

A-Engrossed
House Bill 2218

Ordered by the House April 4
Including House Amendments dated April 4

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires insurer to make lump sum payment of permanent partial disability award if requested by worker unless specified condition exists. Eliminates review of lump sum payment by Director of Department of Consumer and Business Services. Authorizes director to approve or deny certain changes of worker's attending physician or nurse practitioner without advice of physician. Eliminates requirement of adoption of temporary rule by director to award compensation on reconsideration for worker's disability not addressed by standards for evaluation of disabilities. Authorizes director to assess civil penalty against managed care organization on same bases as against employer or insurer.

A BILL FOR AN ACT

1
2 Relating to workers' compensation; amending ORS 656.230, 656.245, 656.268, 656.304, 656.726 and
3 656.745.

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

5 **SECTION 1.** ORS 656.230 is amended to read:

6 656.230. (1) [*Where*] **When** a worker has been awarded compensation for permanent partial dis-
7 ability, [*and the award has become final by operation of law or waiver of the right to appeal its ade-*
8 *quacy, the insurer shall upon the worker's application pay all or any part of the remaining unpaid*
9 *award to the worker in a lump sum, unless the insurer disagrees with payment, in which case the*
10 *insurer, within 14 days, will refer the matter to the Director of the Department of Consumer and*
11 *Business Services to determine whether all or part of the lump sum should be paid. The director's de-*
12 *cision shall be final and not subject to review. Any remaining balance shall be paid pursuant to ORS*
13 *656.216.*] **and the worker requests payment of all or part of the award in a lump sum payment,**

14 **the insurer shall make the payment requested unless the:**

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

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

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

19 (d) **Worker is enrolled and actively engaged in training according to rules adopted pur-**
20 **suant to ORS 656.340 and 656.726.**

21 (2) **Any unpaid balance of the award not paid in a lump sum payment shall be paid pur-**
22 **suant to ORS 656.216.**

23 [(2)] (3) In all cases where the award for permanent partial disability does not exceed \$6,000,

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.

1 the insurer or the self-insured employer shall pay all of the award to the worker in a lump sum.

2 **SECTION 2.** ORS 656.245 is amended to read:

3 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
4 to be provided medical services for conditions caused in material part by the injury for such period
5 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
6 656.225, including such medical services as may be required after a determination of permanent
7 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
8 insurer or the self-insured employer shall cause to be provided only those medical services directed
9 to medical conditions caused in major part by the injury.

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

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

17 (A) Services provided to a worker who has been determined to be permanently and totally dis-
18 abled.

19 (B) Prescription medications.

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

22 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

43 (d) When the medically stationary date in a disabling claim is established by the insurer or
44 self-insured employer and is not based on the findings of the attending physician, the insurer or
45 self-insured employer is responsible for reimbursement to affected medical service providers for

1 otherwise compensable services rendered until the insurer or self-insured employer provides written
2 notice to the attending physician of the worker's medically stationary status.

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

10 (2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
11 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
12 may subsequently change attending physician or nurse practitioner two times without approval from
13 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
14 insurer or self-insured employer may require the director's approval of the selection [*and, if re-*
15 *quested, the director shall determine with the advice of one or more physicians, whether the selection*
16 *by the worker shall be approved*]. The decision of the director is subject to review under ORS
17 656.704. The worker also may choose an attending doctor or physician in another country or in any
18 state or territory or possession of the United States with the prior approval of the insurer or self-
19 insured employer.

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

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

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

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

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

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

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

45 (3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice

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

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

8 (a) Those workers who are subject to the contract shall receive medical services in the manner
9 prescribed in the contract. Workers subject to the contract include those who are receiving medical
10 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
11 jury or medically stationary status, on or after the effective date of the contract. If the managed
12 care organization determines that the change in provider would be medically detrimental to the
13 worker, the worker shall not become subject to the contract until the worker is found to be med-
14 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
15 ganization determines that the change in provider is no longer medically detrimental, whichever
16 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
17 notice of the worker's enrollment in the managed care organization, or upon the third day after the
18 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
19 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
20 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
21 vide compensable medical services under this section under an expired or terminated managed care
22 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
23 and conditions regarding services performed under any subsequent managed care organization con-
24 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
25 primary residence is more than 100 miles outside the managed care organization's certified ge-
26 ographical area. Each such contract must comply with the certification standards provided in ORS
27 656.260. However, a worker may receive immediate emergency medical treatment that is
28 compensable from a medical service provider who is not a member of the managed care organization.
29 Insurers or self-insured employers who contract with a managed care organization for medical ser-
30 vices shall give notice to the workers of eligible medical service providers and such other informa-
31 tion regarding the contract and manner of receiving medical services as the director may prescribe.
32 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
33 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
34 as a processing agent or the assigned claims agent and a managed care organization.

