescribe].

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

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

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

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

(9) As used in this section, "assigned claims agent" means an insurer, casualty adjuster or a third party administrator with whom the director contracts to manage claims of injured workers of noncomplying employers.

**SECTION 2.** ORS 656.170 is amended to read:

656.170. (1) In a collective bargaining agreement between a private employer or groups of employers engaged in construction, construction maintenance or activities limited to rock, sand, gravel, cement and asphalt operations, heavy duty mechanics, surveying or construction inspection, and a union that is the recognized or certified exclusive bargaining representative, a provision establishing either of the following is valid and binding:

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

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

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

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

(D) Establishing arbitration and mediation procedures; or  
(b) The use of a list of medical service providers that the parties may agree is the exclusive source of all medical treatment provided under this chapter.

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

(3) Nothing in this section allows a collective bargaining agreement that diminishes the entitlement of an employee to compensation as provided in this chapter. The portion of an agreement that violates this subsection is void. Notwithstanding any other provision of law, original jurisdiction over the compliance of a proposed collective bargaining agreement with this subsection is with the Director of the Department of Consumer and Business Services. The director shall determine the compliance of the agreement with this subsection prior to the agreement becoming operative. The decision of the director is subject to review as provided under ORS [*chapter 183 and no other review of the director's decision shall be allowed*] **656.704**.

**SECTION 3.** ORS 656.245 is amended to read:

656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

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

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

(J) With the approval of the insurer or self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable the worker to continue current employment or a vocational training program. If the insurer or self-insured employer does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such treatment. The decision of the director is subject to [*the contested case and*] review [*provisions of*] **under** ORS [*chapter 183*] **656.704**.

(K) With the approval of the director, curative care arising from a generally recognized, non-experimental advance in medical science since the worker's claim was closed that is highly likely

to improve the worker's condition and that is otherwise justified by the circumstances of the claim. The decision of the director is subject to *[the contested case and]* review *[provisions of]* **under** ORS *[chapter 183]* **656.704**.

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

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

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

(2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon. The worker may choose the initial attending physician or nurse practitioner and may subsequently change attending physician or nurse practitioner two times without approval from the director. If the worker thereafter selects another attending physician or nurse practitioner, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. The decision of the director is subject to *[a contested case]* review under ORS *[chapter 183]* **656.704**. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

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

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

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

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

(i) Provide compensable medical services for 90 days from the date of the first visit on the claim;

(ii) Authorize the payment of temporary disability benefits for a period not to exceed 60 days from the date of the first visit on the initial claim; and

(iii) When an injured worker treating with a nurse practitioner authorized to provide compensable services under this section becomes medically stationary within the 90-day period in which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of making findings regarding the worker's impairment for the purpose of evaluating the worker's disability. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an attending physician and the insurer shall compensate the nurse practitioner for the examination performed.

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to [a *contested case*] review under ORS [chapter 183] **656.704**.

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

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

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

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

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

(D) If the claim is denied, the worker may receive medical services after the date of denial from sources other than the managed care organization until the denial is reversed. Reasonable and

necessary medical services received from sources other than the managed care organization after the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured employer if the claim is finally determined to be compensable.

(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize physician assistants licensed by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disability compensation for injured workers for a period not to exceed 30 days from the date of the first visit on the claim. In addition, the director, by rule, may authorize such assistants who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such payment.

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

(7) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327.

**SECTION 4.** ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, is amended to read:

656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

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

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

(J) With the approval of the insurer or self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable

the worker to continue current employment or a vocational training program. If the insurer or self-insured employer does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such treatment. The decision of the director is subject to [*the contested case and*] review [*provisions of*] **under** ORS [*chapter 183*] **656.704**.

(K) With the approval of the director, curative care arising from a generally recognized, non-experimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. The decision of the director is subject to [*the contested case and*] review [*provisions of*] **under** ORS [*chapter 183*] **656.704**.

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

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

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

(2)(a) The worker may choose an attending doctor or physician within the State of Oregon. The worker may choose the initial attending physician and may subsequently change attending physician two times without approval from the director. If the worker thereafter selects another attending physician, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved. The decision of the director is subject to [*a contested case*] review under ORS [*chapter 183*] **656.704**. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

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

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

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to [*a contested case*] review under ORS [*chapter 183*] **656.704**.

