

Agenda

Rulemaking Advisory Committee

Workers' Compensation Division Rules
OAR chapter 436, division 001

Implementation of House Bill 2764

Type of meeting:	Rulemaking advisory committee
Date, time, & place:	Aug. 19, 1:30 to 4:00 p.m. Room F, Labor and Industries Building, Salem, Oregon Dial-in number: 213-787-0529 Access code: 9221262#
Facilitators:	Fred Bruyns, Workers' Compensation Division
1:30 to 1:40	Welcome and introductions; meeting objectives
1:40 to 3:50	Request for new issues – discussion of new issues Discussion of issues on file
3:50 to 4:00	Summing up – next steps Thank you!

- [Issues document](#)
- [House Bill 2764](#)
- [Bulletin 356](#)
- [OAR 436-001-0400 through 0420](#)
- [OAR 438-005-0075](#)
- [OAR 438-015-0110](#)

**OAR 436–001 Rules, Addressing the Implementation of
House Bill 2764 and Other Proposed Changes**

Issues Document for
Stakeholders Advisory Committee

August 19, 2015

BACKGROUND AND SUMMARY OF HOUSE BILL 2764

Statute is the sole source for the authorization of attorney fees in Oregon’s workers’ compensation system. Chapter 656 permits defense lawyers to negotiate their fees with insurance carriers or self-insured employers. However, workers’ attorneys are compensated only in defined circumstances and in the manner and amount permitted by statute; they may not negotiate hourly or contingent fees with their clients. Depending on the circumstance, workers’ attorney fees are either paid by an insurer in addition to any compensation awarded to a worker (assessed fees) or paid by a worker out of the worker’s compensation award (out-of-compensation fees). In some situations, the law sets a dollar cap on the assessed attorney fee that may be awarded. It also establishes the jurisdictions that may award fees: the Workers’ Compensation Division (“WCD”), Administrative Law Judges (“ALJs”), Workers’ Compensation Board (“WCB”), or the courts.

House Bill 2764 (“HB 2764”) contains several provisions expanding the circumstances in which WCD is authorized to issue attorney fees, or the amount of attorney fees WCD may award:

1. ORS 656.262(11)(a) is amended to provide for an award of “reasonable attorney fees” and adds that any jurisdiction awarding that fee must “consider the proportionate benefit to the worker.” Prior to the passage of HB 2764, ORS 656.262(11)(a) made no reference to a reasonable fee and simply stated that the fee awarded must be proportionate to the benefit to the worker.
2. ORS 656.262(11)(a) is further amended to increase the dollar cap on the assessed attorney fee that may be awarded to \$4,000 (adjusted annually based on increases to the State Average Weekly Wage).
3. ORS 656.277(1) is amended to add that WCD may award a reasonable assessed attorney fee if the worker’s attorney is instrumental in obtaining an order reclassifying a claim from nondisabling to disabling.
4. ORS 656.313(1)(b) is amended to add that attorney fees and costs withheld pending appeal accrue interest.
5. ORS 656.385(1) is amended to increase the dollar cap on the assessed attorney fee that may be awarded to \$4,000 (adjusted annually based on increases to the State Average Weekly Wage).
6. ORS 656.385(2) is amended to add a new reasonable assessed attorney fee when the insurer refuses or unreasonably resists payment of attorney fees that are related to medical or vocational benefits and due pursuant to an order of WCD or an ALJ.
7. ORS 656.385(3) is amended to add a new reasonable assessed attorney fee when the insurer initiates an appeal and attorney fees awarded under 656.385(1) and (2) are not disallowed or reduced on appeal.

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8. ORS 656.385(3) is further amended to expand the circumstances in which an attorney fee is assessed when an insurer initiates an appeal disputing medical or vocational benefits, by adding that a reasonable fee must be awarded if all or part of the compensation awarded to the worker is not disallowed or reduced on appeal.
9. ORS 656.388(1) is amended to delete a prohibition on attorney fees for representation before WCD in a non-contested case hearing.

HB 2764 will apply to orders issued and attorney fees incurred on or after January 1, 2016, regardless of the date on which the claim was filed.

Many of the provisions relating to WCD are unlikely to require rule changes. First, adjustments to the maximum attorney fee that may be awarded under ORS 656.262(11)(a) and 656.385(1) are published in WCD Bulletin No. 356. As a result, provisions in the bill impacting those maximum fee amounts do not need to be implemented by formal rulemaking. Further, a number of the amendments impacting WCD are only applicable after an underlying administrative order is appealed, and will only be issued by an ALJ or in a Director Review of a Proposed and Final Order. See, *e.g.*, the amendments to ORS 656.313(1)(b), 656.385(3), and 656.388(1). WCD has, historically, not promulgated rules relating to attorney fees that are issued only in those circumstances.

As a result, the primary focus of this Stakeholders Advisory Committee is on HB 2764's amendments to ORS 656.262(11)(a), 656.277(1), and 656.385(2).

Additionally, WCD is exploring several rule changes that are unrelated to HB 2764, but which relate to the conduct of hearings under WCD's jurisdiction. Those potential rule changes are discussed in detail below in Issues 5, 6, and 7.

