LC 2375
2025 Regular Session
10/14/24 (ASD/ps)

D R A F T

SUMMARY

Digest: The Act would make changes to provisions of workers' comp law that deal with the timing of a worker's claim and the worker's engagement in training. (Flesch Readability Score: 60.0).

Allows a worker to receive permanent disability payments and complete the appeal of a notice of closure while engaged in training. Allows the redetermination of a worker's permanent total disability compensation after ceasing to engage in training. Allows a worker to postpone the selection of a training program and engagement in the program until after claim closure becomes final.

A BILL FOR AN ACT

Relating to workers' compensation; amending ORS 656.268 and 656.340.

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

SECTION 1. ORS 656.268 is amended to read:

656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when one of the following conditions is met:

(a) The worker has become medically stationary and there is sufficient information to determine permanent disability. Notwithstanding any other provision of this chapter, a physician or nurse practitioner may not retroactively determine a worker to be medically stationary more than 60

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

days prior to the date of the determination except in the case of claims that are subject to subsection (13) of this section. An insurer or self-insured employer must mail or deliver written notice to a worker and to the worker's attorney, if the worker is represented, within seven days following receipt of information that the worker is medically stationary.

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent disability, the likely permanent disability that would have been due to the current accepted condition shall be estimated.

(c) Without the approval of the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control.

(d) An insurer or self-insured employer finds that a worker who has been receiving permanent total disability benefits has materially improved and is capable of regularly performing work at a gainful and suitable occupation.

(2) If the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately reduced by any sums earned during the training.

(3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the worker, if requested by the worker.

(4) Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

(b) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician or nurse practitioner who has authorized temporary disability benefits for the worker under ORS 656.245 advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician or the nurse practitioner who may authorize temporary disability under ORS 656.245;

(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement;

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter; or

(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending physician or nurse practitioner who has authorized temporary

disability benefits under ORS 656.245 for a home care worker or a personal support worker who has been made a subject worker pursuant to ORS 656.039 advises the home care worker or personal support worker and documents in writing that the home care worker or personal support worker is released to return to modified employment, appropriate modified employment is offered in writing by the Home Care Commission or a designee of the commission to the home care worker or personal support worker for any client of the Department of Human Services who employs a home care worker or personal support worker and the worker fails to begin the employment.

(5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the director.

(b) The insurer or self-insured employer shall issue a notice of closure of the claim to the worker and to the worker's attorney if the worker is represented. The insurer or self-insured employer shall notify the director of the closure in the manner the director prescribes by rule. If the worker is deceased at the time the notice of closure is issued, the insurer or self-insured employer shall mail the worker's copy of the notice of closure, addressed to the estate of the worker, to the worker's last known address and may mail copies of the notice of closure to any known or potential beneficiaries to the estate of the deceased worker.

(c) The notice of closure must inform:

(A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice of closure;

(B) The worker of:

(i) The amount of any further compensation, including permanent disability compensation to be awarded;

(ii) The duration of temporary total or temporary partial disability compensation;

(iii) The right of the worker or beneficiaries of the worker who were mailed a copy of the notice of closure under paragraph (b) of this subsection

to request reconsideration by the director under this section within 60 days of the date of the notice of closure;

(iv) The right of beneficiaries who were not mailed a copy of the notice of closure under paragraph (b) of this subsection to request reconsideration by the director under this section within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection;

(v) The right of the insurer or self-insured employer to request reconsideration by the director under this section within seven days of the date of the notice of closure;

(vi) The aggravation rights; and

(vii) Any other information as the director may require; and

(C) Any beneficiaries of death benefits to which they may be entitled pursuant to ORS 656.204 and 656.208.

(d) If the insurer or self-insured employer has not issued a notice of closure, the worker may request closure. Within 10 days of receipt of a written request from the worker, the insurer or self-insured employer shall issue a notice of closure if the requirements of this section have been met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of:

(A) The decision not to close;

(B) The right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close;

(C) The right to be represented by an attorney; and

(D) Any other information as the director may require.