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

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

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

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

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

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

(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize nurse practitioners certified by the Oregon State Board of Nursing and physician assistants licensed by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disability compensation for injured workers for a period not to exceed 30 days from the date of the first visit on the claim. In addition, the director, by rule, may authorize such practitioners and assistants



who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such payment.

(6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the injured worker, insurer or self-insured employer may request administrative review by the director pursuant to ORS 656.260 or 656.327.

**SECTION 5.** ORS 656.247 is amended to read:

656.247. (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 chapter 183] **review under ORS 656.704** within 60 days of the date of the director's order. [At the contested case hearing, the administrative order] **The order of the director** may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law.

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

(c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS 656.289 (4), all medical services payable under subsection (1) of this section that are provided on or before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer or self-insured employer shall notify each affected service provider of the results of the settlement.

(4)(a) If the claim in which medical services are provided under subsection (1) of this section 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 6.** ORS 656.248 is amended to read:

656.248. (1) The Director of the Department of Consumer and Business Services, in compliance with ORS 656.794 and ORS chapter 183, shall promulgate rules for developing and publishing fee schedules for medical services provided under this chapter. These schedules shall represent the reimbursement generally received for the services provided. Where applicable, and to the extent the

director determines practicable, these fee schedules shall be based upon any one or all of the following:

- (a) The current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein;
- (b) The average rates of fee schedules of the Oregon health insurance industry;
- (c) A reasonable rate of markup for the sale of medical devices or other medical services;
- (d) A commonly used and accepted medical service fee schedule; or
- (e) The actual cost of providing medical services.

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

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

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

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

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

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

- (a) A statistically valid survey by the director of medical service fees or markups;
- (b) That information provided to the director by any person or state agency having access to medical service fee information;
- (c) That information provided to the director pursuant to subsection (5) of this section; or
- (d) The annual percentage increase or decrease in the physician's services component of the national Consumer Price Index published by the Bureau of Labor Statistics of the United States Department of Labor.

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

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

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

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

(12) When a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider shall request administrative review by the director. The decision of the director is subject to review [*as provided in*] **under** ORS [*chapter 183*] **656.704**.

(13) The director may exclude hospitals defined in ORS 442.470 from imposition of a fee schedule authorized by this section upon a determination of economic necessity.

**SECTION 7.** ORS 656.254 is amended to read:

656.254. (1) The Director of the Department of Consumer and Business Services shall establish medical report forms, in duplicate snap-outs where applicable, to be used by insurers, self-insured employers and physicians, including in such forms information necessary to establish facts required in the determination of the claim.

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

(3) *[In accordance with the provisions of ORS chapter 183,]* If the director finds that a health care practitioner has:

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

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

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

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

(5) ORS 656.735 (4) to (6) and 656.740 also apply to orders and penalties assessed under this section.

**SECTION 8.** ORS 656.260 is amended to read:

656.260. (1) Any health care provider or group of medical service providers may make written application to the Director of the Department of Consumer and Business Services to become certified to provide managed care to injured workers for injuries and diseases compensable under this chapter. However, nothing in this section authorizes an organization that is formed, owned or operated by an insurer or employer other than a health care provider to become certified to provide managed care.

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

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

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

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

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

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

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

(a) Proposes to provide services that meet quality, continuity and other treatment standards prescribed by the director and will provide all medical and health care services that may be required by this chapter in a manner that is timely, effective and convenient for the worker.

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

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

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

(A) "Peer review" means evaluation or review of the performance of colleagues by a panel with similar types and degrees of expertise. Peer review requires participation of at least three physicians prior to final determination.