ISSUE #1

Re: Should WCD adjust or cease its use of a fee matrix for determining attorney fees awarded under ORS 656.262(11)(a)?

- a) Should WCD continue to use the fee matrix at OAR 436-001-0410 as a guide in determining attorney fees awarded under ORS 656.262(11)(a)?
- b) Should WCD adopt a separate fee matrix for use as a guide in determining attorney fees awarded under ORS 656.262(11)(a)? If so, what factors should be utilized in that fee matrix?
- c) If WCD ceases to use the fee matrix at OAR 436-001-0410 as a guide in determining attorney fees awarded under ORS 656.262(11)(a), what mechanism should WCD use for the determination of the appropriate fee?

BACKGROUND:

ORS 656.262(11)(a) requires the assessment of an attorney fee when an insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, attorney fees or costs, or unreasonably delays acceptance or denial of a claim. HB 2764 amends ORS 656.262(11)(a) to provide for an award of "reasonable attorney fees" and adds that any

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jurisdiction awarding that fee must “consider the proportionate benefit to the worker.” Prior to the passage of HB 2764, ORS 656.262(11)(a) made no reference to a reasonable fee and simply stated that the fee awarded must be proportionate to the benefit to the worker. Further, under both current law and HB 2764, the Workers’ Compensation Board must adopt rules for establishing the amount of the attorney fee awarded under ORS 656.262(11)(a), giving primary consideration to the results achieved and to the time devoted to the case. The Workers’ Compensation Board is currently conducting rulemaking to implement HB 2764 and may promulgate rules to address the statutory revisions to ORS 656.262(11)(a). WCD will be monitoring the Board’s rulemaking process closely and may need to revise its rules in order to maintain consistency with relevant standards adopted by the Board.

Under WCD’s current administrative rules, 436-001-0420 cross-references the WCB’s rules at OAR 438-015-0110 and states WCD may use the WCD’s fee matrix in OAR 436-001-0410 as “a guide in determining the amount of the fee.” The WCD’s fee matrix in OAR 436-001-0410 applies to attorney fees awarded under ORS 656.385(1) and gives primary consideration to the monetary benefit to the injured worker as well as the time the attorney devoted to the case:

Estimated Benefit Achieved	Professional Hours Devoted (Fees as percentage of adjusted maximum attorney fee under ORS 656.385(1))		
	1-4 hours	4.1-8 hours	over 8 hours
\$1-\$2,000	5.0% - 35.0%	15.0% - 50.0%	40.0% - 62.5%
\$2,001-\$4,000	10.0% - 40.0%	30.0% - 65.0%	52.5% - 75.0%
\$4,001-\$6,000	15.0% - 50.0%	40.0% - 72.5%	65.0% - 87.5%
Over \$6000	20.0% - 65.0%	52.5% - 90.0%	77.5% - 100.0%

ORS 656.385(1) requires the assessment of an attorney fee when a worker prevails in a dispute, or the worker’s attorney is instrumental in obtaining settlement in a dispute, related to medical or vocational benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340. Similar to the amended text of ORS 656.262(11)(a), attorney fees awarded per ORS 656.385(1) must be “reasonable” and “proportionate to the benefit to the injured worker.” Further, the Workers’ Compensation Division must adopt rules for establishing the amount of the attorney fee awarded under ORS 656.385(1), giving primary consideration to the results achieved and to the time devoted to the case. Per WCD’s administrative rules, when awarding a fee under ORS 656.385(1) the fee must fall within the ranges of the matrix. When determining what amount within that range should be awarded, WCD may consider the factors listed at OAR 436-001-0400(3).

RULES:

- OAR 436-001-0410 and 436-001-0420.

ALTERNATIVES:

- Do nothing (continue to use the existing matrix as a guide for the determination of reasonable attorney fees awarded under ORS 656.262(11)(a)).

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- Adopt a separate attorney fee matrix for the determination of reasonable attorney fees awarded under ORS 656.262(11)(a).
- Eliminate usage of the attorney fee matrix for the determination of reasonable attorney fees awarded under ORS 656.262(11)(a).

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

ISSUE #2

Re: Should WCD develop rules to implement its authority, under ORS 656.277(1)(b), to assess a reasonable attorney fee when the worker’s attorney is instrumental in obtaining an order from WCD reclassifying a claim from nondisabling to disabling?

- a) Should WCD develop a rule for determining a reasonable fee awarded under ORS 656.277(1)? If so, what factors should be considered? How should the amount of the award be established?
- b) Should a reasonable fee awarded under ORS 656.277(1) include the workers’ attorney’s efforts in requesting reclassification from the insurer (before the dispute is submitted to WCD for review)?
- c) Does a workers’ attorney have any obligation, beyond submitting a request for reclassification, to attempt to resolve a classification dispute with an insurer before seeking an order from WCD?

BACKGROUND:

HB 2764 amends ORS 656.277(1) to add that WCD may award a reasonable assessed attorney fee if the worker’s attorney is instrumental in obtaining an order reclassifying a claim from nondisabling to disabling.

Before a worker may obtain an order from WCD reclassifying a claim from nondisabling to disabling, the worker must submit a request for reclassification to the insurer. If the insurer denies the request for reclassification, the worker may ask WCD to review the insurer’s classification of the claim.