(e) If a worker, a worker's beneficiary, an insurer or a self-insured employer objects to the notice of closure, the objecting party first must request reconsideration by the director under this section. A worker's request for reconsideration must be made within 60 days of the date of the notice of closure. If the worker is deceased at the time the notice of closure is issued, a request for reconsideration by a beneficiary of the worker who was mailed

a copy of the notice of closure under paragraph (b) of this subsection must be made within 60 days of the date of the notice of closure. A request for reconsideration by a beneficiary to the estate of a deceased worker who was not mailed a copy of the notice of closure under paragraph (b) of this subsection must be made within one year of the date the notice of closure was mailed to the estate of the worker under paragraph (b) of this subsection. A request for reconsideration by an insurer or self-insured employer may be based only on disagreement with the findings used to rate impairment and must be made within seven days of the date of the notice of closure.

(f) If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant.

(g) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from a determination order issued by the director that addresses the extent of the worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f), the penalty shall not be assessed.

(6)(a) Notwithstanding any other provision of law, only one reconsider-

ation proceeding may be held on each notice of closure. At the reconsideration proceeding:

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter, interpreter services, if necessary, and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance with this subparagraph may be received as evidence at a hearing even if the deposition is not prepared in time for use in the reconsideration proceeding.

(B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 at the time of claim closure.

(C) If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

(b) If necessary, the director may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days.

(c) In any reconsideration proceeding under this section in which the worker was represented by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney, out of the additional compensation awarded, an amount equal to 10 percent of any additional com-

pensation awarded to the worker.

(d) Except as provided in subsection (7) of this section, the reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date the reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed or the director postponed the reconsideration pursuant to paragraph (b) of this subsection, or within such additional time as provided in subsection (8) of this section when reconsideration is postponed further because the worker has failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure was mailed on the date the order was due to issue.

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's or a beneficiary's request for reconsideration pursuant to subsection (5)(e) of this section. If the insurer or self-insured employer requests reconsideration, the period for reconsideration begins upon the earlier of the date of the request for reconsideration by the worker or beneficiary, the date of receipt of a waiver from the worker or beneficiary of the right to request reconsideration or the date of expiration of the right of the worker or beneficiary to request reconsideration. If a party elects not to file a separate request for reconsideration, the party does not waive the right to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

(f) Any medical arbiter report may be received as evidence at a hearing

even if the report is not prepared in time for use in the reconsideration proceeding.

(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

(7)(a) The director may delay the reconsideration proceeding and toll the reconsideration timeline established under subsection (6) of this section for up to 45 calendar days if:

(A) A request for reconsideration of a notice of closure has been made to the director within 60 days of the date of the notice of closure;

(B) The parties are actively engaged in settlement negotiations that include issues in dispute at reconsideration;

(C) The parties agree to the delay; and

(D) Both parties notify the director before the 18th working day after the reconsideration proceeding has begun that they request a delay under this subsection.

(b) A delay of the reconsideration proceeding granted by the director under this subsection expires:

(A) If a party requests the director to resume the reconsideration proceeding before the expiration of the delay period;

(B) If the parties reach a settlement and the director receives a copy of the approved settlement documents before the expiration of the delay period; or

(C) On the next calendar day following the expiration of the delay period authorized by the director.

(c) Upon expiration of a delay granted under this subsection, the timeline for the completion of the reconsideration proceeding shall resume as if the delay had never been granted.

(d) Compensation due the worker shall continue to be paid during the period of delay authorized under this subsection.

(e) The director may authorize only one delay period for each reconsid-

eration proceeding.

(8)(a) If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.

(b) If the director determines that insufficient medical information is available to determine disability, the director may appoint, and refer the claim to, a medical arbiter.

(c) At the request of either of the parties, the director shall appoint a panel of as many as three medical arbiters in accordance with criteria that the director sets by rule.

(d) The arbiter, or panel of medical arbiters, must be chosen from among a list of physicians qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) whom the director selected in consultation with the Oregon Medical Board and the committee referred to in ORS 656.790.

(e)(A) The medical arbiter or panel of medical arbiters may examine the worker and perform such tests as may be reasonable and necessary to establish the worker's impairment.