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

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

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

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

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

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

(g) Authorizes workers to receive compensable medical treatment from a primary care physician who is not a member of the managed care organization, but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, to be furnished by another provider that the worker may require and if that primary care physician agrees to comply with all the rules, terms and conditions regarding

services performed by the managed care organization. Nothing in this paragraph is intended to limit the worker's right to change primary care physicians prior to the filing of a workers' compensation claim. As used in this paragraph, "primary care physician" means a physician who is qualified to be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a general practitioner or an internal medicine practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) Upon a request for administrative review, the director shall create a documentary record sufficient for judicial review. The director shall complete administrative review and issue a proposed order within a reasonable time. The proposed [*administrative*] order of the director **issued** pursuant to this section shall become final and not subject to further review unless a written request for a hearing is filed with the director within 30 days of the mailing of the order to all parties.

(16) At the contested case hearing, the [*administrative*] order may be modified only if it is not supported by substantial evidence in the record or reflects an error of law. No new medical evidence or issues shall be admitted. The dispute may also be remanded to the managed care organization for further evidence taking, correction or other necessary action if the **Administrative Law Judge or** director determines the record has been improperly, incompletely or otherwise insufficiently developed. Decisions by the director regarding medical disputes are subject to review under ORS [*chapter 183*] **656.704**.

(17) Any person who is dissatisfied with an action of a managed care organization other than regarding the provision of medical services pursuant to this chapter, peer review, service utilization review or quality assurance activities may request [*a contested case hearing before the director pursuant to ORS chapter 183. The decision of the director is final if an appeal is not made to the Court of Appeals within 60 days of the mailing of the order*] **review under ORS 656.704**.

(18) Notwithstanding any other provision of law, original jurisdiction over contract review disputes is with the director. The director may resolve the matter by issuing an order subject to review under ORS [*chapter 183*] **656.704**, or the director may determine that the matter in dispute would be best addressed in another forum and so inform the parties.

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

**SECTION 9.** 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 or nurse practitioner authorized to provide compensable medical services under ORS 656.245 authorizes the payment of temporary disability compensation. Thereafter, temporary disability compensation shall be paid at least once each two weeks, except where the Director of the Department of Consumer and Business Services determines that payment in installments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules.

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

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

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

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

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

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

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

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

(5) 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 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or 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 659A.

(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 ORS 656.267. The



insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

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

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

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

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

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

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be proportionate to the benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraordinary circumstances. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. *[The director's action and review thereof shall be subject to ORS chapter 183 and such other procedural rules as the director may prescribe.]*  
**The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.**

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

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

(13) 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.

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

(15) In accordance with ORS 656.283 (4), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (13) of this section.

**SECTION 10.** ORS 656.262, as amended by section 10, chapter 811, Oregon Laws 2003, 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 that is not authorized by the managed care organization more than seven days after the mailing of notice by the insurer or self-insured employer.

(5) 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 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or 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 659A.

(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 ORS 656.267. The

insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph or ORS 656.267 may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.

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

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

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition.

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

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

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

(11)(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees assessed under this section. The fees assessed by the director, an Administrative Law Judge, the board or the court under this section shall be proportionate to the benefit to the injured worker. The board shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraordinary circumstances. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount and attorney fees described in this subsection. [*The director's action and review thereof shall be subject to ORS chapter 183 and such other procedural rules as the director may prescribe.*] **The action of the director and the review of the action taken by the director shall be subject to review under ORS 656.704.**

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

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

(13) 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.

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

(15) In accordance with ORS 656.283 (4), the Administrative Law Judge assigned a request for hearing for a claim for compensation involving more than one potentially responsible employer or insurer may specify what is required of an injured worker to reasonably cooperate with the investigation of the claim as required by subsection (13) of this section.

**SECTION 11.** ORS 656.283 is amended to read:

656.283. (1) Subject to ORS 656.319, any party or the Director of the Department of Consumer and Business Services may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS [656.245, 656.248, 656.260, 656.327 and subsection (2) of this section] **656.704.**

(2)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director is hereby charged with the duty of creating a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter.

Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time. If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order containing findings of fact and conclusions of law. The order shall be based on a record sufficient to permit review under paragraph (c) of this subsection. For purposes of this subsection, the term "parties" does not include a noncomplying employer.