Currently, workers’ attorneys often do substantial work in obtaining and providing to the insurer information relative to a request for reclassification. Such requests often center on the calculation of the worker’s average weekly wage (AWW), and, consequently, whether the worker qualifies for temporary partial disability benefits because of lost wages. The worker’s attorney may obtain wage records, various employment/working condition facts, employment contract information, etc., and provide that to the insurer to prove time loss is due. Some of the information provided by the worker’s attorney in these situations may not be available to the insurer

Under HB 2764, an attorney’s work in obtaining and providing to the insurer information relative to a request for reclassification will not be compensated if the insurer agrees to reclassify the claim as disabling, because the worker’s attorney was not instrumental in “obtaining an order

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from the director”. On the other hand, if the workers’ attorney obtains and provides such information to WCD, after initially requesting reclassification from an insurer, and successfully obtains an order from WCD reclassifying the claim as disabling, the attorney would receive a reasonable assessed attorney fee.

RULES:

- N/A

ALTERNATIVES:

- Do nothing (do not adopt rules relating to the award of attorney fees under 656.277(1)(b)).
- Develop rules to implement WCD’s authority to assess a reasonable attorney fee under ORS 656.277(1)(b).

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

ISSUE #3

Re: Should WCD develop rules to implement its authority, under ORS 656.385(2), to assess a reasonable attorney fee when the insurer refuses or unreasonably resists payment of compensation or attorney fees related to medical or vocational benefits and due pursuant to an order of WCD or an ALJ?

- a) Should WCD develop a rule for determining a reasonable fee awarded under ORS 656.385(2)?
- b) If so, what factors should be considered?
- c) How should the amount of the award be established?

BACKGROUND:

HB 2764 amends ORS 656.385(2) to add that WCD may award a reasonable assessed attorney fee when an insurer refuses or unreasonably resists payment of attorney fees related to medical or vocational benefits under ORS 656.245, 656.247, 656.260, 656.327 or 656.340 and due pursuant to an order of WCD or an ALJ. Current law only permits WCD to award an attorney fee under this provision when an insurer refuses or unreasonably resists payment of compensation related to medical or vocational benefits.

Unlike attorney fees awarded under ORS 656.262(11)(a), fees awarded under ORS 656.385(2) are not subject to a maximum fee amount.

WCD does not currently have administrative rules addressing the manner in which it will award and establish the amount of reasonable attorney fees under ORS 656.385(2).

RULES:

- N/A

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ALTERNATIVES:

- Do nothing.
- Develop rules to implement WCD’s authority to assess a reasonable attorney fee under ORS 656.385(2).

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

ISSUE #4

Re: Should WCD develop rules identifying distinctions between medical service disputes under ORS 656.245 and medical fee disputes under ORS 656.248?

- a) Is it necessary to clarify the manner in which disputes should be categorized between ORS 656.245 and ORS 656.248 for the purpose of the award of attorney fees under ORS 656.385(1)?
- b) If so, what guidelines or kinds of guidelines would be useful for drawing that distinction?
- c) Are there certain kinds of disputes that are more at risk for being incorrectly categorized?
- d) Please feel free to submit examples of cases in which, in your opinion, WCD has incorrectly categorized a dispute under ORS 656.248 rather than 656.245.

BACKGROUND:

ORS 656.385(1) requires the assessment of an attorney fee when a worker prevails in a dispute, or the worker’s attorney is instrumental in obtaining settlement in a dispute, related to medical or vocational benefits pursuant to ORS 656.245, 656.247, 656.260, 656.327 or 656.340. As a result, under ORS 656.385(1), workers’ attorneys do not earn an attorney fee for any work done relative to a ORS 656.248 medical fee dispute. In discussions relating to House Bill 2764, parties expressed concern regarding the manner in which WCD has been categorizing ORS 656.245 and 656.248 disputes. Specifically, their opinion was that WCD occasionally incorrectly categorizes certain kinds of disputes under ORS 656.248 rather than 656.245, and thereby incorrectly precludes any award for attorney fees for work done in connection with the dispute.

RULES:

- OAR 436-001-0410

ALTERNATIVES:

- Do nothing (do not develop rules identifying distinctions between medical service disputes under ORS 656.245 and medical fee disputes under ORS 656.248).
- Develop rules identifying distinctions between medical service disputes under ORS 656.245 and medical fee disputes under ORS 656.248.

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

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ISSUE #5

Re: Should WCD adopt a rule stating that when a claimant mistakenly sends a request for hearing to an insurance carrier, and not WCD, the carrier must forward the misdirected request for hearing to WCD?

- a) Does an insurer have a duty to promptly forward a request for hearing to WCD?
- b) If WCD adopts such a rule, how should WCD enforce the insurer’s obligation to forward hearing requests?

BACKGROUND:

The Workers’ Compensation Board has a rule (OAR 438-005-0075) stating that when a claimant mistakenly sends a request for hearing to an employer or carrier, and not the Board, the carrier must promptly forward the misdirected request for hearing to the Board. WCD has no such rule. Adopting a rule would specify that employers and insurers have a duty to forward misdirected requests for hearing and help to ensure that WCD maintains jurisdiction of otherwise valid disputes.