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

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

1 self-insured employer if this election is made.

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

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

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

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

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

29 **SECTION 3.** ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and section
30 4, chapter 26, Oregon Laws 2005, is amended to read:

31 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
32 to be provided medical services for conditions caused in material part by the injury for such period
33 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
34 656.225, including such medical services as may be required after a determination of permanent
35 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
36 insurer or the self-insured employer shall cause to be provided only those medical services directed
37 to medical conditions caused in major part by the injury.

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

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

45 (A) Services provided to a worker who has been determined to be permanently and totally dis-

1 abled.

2 (B) Prescription medications.

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

5 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

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

45 (b) A medical service provider who is not a member of a managed care organization is subject

1 to the following provisions:

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

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

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

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

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

45 (b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-

1 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
 2 vices from the managed care organization.

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

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

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

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

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

30 **SECTION 4.** ORS 656.268 is amended to read:

31 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
 32 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
 33 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
 34 Department of Consumer and Business Services, and determine the extent of the worker's permanent
 35 disability, provided the worker is not enrolled and actively engaged in training according to rules
 36 adopted by the director pursuant to ORS 656.340 and 656.726, when:

37 (a) The worker has become medically stationary and there is sufficient information to determine
 38 permanent disability;

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

45 (c) Without the approval of the attending physician or nurse practitioner authorized to provide

1 compensable medical services under ORS 656.245, the worker fails to seek medical treatment for a
2 period of 30 days or the worker fails to attend a closing examination, unless the worker
3 affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or

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

7 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
8 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
9 duced by any sums earned during the training.

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

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

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

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

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

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

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

30 (C) Is not with the employer at injury;

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

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

34 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
35 gaining agreement; or

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

38 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
39 ability in closure of the claim shall be pursuant to the standards prescribed by the director. The
40 insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the
41 worker's attorney if the worker is represented, and to the director. The notice must inform:

42 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
43 isfied with the terms of the notice;

44 (B) The worker of the amount of any further compensation, including permanent disability
45 compensation to be awarded; of the duration of temporary total or temporary partial disability

1 compensation; of the right of the worker to request reconsideration by the director under this sec-
 2 tion within 60 days of the date of the notice of claim closure; of the right of the insurer or self-
 3 insured employer to request reconsideration by the director under this section within seven days
 4 of the date of the notice of claim closure; of the aggravation rights; and of such other information
 5 as the director may require; and

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

8 (b) If the insurer or self-insured employer has not issued a notice of closure, the worker may
 9 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
 10 self-insured employer shall issue a notice of closure if the requirements of this section have been
 11 met or a notice of refusal to close if the requirements of this section have not been met. A notice
 12 of refusal to close shall advise the worker of the decision not to close; of the right of the worker
 13 to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to
 14 close the claim; of the right to be represented by an attorney; and of such other information as the
 15 director may require.

16 (c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting
 17 party first must request reconsideration by the director under this section. A worker's request for
 18 reconsideration must be made within 60 days of the date of the notice of closure. A request for re-
 19 consideration by an insurer or self-insured employer may be based only on disagreement with the
 20 findings used to rate impairment and must be made within seven days of the date of the notice of
 21 closure.

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

28 (e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
 29 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
 30 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
 31 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
 32 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
 33 the claimant. If the increase in compensation results from information that the insurer or self-
 34 insured employer demonstrates the insurer or self-insured employer could not reasonably have
 35 known at the time of claim closure, from new information obtained through a medical arbiter ex-
 36 amination or from *[the adoption of a temporary emergency rule]* **a determination order issued by**
 37 **the director that addresses the extent of the worker's permanent disability that is not based**
 38 **on the standards adopted pursuant to ORS 656.726 (4)(f)**, the penalty shall not be assessed.