(c) Director approval of an agreement resolving a vocational assistance matter shall be subject to reconsideration by the director under limitations prescribed by the director, but shall not be subject to review by any other forum. When the director issues an order after review under paragraph (b) of this subsection, the order shall be subject to review *[only by the director]* **under ORS 656.704**. At the contested case hearing, the decision of the director's administrative review shall be modified only if it:

- (A) Violates a statute or rule;
- (B) Exceeds the statutory authority of the agency;
- (C) Was made upon unlawful procedure; or
- (D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(d) An appeal of the director's administrative review under paragraph (b) of this subsection must be made within 60 days of the review issue date. *[Judicial review of the order shall be pursuant to ORS chapter 183.]*

(3) A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the Workers' Compensation Board.

(4)(a) The board shall refer the request for hearing to an Administrative Law Judge for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party.

(b) When a hearing set pursuant to paragraph (a) of this subsection is postponed because of the need to join one or more potentially responsible employers or insurers, the assigned Administrative Law Judge shall reschedule the hearing as expeditiously as possible after all potentially responsible employers and insurers have been joined in the proceeding and the medical record has been fully developed. The board shall adopt rules for hearings on claims involving one or more potentially responsible employers and insurers that:

(A) Require the parties to participate in any prehearing conferences required to expedite the hearing; and

(B) Authorize the Administrative Law Judge conducting the hearing to:

(i) Establish a prehearing schedule for investigation of the claim, including but not limited to the interviewing of the claimant;

(ii) Make prehearing rulings necessary to promote full discovery and completion of the medical record required for determination of the issues arising from the claim; and

(iii) Specify what is required of the claimant to meet the obligation to reasonably cooperate with the investigation of claims.

(c) Nothing in paragraph (b) of this subsection alters the obligation of an insurer or self-insured employer to accept or deny a claim for compensation as required under this chapter.

(d) If a hearing has been postponed in accordance with paragraph (b) of this subsection, the director may not consider the timeliness of a denial issued in the claim that is the subject of the hearing for the purpose of imposing a penalty against an insurer or self-insured employer that is potentially responsible for the claim.

(5) At least 10 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. Hearings shall be held in the county where the worker resided at the time of the injury or such other place selected by the Administrative Law Judge.

(6) A record of all proceedings at the hearing shall be kept but need not be transcribed unless a party requests a review of the order of the Administrative Law Judge. Transcription shall be in written form as provided by ORS 656.295 (3).

(7) Except as otherwise provided in this section and rules of procedure established by the board, the Administrative Law Judge is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Neither the board nor an Administrative Law Judge may prevent a party from withholding impeachment evidence until the opposing party's case in chief has been presented, at which time the impeachment evidence may be used. Impeachment evidence consisting of medical or vocational reports not used during the course of a hearing must be provided to any opposing party at the conclusion of the presentation of evidence and before closing arguments are presented. Impeachment evidence other than medical or vocational reports that is not presented as evidence at hearing is not subject to disclosure. Evaluation of the worker's disability by the Administrative Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Evidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. If the Administrative Law Judge finds that the claim has been closed prematurely, the Administrative Law Judge shall issue an order rescinding the notice of closure.

(8) Any party shall be entitled to issuance and service of subpoenas under the provisions of ORS 656.726 (2)(c). Any party or representative of the party may serve such subpoenas.

(9) After a party requests a hearing and before the hearing commences, the board, by rule, may require the requesting party, if represented by an attorney, to notify the Administrative Law Judge in writing that the attorney has conferred with the other party and that settlement has been achieved, subject to board approval, or that settlement cannot be achieved.

**SECTION 12.** ORS 656.327 is amended to read:

656.327. (1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer *[shall]* **must** request **administrative** review of the treatment by the director **prior to requesting a hearing on the issue** and so notify the parties.

(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the Workers' Compensation Board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.

(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue *[that is subject to the jurisdiction of the director]* under this section until the director issues an order under subsection (2) of this section.



(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS 656.325 (1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request *[a contested case hearing before the director pursuant to ORS chapter 183]* **review under ORS 656.704.** *[At the contested case hearing,]* The administrative order may be modified **at hearing** only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. *[If the director issues an order declaring medical treatment to be not compensable,]* The worker is not obligated to pay for *[such treatment. Review of the director's order shall be by the Court of Appeals pursuant to ORS chapter 183]* **medical treatment determined not to be compensable under this subsection.**

(3) Upon request of either party, the director may delegate to a physician or a panel of physicians the review of medical treatment under this section. At least one member of any such panel shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed. No member of any such panel shall be a physician whose treatment is the subject of review. The panel shall be chosen in such manner as the director may prescribe, in consultation with the committee referred to in ORS 656.790. The physician or panel shall submit findings to the director within the time limits as prescribed by the director.