RULES:

- N/A

ALTERNATIVES:

- Do nothing.
- Adopt a rule stating that when a claimant mistakenly sends a request for hearing to an employer or carrier, and not WCD, the carrier must promptly forward the misdirected request for hearing to WCD.

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

ISSUE #6

Re: Should Division 001 prescribe a form or format for parties to request that WCD issue a subpoena?

BACKGROUND:

Under ORS 656.726(4)(d), WCD may 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.

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WCD's administrative rules currently contain no information on the form and format to request that WCD issue a subpoena.

A stakeholder has proposed that subpoena requests to the director should include:

1. A cover letter outlining the issues presented and including a statement of the purpose and need for the subpoena.
2. A copy of the proposed subpoena or subpoena duces tecum.
3. A document that designates a process server or other individual as a representative of the Director solely for the purpose of service of the subpoena(s).
4. Payment of any fees or costs related to service of process or other administrative expense.

RULES:

- OAR 436-001-0019 through 436-001-0300

ALTERNATIVES:

- Do nothing.
- Adopt a rule prescribing a form or format for parties to request that WCD issue a subpoena.

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

ISSUE #7

Re: Should WCD adopt an administrative rule stating WCD will not refund civil penalty overpayments when the amount is below a stated minimum, unless the party submits a written request for a refund?

- a) Is WCD obligated to refund all civil penalty overpayments, regardless of the amount of overpayment?
- b) If not, should WCD adopt an administrative rule stating WCD will not refund civil penalty overpayments when the amount is below a stated minimum, unless the party submits a written request for a refund?
- c) What would be an appropriate minimum overpayment amount?

BACKGROUND:

WCD has the authority to issue civil penalties in a number of circumstances. Sometimes, civil penalties are overpaid. Overpayments may occur for a number of reasons, for example if an insurer and service company both paid the same penalty, if the penalty was amended or rescinded but the party paid the full amount, if the insurer mistakenly paid twice, simple typographical error, etc. Processing refunds for minimal overpayments (which may be for a few dollars or cents) imposes an administrative burden on WCD, which may outweigh the benefit of processing such refunds.

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RULES:

- N/A

ALTERNATIVES:

- Do nothing.
- Adopt a rule stating WCD will not refund civil penalty overpayments when the amount is below a stated minimum, unless the party submits a written request for a refund

FISCAL IMPACTS [including cost of compliance for small business]:

RECOMMENDATION [Include on final issues document only]

Enrolled House Bill 2764

Sponsored by Representatives FAGAN, WILLIAMSON; Representatives BUCKLEY, CLEM, FREDERICK, GOMBERG, KENY-GUYER, KOMP, LININGER, NOSSE, SMITH WARNER, VEGA PEDERSON, WITT (Pre-session filed.)

CHAPTER

AN ACT

Relating to payments made in workers' compensation claims; creating new provisions; and amending ORS 656.012, 656.262, 656.277, 656.313, 656.382, 656.385, 656.386 and 656.388.

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

SECTION 1. ORS 656.012 is amended to read:

656.012. (1) The Legislative Assembly finds that:

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

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

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

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

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

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

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

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

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

(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner.

SECTION 2. 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)(a) Payment of compensation under subsection (4) of this section or payment, in amounts per claim not to exceed the maximum amount established annually by the Director of the Department of Consumer and Business Services, for medical services for nondisabling claims, may be made by the subject employer if the employer so chooses. The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported. However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection.

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

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

(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Once the claim is accepted, the insurer or self-insured employer shall not revoke acceptance except as provided in this section. The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the insurer or self-insured employer accepts a

claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by an Administrative Law Judge, the Workers' Compensation Board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial. Except as provided in ORS 656.247, pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or funeral expenses. The insurer shall also furnish the employer a copy of the notice of acceptance.

(b) The notice of acceptance shall:

(A) Specify what conditions are compensable.

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

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

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

(E) Inform the claimant of assistance available to employers and workers from the Reemployment Assistance Program under ORS 656.622.

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

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

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

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

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

(c) When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of accept-

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

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

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

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

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

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

(12)(a) If payment is due on a disputed claim settlement authorized by ORS 656.289 and the insurer or self-insured employer has failed to make the payment in accordance with the requirements specified in the disputed claim settlement, the claimant or the claimant's attorney shall clearly notify the insurer or self-insured employer in writing that the payment is past due. If the required payment is not made within five business days after receipt of the notice by the insurer or self-insured employer, the director may assess a penalty and attorney fee in accordance with a matrix adopted by the director by rule.

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

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

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

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

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

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

SECTION 3. ORS 656.277 is amended to read:

656.277. (1)(a) A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order.

(b) If the worker is represented by an attorney and the attorney is instrumental in obtaining an order from the director that reclassifies the claim from nondisabling to disabling, the director may award the attorney a reasonable assessed attorney fee.

(2) A request by the worker that an accepted nondisabling injury was or has become disabling shall be made pursuant to ORS 656.273 as a claim for aggravation, provided the claim has been classified as nondisabling for at least one year after the date of acceptance.