(B) If the director determines that the worker failed to attend the examination without good cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

(C) At the conclusion of the 60-day postponement period, if the worker has not attended and cooperated with a medical arbiter examination or established good cause, the worker may not attend a medical arbiter examination for this claim closure. The reconsideration record must be closed, and

the director shall issue an order on reconsideration based upon the existing record.

(D) All disability benefits suspended under this subsection, including all disability benefits awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Compensation Board or upon court review, are not due and payable to the worker.

(f) The insurer or self-insured employer shall pay the costs of examination and review by the medical arbiter or panel of medical arbiters.

(g) The findings of the medical arbiter or panel of medical arbiters must be submitted to the director for reconsideration of the notice of closure.

(h) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the director, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure.

(i)(A) If the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of the reconsideration or that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter before completing the reconsideration proceeding.

(B) If the worker's condition has substantially changed since the notice of closure, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section.

(9) No hearing shall be held on any issue that was not raised and preserved before the director at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing.

(10)**(a)** If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, [*any permanent disability payments due for work disability under the closure shall be suspended, and*] the

worker shall receive temporary disability compensation and any permanent disability payments due for impairment while the worker is enrolled and actively engaged in the training.

(b) Nothing in this chapter shall be interpreted to prevent a worker from completing the appeal of a notice of closure while enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726.

(c) When the worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for work disability **and permanent total disability** only.

(d) If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

(11) If the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter.

(12) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent

or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

(13) An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker may not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

(14)(a) An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker.

(b) An insurer or self-insured employer may suspend and offset any compensation payable to the beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the death of the worker.

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

(16)(a) Except as provided under subsection (13) of this section, an insurer or self-insured employer may not recover an overpayment from a worker's permanent partial disability compensation for overpayments, offsets or credits of wage loss in an amount that exceeds 50 percent of the total compen-

sation awarded to the worker.

(b) An insurer or self-insured employer may not declare an overpayment of any compensation that was paid more than two years prior to the date of the declaration.

SECTION 2. ORS 656.340 is amended to read:

656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be provided to an injured worker who is eligible for assistance in returning to work.

(b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for vocational assistance within five days of:

(A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical or investigation report, notification from the worker, or otherwise; or

(B) The time the worker is medically stationary, if the worker has not returned to or been released for the worker's regular employment or has not returned to other suitable employment with the employer at the time of injury or aggravation and the worker is not receiving vocational assistance.

(c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new information that would change the eligibility determination.

(2) Contact under subsection (1) of this section shall include informing the worker about reemployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job site modification assistance and the provisions of the preferred worker program pursuant to rules adopted by the Director of the Department of Consumer and Business Services.

(3) Within five days after notification that the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 has released a worker to return to work, the insurer or self-insured employer shall inform the worker about the opportunity to seek re-

employment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the employer of the worker's reemployment rights, wage subsidy and the job site modification assistance and the provisions of the preferred worker program.

(4) As soon as possible, and not more than 30 days after the contact required by subsection (1) of this section, the insurer or self-insured employer shall cause an individual certified by the director to provide vocational assistance to determine whether the worker is eligible for vocational assistance. The insurer or self-insured employer shall notify the worker of the decision regarding the worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the worker is not eligible, the worker may apply to the director for review of the decision as provided in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under standards prescribed by the director, may not be found eligible thereafter unless that eligibility determination is rejected by the director under subsection (16) of this section or the worker's condition worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for such benefits arises from a worsening of the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS 656.273.

(5) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the weekly wage currently being paid for employment which was the worker's regular employment even though the wage available following employment may be less than the wage prescribed by subsection (6) of this section. As used in this subsection and subsection (6) of this section, "regular employment" means the employment the worker held at the time of the injury or the claim for aggravation under ORS 656.273, whichever gave rise to the potential eligibility for vocational as-

sistance; or, for a worker not employed at the time of the aggravation, the employment the worker held on the last day of work prior to the aggravation.