(4) The physician or the panel of physicians and the medical arbiter or panel of medical arbiters appointed pursuant to ORS 656.268 acting pursuant to the authority of the director are agents of the Department of Consumer and Business Services and are subject to the provisions of ORS 30.260 to 30.300. The findings of the physician or panel of physicians, the medical arbiter or panel of medical arbiters, all of the records and all communications to or before a panel or arbiter are privileged and are not discoverable or admissible in any proceeding other than those proceedings under this chapter. No member of a panel or a medical arbiter shall be examined or subject to administrative or civil liability regarding participation in or the findings of the panel or medical arbiter or any matter before the panel or medical arbiter other than in proceedings under this chapter.

(5) The costs of review of medical treatment by the physician or panel of physicians pursuant to this section and costs incurred by the worker in attending any examination required under this section, including child care, transportation, lodging and meals, shall be paid by the insurer or self-insured employer.

**SECTION 13.** ORS 656.385 is amended to read:

656.385. (1) In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, **656.247**, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced, *[before]* the Director of the Department of Consumer and Business Services, *the director* **or the Administrative Law Judge** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director **or an Administrative Law Judge**, the director **or Administrative Law Judge** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant or claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department. The attorney fee assessed *[by the director, or on appeal from an order of the director,]* under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraordinary circumstances.

(2) If an insurer or self-insured employer refuses to pay compensation due under ORS 656.245, **656.247**, 656.260, 656.327 or 656.340 pursuant to *[a final contested case]* **an** order of the director, **an Administrative Law Judge** or *[order of]* the court or otherwise unreasonably resists the payment

of such compensation, the insurer or self-insured employer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (3) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

(3) If a request for a contested case hearing, review on appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an insurer or self-insured employer, and the director, **Administrative Law Judge** or court finds that the compensation awarded under ORS 656.245, **656.247**, 656.260, 656.327 or 656.340 to a claimant should not be disallowed or reduced, the insurer or self-insured employer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the director, **the Administrative Law Judge** or the court for legal representation by an attorney for the claimant at the contested case hearing, review on appeal or cross-appeal.

(4) If upon reaching a final contested case decision where such contested case was initiated by an insurer or self-insured employer it is found [*by the director*] that the insurer or self-insured employer initiated the contested case hearing for the purpose of delay or other vexatious reason or without reasonable ground, the director **or Administrative Law Judge** may order the insurer or self-insured employer to pay to the claimant such penalty not exceeding \$750 and not less than \$100 as may be reasonable in the circumstances.

(5) [*Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director.*] Penalties and attorney fees awarded pursuant to this section by the director, **an Administrative Law Judge** or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant.

**SECTION 14.** ORS 656.440 is amended to read:

656.440. (1) Before revocation of certification under ORS 656.434 becomes effective, the Director of the Department of Consumer and Business Services shall give the employer notice that the certification will be revoked stating the grounds for the revocation. The notice shall be served on the employer in the manner provided by ORS 656.427 (3). The revocation shall become effective within 10 days after receipt of such notice by the employer unless within such period of time the employer corrects the grounds for the revocation or appeals in writing to the [*Department of Consumer and Business Services*] **director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge.**

(2) If the employer appeals, the [*director*] **Hearings Division of the Workers' Compensation Board under ORS 656.283** shall set a date for a hearing, which date shall be within [20] **30** days after receiving the appeal request, and shall give the employer at least five days' notice of the time and place of the hearing. A record of the hearing shall be kept but it need not be transcribed unless requested by the employer.[: *and*] The cost of transcription shall be charged to the employer. Within [*five*] **10** days after the hearing, the [*director*] **Administrative Law Judge** shall either affirm or disaffirm the revocation and give the employer written notice thereof by registered or certified mail.