(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

- (a) When a notice of claim denial is filed;
- (b) When the status of the claim is as described in subsection (1) or (2) of this section; or
- (c) When otherwise required by the director.

SECTION 4. ORS 656.313 is amended to read:

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

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

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

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

(D) Vocational benefits ordered by the director pursuant to ORS 656.340 (16). If a denial of vocational benefits is upheld by a final order, the insurer or self-insured employer shall be reimbursed from the Workers' Benefit Fund pursuant to ORS 656.605 for all costs incurred in providing vocational benefits as a result of the order that was appealed.

(b) If ultimately found payable under a final order, benefits withheld under this subsection, **and attorney fees and costs**, shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment. The board shall expedite review of appeals in which payment of compensation has been stayed under this section.

(2) If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal.

(3) If an insurer or self-insured employer denies the compensability of all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. Except for medical services payable in accordance with ORS 656.247, after receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy. If the injured worker has no health insurance, such bills may be submitted to the injured worker. A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined.

(4) Except for medical services payable in accordance with ORS 656.247:

(a) When the compensability issue has been finally determined or when disposition or settlement of the claim has been made pursuant to ORS 656.236 or 656.289 (4), the insurer or self-insured employer shall notify each affected service provider and health insurance provider of the results of the disposition or settlement.

(b) If the services are determined to be compensable, the insurer or self-insured employer shall reimburse each health insurance provider for the amount of claims paid by the health insurance provider pursuant to this section. Such reimbursement shall be in addition to compensation or medical benefits the worker receives. Medical service reimbursement shall be paid directly to the health insurance provider.

(c) If the services are settled pursuant to ORS 656.289 (4), the insurer or self-insured employer shall reimburse, out of the settlement proceeds, each medical service provider for billings received by the insurer or self-insured employer on and before the date on which the terms of settlement are agreed as specified in the settlement document that are not otherwise partially or fully reimbursed.

(d) Reimbursement under this section shall be made only for medical services related to the claim that would be compensable under this chapter if the claim were compensable and shall be made at one-half the amount provided under ORS 656.248. In no event shall reimbursement made to medical service providers exceed 40 percent of the total present value of the settlement amount, except with the consent of the worker. If the settlement proceeds are insufficient to allow each medical service provider the reimbursement amount authorized under this subsection, the insurer or self-insured employer shall reduce each provider's reimbursement by the same proportional amount. Reimbursement under this section shall not prevent a medical service provider or health insurance provider from recovering the balance of amounts owing for such services directly from the worker, unless the worker agrees to pay all medical service providers directly from the settlement proceeds the amount provided under ORS 656.248.

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

SECTION 5. ORS 656.382 is amended to read:

656.382. (1) If an insurer or self-insured employer refuses to pay compensation, **costs or attorney fees** due under an order of an Administrative Law Judge, **the board or the court**, or otherwise unreasonably resists the payment of compensation, **costs or attorney fees**, except as provided in ORS 656.385, the employer or insurer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

(2) If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that **all or part of** the compensation awarded to a claimant should not be disallowed or reduced, or, through the assistance of an attorney, that an order rescinding a notice of closure should not be reversed or **all or part of** the compensation awarded by a reconsideration order issued under ORS 656.268 should not be reduced or disallowed, the employer or insurer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or [the] court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal.

(3) If an employer or insurer raises attorney fees, penalties or costs as a separate issue in a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court initiated by the employer or insurer under this section, and the Administrative Law Judge, board or court finds that the attorney fees, penalties or costs awarded to the claimant should not be disallowed or reduced, the Administrative Law Judge, board or court shall award reasonable additional attorney fees to the attorney for the claimant for efforts in defending the fee, penalty or costs.

(4) If an employer or insurer initiates an appeal to the board or Court of Appeals and the matter is briefed, but the employer or insurer withdraws the appeal prior to a decision by the board or court, resulting in the claimant's prevailing in the matter, the claimant's attorney is entitled to a reasonable attorney fee for efforts in briefing the matter to the board or court.

[3)] (5) If upon reaching a decision on a request for hearing initiated by an employer it is found by the Administrative Law Judge that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, the Administrative Law Judge may order the employer to pay to the claimant such penalty not exceeding \$750 and not less than \$100 as may be reasonable in the circumstances.

SECTION 6. 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, the Director of the Department of Consumer and Business Services, [or] the Administrative Law Judge **or the court** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, [or] an Administrative Law Judge **or the court**, the director, [or] Administrative Law Judge **or court** shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department **or court**. The attorney fee assessed under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed [~~\$3,000~~] **\$4,000** absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this subsection shall be adjusted annually on July 1 by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any.

(2) If an insurer or self-insured employer refuses to pay compensation due under, **or attorney fees related to**, ORS 656.245, 656.247, 656.260, 656.327 or 656.340 pursuant to an order of the director, an Administrative Law Judge or the court or otherwise unreasonably resists the payment of such compensation **or attorney fees**, the insurer or self-insured employer shall pay to the attorney of the claimant a reasonable attorney fee as provided in subsection (3) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.