39 (6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
 40 held on each notice of closure. At the reconsideration proceeding:

41 (A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
 42 worker about the worker's condition at the time of claim closure, shall become part of the recon-
 43 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
 44 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
 45 cost of the court reporter and one original of the transcript of the deposition for the Department

1 of Consumer and Business Services and one copy of the transcript of the deposition for each party
2 shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be
3 postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance
4 with this subparagraph may be received as evidence at a hearing even if the deposition is not pre-
5 pared in time for use in the reconsideration proceeding.

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

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

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

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

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

30 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
31 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
32 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
33 the period for reconsideration begins upon the earlier of the date of the request for reconsideration
34 by the worker, the date of receipt of a waiver from the worker of the right to request reconsider-
35 ation or the date of expiration of the right of the worker to request reconsideration. If a party elects
36 not to file a separate request for reconsideration, the party does not waive the right to fully par-
37 ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration
38 if the initiating party withdraws the request for reconsideration.

39 (f) Any medical arbiter report may be received as evidence at a hearing even if the report is
40 not prepared in time for use in the reconsideration proceeding.

41 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
42 656.283 within 30 days from the date of the reconsideration order.

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

1 (b) If neither party requests a medical arbiter and the director determines that insufficient
2 medical information is available to determine disability, the director may refer the claim to a med-
3 ical arbiter appointed by the director.

4 (c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

5 (d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians
6 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the
7 director in consultation with the Board of Medical Examiners for the State of Oregon and the
8 committee referred to in ORS 656.790.

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

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

18 (C) At the conclusion of the 60-day postponement period, if the worker has not attended and
19 cooperated with a medical arbiter examination or established good cause, there shall be no further
20 opportunity for the worker to attend a medical arbiter examination for this claim closure. The re-
21 consideration record shall be closed, and the director shall issue an order on reconsideration based
22 upon the existing record.

23 (D) All disability benefits suspended pursuant to this subsection, including all disability benefits
24 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Com-
25 pensation Board or upon court review, shall not be due and payable to the worker.

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

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

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

33 (i)(A) When the basis for objection to a notice of closure issued under this section is a disa-
34 greement with the impairment used in rating the worker's disability, and the director determines
35 that the worker is not medically stationary at the time of the reconsideration or that the closure
36 was not made pursuant to this section, the director is not required to appoint a medical arbiter prior
37 to the completion of the reconsideration proceeding.

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

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

44 (9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
45 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,

1 any permanent disability payments due for work disability under the closure shall be suspended, and
 2 the worker shall receive temporary disability compensation and any permanent disability payments
 3 due for impairment while the worker is enrolled and actively engaged in the training. When the
 4 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
 5 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
 6 if the worker's accepted injury is no longer the major contributing cause of the worker's combined
 7 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
 8 duration of temporary total or temporary partial disability compensation. Permanent disability
 9 compensation shall be redetermined for work disability only. If the worker has returned to work or
 10 the worker's attending physician has released the worker to return to regular or modified employ-
 11 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
 12 be appealed only in the same manner as are other notices of closure under this section.

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

17 (11) Any notice of closure made under this section may include necessary adjustments in com-
 18 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
 19 bility payments prematurely made, crediting temporary disability payments against current or future
 20 permanent or temporary disability awards or payments and requiring the payment of temporary
 21 disability payments which were payable but not paid.

22 (12) An insurer or self-insured employer may take a credit or offset of previously paid workers'
 23 compensation benefits or payments against any further workers' compensation benefits or payments
 24 due a worker from that insurer or self-insured employer when the worker admits to having obtained
 25 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
 26 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
 27 fits or payments obtained through fraud by a worker shall not be included in any data used for
 28 ratemaking or individual employer rating or dividend calculations by a guaranty contract insurer,
 29 a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund
 30 Corporation or the director.

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

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

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

42 **SECTION 5.** ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12,
 43 chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461,
 44 Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

45 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and

1 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
2 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
3 Department of Consumer and Business Services, and determine the extent of the worker's permanent
4 disability, provided the worker is not enrolled and actively engaged in training according to rules
5 adopted by the director pursuant to ORS 656.340 and 656.726, when:

6 (a) The worker has become medically stationary and there is sufficient information to determine
7 permanent impairment;

8 (b) The accepted injury is no longer the major contributing cause of the worker's combined or
9 consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because
10 the accepted injury is no longer the major contributing cause of the worker's combined or conse-
11 quential condition or conditions, and there is sufficient information to determine permanent impair-
12 ment, the likely impairment and adaptability that would have been due to the current accepted
13 condition shall be estimated;

14 (c) Without the approval of the attending physician, the worker fails to seek medical treatment
15 for a period of 30 days or the worker fails to attend a closing examination, unless the worker
16 affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or

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

20 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
21 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
22 duced by any sums earned during the training.