(3) If revocation is affirmed on review by the [*director*] **Administrative Law Judge**, the revocation is effective five days after the employer receives notice of the affirmance unless within such period of time the employer corrects the grounds for the revocation or petitions for judicial review of the affirmance pursuant to ORS [*chapter 183*] **183.480 to 183.497.**

(4) If the revocation is affirmed following judicial review, the revocation is effective five days after entry of the final judgment of affirmance, unless within such period the employer corrects the grounds for the revocation.

**SECTION 15.** ORS 656.704 is amended to read:

656.704. (1) Actions and orders of the Director of the Department of Consumer and Business Services **regarding matters concerning a claim under this chapter**, and administrative and judicial review [*thereof*] **of those matters**, [*regarding matters concerning a claim under this chapter*] are subject to the procedural provisions of this chapter and such procedural rules as the Workers' Compensation Board may prescribe.

(2)(a) *[Notwithstanding ORS 183.315 (1), actions and orders of the director and the conduct of hearings and other proceedings pursuant to this chapter, and judicial review thereof, regarding all matters other than those concerning a claim under this chapter, are subject to ORS chapter 183. Except as provided in subsections (4) and (5) of this section, contested case hearings under this subsection shall be conducted by an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605.]* **A party dissatisfied with an action or order regarding a matter other than a matter concerning a claim under this chapter may request a hearing on the matter in writing to the director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge. Review of an order issued by the Administrative Law Judge shall be by the director and the director shall issue a final order that is subject to judicial review as provided by ORS 183.480 to 183.497.**

(b) The director *[by rule]* shall prescribe the classes of orders issued **under this subsection** by Administrative Law Judges and other personnel that are final, appealable orders and those orders that are preliminary orders subject to revision by the director.

(3)(a) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, subject to paragraph (b) of this subsection, such matters do not include any disputes arising under ORS 656.245, **656.247**, 656.248, 656.260[,] **or** 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide.

(b) The respective authority of the board and the director to resolve medical service disputes[, *other than disputes arising under ORS 656.260,*] shall be determined according to the following principles:

(A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim.

(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245 (1)(c), is not a matter concerning a claim.

(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.

*[(D) The board and the director shall adopt rules to facilitate the fair and orderly determination of disputes that involve matters concerning a claim and additional issues. Such rules shall first require the determination of those issues that are matters concerning a claim.]*

**(c) Notwithstanding ORS 656.283 (4), if parties to a hearing scheduled before an Administrative Law Judge are involved in a dispute regarding both matters concerning a claim and matters not concerning a claim, the Administrative Law Judge may defer any action on the matter concerning a claim until the director has completed an administrative review of the matters other than those concerning a claim. The director shall mail a copy of the administrative order to the parties and to the Administrative Law Judge. A party may request a hearing on the order of the director. At the request of a party or by the own motion of the Administrative Law Judge, the hearings on the separate matters may be consolidated. The Administrative Law Judge shall issue an order for those matters concerning a claim and a separate order for matters other than those concerning a claim.**

*[(4) If a hearing involves actions and orders of the director that are subject to hearing under this section and also involves issues subject to hearing by an Administrative Law Judge from the board's Hearings Division, the director may direct that the hearing be conducted by an Administrative Law*

*Judge from the board's Hearings Division in lieu of an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605.]*

[(5)] (4) Hearings under ORS 656.740 shall be conducted by an Administrative Law Judge from the board's Hearings Division.

**(5) If a request for hearing or administrative review is filed with either the director or the board and it is determined that the request should have been filed with the other, the dispute shall be transferred. Filing a request will be timely filed if the original filing was completed within the prescribed time.**

**SECTION 16.** ORS 656.726, as amended by section 3, chapter 657, Oregon Laws 2003, is amended to read:

656.726. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS [chapter 183] **656.704**. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criterion for evaluation of permanent impairment under ORS 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. Permanent impairment is expressed as a percentage of the whole person. The impairment value may not exceed 100 percent of the whole person.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) The criterion for evaluation of work disability under ORS 656.214 is permanent impairment as modified by the factors of age, education and adaptability to perform a given job.