(3) If a request for a contested case hearing, review on appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an insurer or self-insured employer, and the director, Administrative Law Judge or court finds that **all or part of** the compensation awarded under ORS 656.245, 656.247, 656.260, 656.327 or 656.340 to a claimant, **or attorney fees under this section**, should not be disallowed or reduced, the insurer or self-insured employer shall be required to pay to the attorney of the claimant a reasonable attorney fee in an amount set by the director, [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 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 **or court** may order the insurer or self-insured employer to pay to the claimant such penalty not exceeding \$750 and not less than \$100 as may be reasonable in the circumstances.

(5) Penalties and attorney fees awarded pursuant to this section by the director, an Administrative Law Judge or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant.

SECTION 7. ORS 656.386 is amended to read:

656.386. (1)(a) In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall

allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.

(b) For purposes of this section, a “denied claim” is:

(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

(B) A claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262 (6)(d), which the insurer or self-insured employer does not respond to within 60 days;

(C) A claim for an aggravation made pursuant to ORS 656.273 (2) or for a new medical condition made pursuant to ORS 656.267, which the insurer or self-insured employer does not respond to within 60 days; or

(D) A claim for an initial injury or occupational disease to which the insurer or self-insured employer does not respond within 60 days.

(c) A denied claim shall not be presumed or implied from an insurer’s or self-insured employer’s failure to pay compensation for a previously accepted injury or condition in timely fashion. Attorney fees provided for in this subsection shall be paid by the insurer or self-insured employer.

(2)(a) If a claimant finally prevails against a denial as provided in subsection (1) of this section, the court, board or Administrative Law Judge may order payment of the claimant’s reasonable expenses and costs for records, expert opinions and witness fees.

(b) The court, board or Administrative Law Judge shall determine the reasonableness of witness fees, expenses and costs for the purpose of paragraph (a) of this subsection.

(c) Payments for witness fees, expenses and costs ordered under this subsection shall be made by the insurer or self-insured employer and are in addition to compensation payable to the claimant.

(d) Payments for witness fees, expenses and costs ordered under this subsection may not exceed \$1,500 unless the claimant demonstrates extraordinary circumstances justifying payment of a greater amount.

(3) If a claimant requests claim reclassification as provided in ORS 656.277 and the insurer or self-insured employer does not respond within 14 days of the request, or if the **claimant**, insurer or self-insured employer requests a hearing, review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court and the Director of the Department of Consumer and Business Services, Administrative Law Judge, board or *[the]* court finally determines that the claim should be classified as disabling, the director, Administrative Law Judge, board or *[the]* court may assess a reasonable attorney fee.

(4) In disputes involving a claim for costs, if the claimant prevails on the claim for any increase of costs, the Administrative Law Judge, board, Court of Appeals or Supreme Court shall award a reasonable assessed attorney fee to the claimant’s attorney.

~~[(4)]~~ **(5)** In all other cases, attorney fees shall be paid from the increase in the claimant’s compensation, if any, except as otherwise expressly provided in this chapter.

SECTION 8. ORS 656.388 is amended to read:

656.388. (1) No claim or payment for legal services by an attorney representing the worker or for any other services rendered before an Administrative Law Judge or the Workers’ Compensation Board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Administrative Law Judge or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law Judge, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307 (5), 656.308 (2), 656.382 or 656.386. No attorney fees shall be approved or allowed for representation of the claimant before the managed care organization *[or*

Director of the Department of Consumer and Business Services except for representation at the contested case hearing].

(2) Any claim for payment to a claimant's attorney by the claimant so approved shall, in the manner and to the extent fixed by the Administrative Law Judge, board or such court, be a lien upon compensation.

(3) If an injured worker signs an attorney fee agreement with an attorney for representation on a claim made pursuant to this chapter and additional compensation is awarded to the worker or a settlement agreement is consummated on the claim after the fee agreement is signed and it is shown that the attorney with whom the fee agreement was signed was instrumental in obtaining the additional compensation or settling the claim, the Administrative Law Judge or the board shall grant the attorney a lien for attorney fees out of the additional compensation awarded or proceeds of the settlement in accordance with rules adopted by the board governing the payment of attorney fees.

(4) The board shall, after consultation with the Board of Governors of the Oregon State Bar, establish a schedule of fees for attorneys representing a worker and representing an insurer or self-insured employer, under this chapter. **The Workers' Compensation Board shall review all attorney fee schedules biennially for adjustment.**

(5) The board shall, in establishing the schedule of attorney fees awarded under this chapter, consider the contingent nature of the practice of workers' compensation law and the necessity of allowing the broadest access to attorneys by injured workers and shall give consideration to fees earned by attorneys for insurers and self-insured employers.

[(5)] (6) The board shall approve no claim for legal services by an attorney representing a claimant to be paid by the claimant if fees have been awarded to the claimant or the attorney of the claimant in connection with the same proceeding under ORS 656.268.

[(6)] (7) Insurers and self-insured employers shall make an annual report to the Director of the Department of Consumer and Business Services reporting attorney salaries and other costs of legal services incurred pursuant to this chapter. The report shall be in such form and shall contain such information as the director prescribes.

SECTION 9. Section 10 of this 2015 Act is added to and made a part of ORS chapter 656.