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

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

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

28 (b) The attending physician advises the worker and documents in writing that the worker is
29 released to return to regular employment;

30 (c) The attending physician advises the worker and documents in writing that the worker is
31 released to return to modified employment, such employment is offered in writing to the worker and
32 the worker fails to begin such employment. However, an offer of modified employment may be re-
33 fused by the worker without the termination of temporary total disability benefits if the offer:

34 (A) Requires a commute that is beyond the physical capacity of the worker according to the
35 worker's attending physician;

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

40 (C) Is not with the employer at injury;

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

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

44 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
45 gaining agreement; or

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

3 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
4 ability in closure of the claim shall be pursuant to the standards prescribed by the director. The
5 insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the
6 worker's attorney if the worker is represented, and to the director. The notice must inform:

7 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
8 isfied with the terms of the notice;

9 (B) The worker of the amount of any further compensation, including permanent disability
10 compensation to be awarded; of the duration of temporary total or temporary partial disability
11 compensation; of the right of the worker to request reconsideration by the director under this sec-
12 tion within 60 days of the date of the notice of claim closure; of the right of the insurer or self-
13 insured employer to request reconsideration by the director under this section within seven days
14 of the date of the notice of claim closure; of the aggravation rights; and of such other information
15 as the director may require; and

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

18 (b) If the insurer or self-insured employer has not issued a notice of closure, the worker may
19 request closure. Within 10 days of receipt of a written request from the worker, the insurer or
20 self-insured employer shall issue a notice of closure if the requirements of this section have been
21 met or a notice of refusal to close if the requirements of this section have not been met. A notice
22 of refusal to close shall advise the worker of the decision not to close; of the right of the worker
23 to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to
24 close the claim; of the right to be represented by an attorney; and of such other information as the
25 director may require.

26 (c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting
27 party first must request reconsideration by the director under this section. A worker's request for
28 reconsideration must be made within 60 days of the date of the notice of closure. A request for re-
29 consideration by an insurer or self-insured employer may be based only on disagreement with the
30 findings used to rate impairment and must be made within seven days of the date of the notice of
31 closure.

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

38 (e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
39 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
40 for either a scheduled or unscheduled permanent disability and the worker is found upon reconsid-
41 eration to be at least 20 percent permanently disabled, a penalty shall be assessed against the
42 insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all
43 compensation determined to be then due the claimant. If the increase in compensation results from
44 information that the insurer or self-insured employer demonstrates the insurer or self-insured em-
45 ployer could not reasonably have known at the time of claim closure, from new information obtained

1 through a medical arbiter examination or from *[the adoption of a temporary emergency rule]* a **de-**
 2 **termination order issued by the director that addresses the extent of the worker's perma-**
 3 **nent disability that is not based on the standards adopted pursuant to ORS 656.726 (4)(f)**, the
 4 penalty shall not be assessed.

5 (6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
 6 held on each notice of closure. At the reconsideration proceeding:

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

17 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
 18 may correct information in the record that is erroneous and may submit any medical evidence that
 19 should have been but was not submitted by the attending physician at the time of claim closure.

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

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

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

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

40 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
 41 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
 42 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
 43 the period for reconsideration begins upon the earlier of the date of the request for reconsideration
 44 by the worker, the date of receipt of a waiver from the worker of the right to request reconsider-
 45 ation or the date of expiration of the right of the worker to request reconsideration. If a party elects

1 not to file a separate request for reconsideration, the party does not waive the right to fully par-
2 ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration
3 if the initiating party withdraws the request for reconsideration.

4 (f) Any medical arbiter report may be received as evidence at a hearing even if the report is
5 not prepared in time for use in the reconsideration proceeding.

6 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
7 656.283 within 30 days from the date of the reconsideration order.

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

11 (b) If neither party requests a medical arbiter and the director determines that insufficient
12 medical information is available to determine disability, the director may refer the claim to a med-
13 ical arbiter appointed by the director.

14 (c) At the request of either of the parties, a panel of three medical arbiters shall be appointed.