(D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

(E) Notwithstanding any other provision of this section, only impairment benefits shall be awarded under ORS 656.214 if:

(i) The worker returns to regular work at the job held at the time of injury;

(ii) The attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

(iii) The attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295 and 654.750 to 654.780 and this chapter.

(5) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal prehearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity.

**SECTION 17.** ORS 656.726, as amended by sections 3 and 4, chapter 657, Oregon Laws 2003, and section 18, chapter 811, Oregon Laws 2003, is amended to read:

656.726. (1) The Workers' Compensation Board in its name and the Director of the Department of Consumer and Business Services in the director's name as director may sue and be sued, and each shall have a seal.

(2) The board hereby is charged with reviewing appealed orders of Administrative Law Judges in controversies concerning a claim arising under this chapter, exercising own motion jurisdiction under this chapter and providing such policy advice as the director may request, and providing such other review functions as may be prescribed by law. To that end any of its members or assistants authorized thereto by the members shall have power to:

(a) Hold sessions at any place within the state.

(b) Administer oaths.

(c) Issue and serve by the board's representatives, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter.

(d) Generally provide for the taking of testimony and for the recording of proceedings.

(3) The board chairperson is hereby charged with the administration of and responsibility for the Hearings Division.

(4) The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

(a) Make and declare all rules and issue orders which are reasonably required in the performance of the director's duties. Unless otherwise specified by law, all reports, claims or other documents shall be deemed timely provided to the director or board if mailed by regular mail or delivered within the time required by law. Notwithstanding any other provision of this chapter, the director may adopt rules to allow for the electronic transmission and filing of reports, claims or other documents required to be filed under this chapter. Notwithstanding ORS 183.310 to 183.410, if a matter comes before the director that is not addressed by rule and the director finds that adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily burdensome to the public, the director may resolve the matter by issuing an order, subject to review under ORS [chapter 183] **656.704**. Such order shall not have precedential effect as to any other situation.

(b) Hold sessions at any place within the state.

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

(e) Generally provide for the taking of testimony and for the recording of such proceedings.

(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

(A) The criteria for evaluation of disabilities under ORS 656.214 (5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job.

(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

(C) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214 (5) if:

(i) The worker returns to regular work at the job held at the time of injury;

(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury.

(g) Prescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter regarding all matters other than those specifically allocated to the board or the Hearings Division.

(h) Participate fully in any proceeding before the Hearings Division, board or Court of Appeals in which the director determines that the proceeding involves a matter that affects or could affect the discharge of the director's duties of administration, regulation and enforcement of ORS 654.001 to 654.295 and 654.750 to 654.780 and this chapter.

(5) The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278. The board shall adopt standards governing the format and timing of the evidence. The standards shall be uniformly followed by all Administrative Law Judges and practitioners. The rules may provide for informal pre-hearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who may appear with parties at prehearing conferences and hearings.

(6) The director and the board chairperson may incur such expenses as they respectively determine are reasonably necessary to perform their authorized functions.

(7) The director, the board chairperson and the State Accident Insurance Fund Corporation shall have the right, not subject to review, to contract for the exchange of, or payment for, such services between them as will reduce the overall cost of administering this chapter.

(8) The director shall have lien and enforcement powers regarding assessments to be paid by subject employers in the same manner and to the same extent as is provided for lien and enforcement of collection of premiums and assessments by the corporation under ORS 656.552 to 656.566.

(9) The director shall have the same powers regarding inspection of books, records and payrolls of employers as are granted the corporation under ORS 656.758. The director may disclose information obtained from such inspections to the Director of the Department of Revenue to the extent the Director of the Department of Revenue requires such information to determine that a person complies with the revenue and tax laws of this state and to the Director of the Employment Department to the extent the Director of the Employment Department requires such information to determine that a person complies with ORS chapter 657.

(10) The director shall collect hours-worked data information in addition to total payroll for workers engaged in various jobs in the construction industry classifications described in the job classification portion of the Workers' Compensation and Employers Liability Manual and the Oregon Special Rules Section published by the National Council on Compensation Insurance. The information shall be collected in the form and format necessary for the National Council on Compensation Insurance to analyze premium equity.