SECTION 10. The claimant's attorney shall be allowed a reasonable assessed attorney fee if:

(1) The claimant's attorney is instrumental in obtaining temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 prior to a decision by an Administrative Law Judge; or

(2) The claimant finally prevails in a dispute over temporary disability compensation benefits pursuant to ORS 656.210, 656.212, 656.262, 656.268 or 656.325 after a request for hearing has been filed.

SECTION 11. Section 10 of this 2015 Act and the amendments to ORS 656.012, 656.262, 656.277, 656.313, 656.382, 656.385, 656.386 and 656.388 by sections 1 to 8 of this 2015 Act apply to orders issued and attorney fees incurred on or after the effective date of this 2015 Act, regardless of the date on which the claim was filed.

Passed by House May 5, 2015

Repassed by House June 10, 2015

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 8, 2015

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2015

Approved:

.....M,....., 2015

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2015

.....
Jeanne P. Atkins, Secretary of State



Oregon

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BULLETIN NO. 356 (Revised) May 18, 2015

TO: All interested parties

SUBJECT: Attorney fees

EFFECTIVE: July 1, 2015

This bulletin publishes the attorney fee matrix under OAR 436-001-0410(1)(d) for attorney fees awarded under ORS 656.385(1). This bulletin replaces Bulletin No. 356 issued May 28, 2014.

ORS 656.385(1) provides that the maximum attorney fee awarded under that subsection is to be adjusted annually on July 1 by the same percentage increase, if any, as made to the average weekly wage defined in ORS 656.211. OAR 436-001-0410(1)(d) provides a matrix for determining the amount of the fee, showing the maximum fee and fee ranges as percentages of the adjusted statutory maximum. The matrix below translates those percentages into dollar amounts, rounded to the nearest whole dollar.

Effective July 1, 2015, the average weekly wage is **\$922.39**, an increase of **3.828** percent over the previous year's average weekly wage. See Bulletin 111 for more information about the average weekly wage. The maximum attorney fee that may be awarded under ORS 656.385(1), absent a showing of extraordinary circumstances, is **\$3,462**.

This matrix applies to attorney fees awarded under ORS 656.385(1) by orders issued July 1, 2015 through June 30, 2016			
Estimated Benefit Achieved	Professional Hours Devoted		
	1-4 hours	4.1-8 hours	over 8 hours
\$1-\$2,000	\$173 - \$1,212	\$519 - \$1,731	\$1,385 - \$2,164
\$2,001-\$4,000	\$346 - \$1,385	\$1,039 - \$2,250	\$1,818 - \$2,597
\$4,001-\$6,000	\$519 - \$1,731	\$1,385 - \$2,510	\$2,250 - \$3,029
Over \$6,000	\$692 - \$2,250	\$1,818 - \$3,116	\$2,683 - \$3,462

This matrix applies to attorney fees awarded under ORS 656.385(1) by orders issued July 1, 2014 through June 30, 2015			
Estimated Benefit Achieved	Professional Hours Devoted		
	1-4 hours	4.1-8 hours	over 8 hours
\$1-\$2,000	\$167 - \$1,167	\$500 - \$1,667	\$1,334 - \$2,084
\$2,001-\$4,000	\$333 - \$1,334	\$1,000 - \$2,167	\$1,750 - \$2,501
\$4,001-\$6,000	\$500 - \$1,667	\$1,334 - \$2,417	\$2,167 - \$2,917
Over \$6,000	\$667 - \$2,167	\$1,750 - \$3,001	\$2,584 - \$3,334

You can find the statutes and rules referenced in this bulletin by going to the Workers' Compensation Division's website at www.wcd.oregon.gov and clicking on "Laws & Rules."

If you have questions about this bulletin, contact the division's legal issues coordinator at 503-947-7162.

/s/ John L. Shilts

John L. Shilts, Administrator
Workers' Compensation Division

Distribution: WCD-LY, electronic mailing lists

436-001-0400 General provisions and requirements for attorney fees awarded by the director

(1) In order to be awarded an attorney fee, the attorney must file with the director a signed attorney retainer agreement.

(2) In cases in which time devoted is a factor in determining the amount of the fee, the attorney should submit a statement of the number of hours spent on the case. If the attorney has submitted a statement of hours and then spends more time on the case, the attorney may submit an updated statement, which the director will consider if an order has not already been issued. If the attorney does not submit a statement of hours, the director will presume the attorney spent one to two hours on the case.

(3) In cases in which a reasonable fee is to be assessed, the director may consider the following factors:

- (a) The time devoted to the case.
- (b) The complexity of the issues involved.
- (c) The value of the interest involved.
- (d) The skill of the attorney and the quality of representation.
- (e) The nature of the proceedings.
- (f) The benefit secured for the worker.
- (g) The risk in a particular case that an attorney's efforts may go uncompensated.
- (h) The assertion of frivolous issues or defenses.

Statutory authority: ORS 656.385(1), 656.726(4)

Statutes implemented: ORS 656.262, 656.385, 656.388, and 656.704

Hist: Amended and renumbered 12-1-2009 from OAR 436-001-0265 as WCD Admin. Order 09-053, eff. 1-1-2010

436-001-0410 Attorney fees awarded under ORS 656.385(1)

(1) In cases in which the director or administrative law judge awards a fee under ORS 656.385(1):

(a) The fee must fall within the ranges of the matrix in subsection (1)(d), unless extraordinary circumstances are shown or the parties otherwise agree.