(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A "substantial handicap to employment" exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) "Suitable employment" means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and

(iii) Employment that produces a weekly wage within 20 percent of that currently being paid for employment that was the worker's regular employment as defined in subsection (5) of this section. The director shall adopt rules providing methods of calculating the weekly wage currently being paid for the worker's regular employment for use in determining eligibility and for providing assistance to eligible workers. If the worker's regular employment was seasonal or temporary, the worker's wage shall be averaged based on a combination of the worker's earned income and any unemployment insurance payments. Only earned income evidenced by verifiable documentation such as federal or state tax returns shall be used in the calculation. Earned income does not include fringe benefits or reimbursement of the worker's employment expenses.

(7) Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance,

including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training.

(8) An insurer or self-insured employer may utilize its own staff or may engage any other individual certified by the director to perform the vocational evaluation required by subsection (4) of this section.

(9) The director shall adopt rules providing:

(a) Standards for and methods of certifying individuals qualified by education, training and experience to provide vocational assistance to injured workers;

(b) Standards for registration of vocational assistance providers;

(c) Conditions and procedures under which the certification of an individual to provide vocational assistance services or the registration of a vocational assistance provider may be suspended or revoked for failure to maintain compliance with the certification or registration standards;

(d) Standards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work; and

(e) Procedures, schedules and conditions relating to the payment for services performed by a vocational assistance provider, that are based on payment for specific services performed and not fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for direct worker purchases and for all vocational assistance providers and shall be the same within suitable geographic areas.

(10) Insurers and self-insured employers shall maintain records and make reports to the director of vocational assistance actions at times and in the manner as the director may prescribe. The requirements prescribed shall be for the purpose of assisting the Department of Consumer and Business Services in monitoring compliance with this section to insure that workers receive timely and appropriate vocational assistance. The director shall

minimize to the greatest extent possible the number, extent and kinds of reports required. The director shall compile a list of organizations or agencies registered to provide vocational assistance. A current list shall be distributed by the director to all insurers and self-insured employers. The insurer shall send the list to each worker with the notice of eligibility.

(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer shall notify the director and the director shall select a provider. Any change in the choice of vocational assistance provider is subject to the approval of the director.

(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months. The insurer or self-insured employer may voluntarily extend the payment of temporary disability compensation to a maximum of 21 months. The director may order the payment of temporary disability compensation for up to 21 months upon good cause shown by the injured worker. The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months.

(13) As used in this section, "vocational assistance provider" means a public or private organization or agency that provides vocational assistance to injured workers.

(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the same type or extent of assistance.

(b) Training shall not be provided to an eligible worker solely because the worker cannot obtain employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage signif-

icantly closer to that prescribed in subsection (6) of this section.

(c) Nothing in this section shall be interpreted to expand the availability of training under this section.

(15) A physical capacities evaluation shall be performed in conjunction with vocational assistance or determination of eligibility for such assistance at the request of the insurer or self-insured employer or worker. The request shall be made to the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245. The attending physician or nurse practitioner, within 20 days of the request, shall perform a physical capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer and the worker in writing that the injured worker is incapable of participating in a physical capacities evaluation.

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

(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter. Application for review must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time.

(c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. The agreement is subject to reconsideration by the director under limitations pre-

scribed by the director, but is not subject to review by any other forum.

(d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order based on a record sufficient to permit review. The order is subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the date the order was issued. At the hearing, the order of the director shall be modified only if it:

(A) Violates a statute or rule;

(B) Exceeds the statutory authority of the agency;

(C) Was made upon unlawful procedure; or

(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(e) For purposes of this subsection, the term "parties" does not include a noncomplying employer.

(17) Notwithstanding any other provision of this chapter, a worker may postpone the selection of a training program, and the date of enrollment and active engagement in the program, according to rules adopted pursuant to this section and ORS 656.726, until the claim is closed and any appeal of the claim closure becomes final.

(18) Nothing in this chapter shall be interpreted to prevent an injured worker from requesting a lump sum payment of the worker's permanent partial disability after the date of enrollment and active engagement in training according to rules adopted pursuant to this section and ORS 656.726.