**SECTION 18.** ORS 183.635 is amended to read:

183.635. (1) Except as provided in this section, all agencies must use administrative law judges assigned from the Office of Administrative Hearings established under ORS 183.605 to conduct contested case hearings, without regard to whether those hearings are subject to the procedural requirements for contested case hearings.

(2) The following agencies need not use administrative law judges assigned from the office:

(a) The Department of Education, the State Board of Education and the Superintendent of Public Instruction.

(b) Employment Appeals Board.

(c) Employment Relations Board.

(d) Public Utility Commission.

(e) Bureau of Labor and Industries and the Commissioner of the Bureau of Labor and Industries.

(f) Land Conservation and Development Commission.

(g) Land Use Board of Appeals.

(h) Department of Revenue.

(i) Local government boundary commissions created pursuant to ORS 199.425 or 199.430.

(j) State Accident Insurance Fund Corporation.

(k) Psychiatric Security Review Board.

(L) State Board of Parole and Post-Prison Supervision.

(m) Department of Corrections.

(n) Energy Facility Siting Council.

(o) Department of Human Services for vocational rehabilitation services cases under 29 U.S.C. 722(c) and disability determination cases under 42 U.S.C. 405.

(p) Secretary of State.

(q) State Treasurer.

(r) Attorney General.

(s) Fair Dismissal Appeals Board.

(t) Department of State Police.

(u) Oregon Youth Authority.

(v) Boards of stewards appointed by the Oregon Racing Commission.

(w) The Department of Higher Education and the institutions of higher education listed in ORS 352.002.

(x) The Governor.

(y) State Land Board.

(z) Wage and Hour Commission.

(aa) State Apprenticeship and Training Council.

(3) The Workers' Compensation Board is exempt from using administrative law judges assigned from the office for any hearing conducted by the board under ORS chapters 147, 654 and 656. [*The Director of the Department of Consumer and Business Services must use administrative law judges assigned from the office for all contested case hearings regarding matters other than those concerning a claim under ORS chapter 656, as provided in ORS 656.704 (2).*] Except as specifically provided in this subsection, the Department of Consumer and Business Services must use administrative law judges assigned from the office only for contested cases arising out of the department's powers and duties under:

(a) ORS chapter 59;

(b) ORS 200.005 to 200.075;

(c) ORS chapter 455;

(d) ORS chapter 674;

(e) ORS chapters 706 to 716;

(f) ORS chapter 717;

(g) ORS chapters 722, 723, 725 and 726; and

(h) ORS chapters 731, 732, 733, 734, 735, 737, 742, 743, 744, 746, 748 and 750.



(4) Notwithstanding any other provision of law, in any proceeding in which an agency is required to use an administrative law judge assigned from the office, an officer or employee of the agency may not conduct the hearing on behalf of the agency.

(5) Notwithstanding any other provision of ORS 183.600 to 183.690, an agency is not required to use an administrative law judge assigned from the office if:

- (a) Federal law requires that a different administrative law judge or hearing officer be used; or
- (b) Use of an administrative law judge from the office could result in a loss of federal funds.

(6) Notwithstanding any other provision of this section, the Department of Environmental Quality must use administrative law judges assigned from the office only for contested case hearings conducted under the provisions of ORS 183.413 to 183.470.

**SECTION 19. The amendments to ORS 183.635, 656.054, 656.170, 656.245, 656.247, 656.248, 656.254, 656.260, 656.262, 656.283, 656.327, 656.385, 656.440, 656.704 and 656.726 by sections 1, 2, 3, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16 and 18 of this 2005 Act apply to hearings held on or after January 2, 2006.**

**SECTION 20. The amendments to ORS 656.245, 656.262 and 656.726 by sections 4, 10 and 17 of this 2005 Act apply to hearings held on or after January 2, 2008.**

**Passed by House March 24, 2005**

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Chief Clerk of House

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Speaker of House

**Passed by Senate April 27, 2005**

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President of Senate

**Received by Governor:**

.....M.,....., 2005

**Approved:**

.....M.,....., 2005

.....  
Governor

**Filed in Office of Secretary of State:**

.....M.,....., 2005

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Secretary of State