(b) Extraordinary circumstances are not established merely by exceeding eight hours or a benefit of \$6,000.

(c) The matrix in subsection (1)(d) shows the maximum fee and fee ranges as percentages of the maximum fee under ORS 656.385(1), as adjusted annually by the same percentage increase, if any, to the average weekly wage defined in ORS 656.211. Before July 1 of each year the director will publish, in Bulletin 356, the matrix showing the maximum fee and fee ranges as dollar amounts after the annual adjustment to the statutory maximum fee. Dollar amounts will be rounded to the nearest whole dollar. If the average weekly wage does not change or decreases, the maximum attorney fee awarded under ORS 656.385(1) will not be adjusted for that year.

(d)

Estimated Benefit Achieved	Professional Hours Devoted (Fees as percentage of adjusted maximum attorney fee under ORS 656.385(1))		
	1-4 hours	4.1-8 hours	over 8 hours
\$1-\$2,000	5.0% - 35.0%	15.0% - 50.0%	40.0% - 62.5%
\$2,001-\$4,000	10.0% - 40.0%	30.0% - 65.0%	52.5% - 75.0%
\$4,001-\$6,000	15.0% - 50.0%	40.0% - 72.5%	65.0% - 87.5%
Over \$6000	20.0% - 65.0%	52.5% - 90.0%	77.5% - 100.0%

(2) For purposes of applying the matrix in medical disputes under ORS 656.245, 656.247, 656.260, and 656.327, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The fee allowed by the medical fee schedule in OAR 436-009 for the medical service at issue.

(b) The overall cost of the medical service at issue.

(3) For purposes of applying the matrix in vocational disputes under ORS 656.340, the value of vocational assistance or a training plan, unless determined to be otherwise, falls within the highest range of the matrix for “benefit achieved.” In addition, the following may be considered in determining the value of the results achieved or the benefit to the worker:

(a) The actual or projected cost of the service at issue.

(b) The maximum spending limit in the fee schedule for vocational assistance costs in OAR 436-120-0720 for the service at issue.

Statutory authority: ORS 656.385(1), 656.726(4)

Statutes implemented: ORS 656.262, 656.385, 656.388, and 656.704

Hist: Amended and renumbered 12-1-2009 from OAR 436-001-0265 as WCD Admin. Order 09-053, eff. 1-1-2010

Amended 6-13-2012 as WCD Admin. Order 12-054, eff. 7-1-2012

Amended 11-16-2012 as WCD Admin. Order 12-060, eff. 12-28-12

436-001-0420 Attorney fees awarded under ORS 656.262(11)

In cases in which the director awards a fee under ORS 656.262(11):

(1) OAR 438-015-0110 applies.

(2) The director may use the matrix in OAR 436-001-0410 as a guide in determining the amount of the fee.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.262

Hist: Adopted 12-1-2009 as WCD Admin. Order 09-053, eff. 1-1-2010

Amended 11-16-2012 as WCD Admin. Order 12-060, eff. 12-28-12

438-005-0075

Duty to Forward Misdirected Request

If a claimant sends a request for hearing or Board review to the employer or insurer, the employer or insurer shall promptly forward the request to the Board.

Stat. Auth.: ORS 656.307, ORS 656.388, ORS 656.593 & ORS 656.726(4)

Stats. Implemented: ORS 656.726(4)

Hist.: WCB 5-1987, f. 12-18-87, ef. 1-1-88; WCB 2-1989, f. 3-3-89, ef. 4-1-89

438-015-0110

Attorney Fees in Cases Involving ORS 656.262(11)(a)

If the Director, an Administrative Law Judge, the Board, or the Court find that the insurer or self-insured employer unreasonably delayed or unreasonably refused to pay compensation, or unreasonably delayed acceptance or denial of a claim, an assessed attorney fee shall be awarded in a reasonable amount that:

- (1) Is proportionate to the benefit to the claimant;
- (2) Takes into consideration the factors set forth in OAR 438-015-0010(4), giving primary consideration to the results achieved and to the time devoted to the case; and
- (3) Does not exceed \$3,000, absent a showing of extraordinary circumstances. The maximum attorney fee awarded under this section is subject to an annual adjustment on July 1 as calculated by the Workers' Compensation Division (on behalf of the Director) by the same percentage increase as made to the average weekly wage defined in ORS 656.211, if any. Before July 1 of each year, the Board, by bulletin, will publish the maximum fee, after adjusting the fee by the same percentage increase, if any, to the average weekly wage. Dollar amounts will be rounded to the nearest whole number.

Stat. Auth.: ORS 656.283, 656.388 & 656.726(5)

Stats. Implemented: ORS 656.262(11)(a)

Hist.: WCB 3-2003, f. 12-12-03 cert. ef. 1-1-04; WCB 1-2009, f. 10-7-09, cert. ef. 1-1-10; WCB 2-2012, f. 11-13-12, cert. ef. 1-1-13