15 (d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians
16 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the
17 director in consultation with the Board of Medical Examiners for the State of Oregon and the
18 committee referred to in ORS 656.790.

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

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

28 (C) At the conclusion of the 60-day postponement period, if the worker has not attended and
29 cooperated with a medical arbiter examination or established good cause, there shall be no further
30 opportunity for the worker to attend a medical arbiter examination for this claim closure. The re-
31 consideration record shall be closed, and the director shall issue an order on reconsideration based
32 upon the existing record.

33 (D) All disability benefits suspended pursuant to this subsection, including all disability benefits
34 awarded in the order on reconsideration, or by an Administrative Law Judge, the Workers' Com-
35 pensation Board or upon court review, shall not be due and payable to the worker.

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

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

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

43 (i)(A) When the basis for objection to a notice of closure issued under this section is a disa-
44 greement with the impairment used in rating the worker's disability, and the director determines
45 that the worker is not medically stationary at the time of the reconsideration or that the closure

1 was not made pursuant to this section, the director is not required to appoint a medical arbiter prior
2 to the completion of the reconsideration proceeding.

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

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

9 (9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
10 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
11 any permanent disability payments due under the closure shall be suspended, and the worker shall
12 receive temporary disability compensation while the worker is enrolled and actively engaged in the
13 training. When the worker ceases to be enrolled and actively engaged in the training, the insurer
14 or self-insured employer shall again close the claim pursuant to this section if the worker is med-
15 ically stationary or if the worker's accepted injury is no longer the major contributing cause of the
16 worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure
17 shall include the duration of temporary total or temporary partial disability compensation. Perma-
18 nent disability compensation shall be redetermined for unscheduled disability only. If the worker has
19 returned to work or the worker's attending physician has released the worker to return to regular
20 or modified employment, the insurer or self-insured employer shall again close the claim. This notice
21 of closure may be appealed only in the same manner as are other notices of closure under this
22 section.

23 (10) If the attending physician has approved the worker's return to work and there is a labor
24 dispute in progress at the place of employment, the worker may refuse to return to that employment
25 without loss of reemployment rights or any vocational assistance provided by this chapter.

26 (11) Any notice of closure made under this section may include necessary adjustments in com-
27 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
28 bility payments prematurely made, crediting temporary disability payments against current or future
29 permanent or temporary disability awards or payments and requiring the payment of temporary
30 disability payments which were payable but not paid.

31 (12) An insurer or self-insured employer may take a credit or offset of previously paid workers'
32 compensation benefits or payments against any further workers' compensation benefits or payments
33 due a worker from that insurer or self-insured employer when the worker admits to having obtained
34 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
35 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
36 fits or payments obtained through fraud by a worker shall not be included in any data used for
37 ratemaking or individual employer rating or dividend calculations by a guaranty contract insurer,
38 a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund
39 Corporation or the director.

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

45 (b) An insurer or self-insured employer may suspend and offset any compensation payable to the

1 beneficiary of the worker, and recover an overpayment of permanent total disability benefits caused
2 by the failure of the worker's beneficiaries to notify the insurer or self-insured employer about the
3 death of the worker.

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

6 **SECTION 6.** ORS 656.304 is amended to read:

7 656.304. A claimant may accept and cash any check given in payment of any award or compen-
8 sation without affecting the right to a hearing, except that the right of hearing on any award shall
9 be waived by acceptance of a lump sum award by a claimant where such lump sum award was
10 granted [on] **as a result of** the claimant's own [application] **request** under ORS 656.230. This section
11 shall not be construed as a waiver of the necessity of complying with ORS 656.283 to 656.298.

12 **SECTION 7.** ORS 656.726 is amended to read:

13 656.726. (1) The Workers' Compensation Board in its name and the Director of the Department
14 of Consumer and Business Services in the director's name as director may sue and be sued, and each
15 shall have a seal.

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

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

22 (b) Administer oaths.

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

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

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

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

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

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

42 (c) Administer oaths.

43 (d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
44 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
45 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director

1 or the director's representatives. The director may require the attendance and testimony of em-
2 ployers, their officers and representatives in any inquiry under this chapter, and the production by
3 employers of books, records, papers and documents without the payment or tender of witness fees
4 on account of such attendance.

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

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

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

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

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

16 (D) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that
17 the worker's disability is not addressed by the standards adopted pursuant to this paragraph,
18 notwithstanding ORS 656.268, the director shall *[stay further proceedings on the reconsideration of the*
19 *claim and shall adopt temporary rules amending the standards to accommodate]*, **in the order on**
20 **reconsideration, determine the extent of permanent disability that addresses** the worker's
21 impairment.

22 (E) Notwithstanding any other provision of this section, only impairment benefits shall be
23 awarded under ORS 656.214 if the worker has been released to regular work by the attending phy-
24 sician or nurse practitioner authorized to provide compensable medical services under ORS 656.245
25 or has returned to regular work at the job held at the time of injury.

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

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

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

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

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

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

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

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

17 **SECTION 8.** ORS 656.726, as amended by section 4, chapter 657, Oregon Laws 2003, section 18,
 18 chapter 811, Oregon Laws 2003, section 17, chapter 26, Oregon Laws 2005, and section 2a, chapter
 19 653, Oregon Laws 2005, is amended to read:

20 656.726. (1) The Workers' Compensation Board in its name and the Director of the Department
 21 of Consumer and Business Services in the director's name as director may sue and be sued, and each
 22 shall have a seal.

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

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

29 (b) Administer oaths.

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

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

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

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

38 (a) Make and declare all rules and issue orders which are reasonably required in the perform-
 39 ance of the director's duties. Unless otherwise specified by law, all reports, claims or other docu-
 40 ments shall be deemed timely provided to the director or board if mailed by regular mail or
 41 delivered within the time required by law. Notwithstanding any other provision of this chapter, the
 42 director may adopt rules to allow for the electronic transmission and filing of reports, claims or
 43 other documents required to be filed under this chapter. Notwithstanding ORS 183.310 to 183.410,
 44 if a matter comes before the director that is not addressed by rule and the director finds that
 45 adoption of a rule to accommodate the matter would be inefficient, unreasonable or unnecessarily

1 burdensome to the public, the director may resolve the matter by issuing an order, subject to review
2 under ORS 656.704. Such order shall not have precedential effect as to any other situation.

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

4 (c) Administer oaths.

5 (d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the at-
6 tendance of witnesses and the production of papers, contracts, books, accounts, documents and tes-
7 timony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director
8 or the director's representatives. The director may require the attendance and testimony of em-
9 ployers, their officers and representatives in any inquiry under this chapter, and the production by
10 employers of books, records, papers and documents without the payment or tender of witness fees
11 on account of such attendance.

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

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

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

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

20 (C) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that
21 the worker's disability is not addressed by the standards adopted pursuant to this paragraph,
22 notwithstanding ORS 656.268, the director shall *[stay further proceedings on the reconsideration of the*
23 *claim and shall adopt temporary rules amending the standards to accommodate]*, **in the order on**
24 **reconsideration, determine the extent of permanent disability that addresses** the worker's
25 impairment.

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

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

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

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

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

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

40 (5) The board may make and declare all rules which are reasonably required in the performance
41 of its duties, including but not limited to rules of practice and procedure in connection with hearing
42 and review proceedings and exercising its authority under ORS 656.278. The board shall adopt
43 standards governing the format and timing of the evidence. The standards shall be uniformly fol-
44 lowed by all Administrative Law Judges and practitioners. The rules may provide for informal pre-
45 hearing conferences in order to expedite claim adjudication, amicably dispose of controversies, if

1 possible, narrow issues and simplify the method of proof at hearings. The rules shall specify who
2 may appear with parties at prehearing conferences and hearings.

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

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

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

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

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

24 **SECTION 9.** ORS 656.745 is amended to read:

25 656.745. (1) The Director of the Department of Consumer and Business Services shall assess a
26 civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for
27 compensation to fail to report accidental injuries, causes employees to collect accidental injury
28 claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or
29 makes it necessary for claimants to resort to proceedings against the employer to secure compen-
30 sation due.

31 (2) The director may assess a civil penalty against an employer, [or] insurer [who] **or managed**
32 **care organization that:**

33 (a) Fails to pay assessments or other payments due to the director under this chapter and is in
34 default; or

35 (b) Fails to comply with statutes, rules or orders of the director regarding reports or other re-
36 quirements necessary to carry out the purposes of this chapter.

37 (3) A civil penalty shall be not more than \$2,000 for each violation or \$10,000 in the aggregate
38 for all violations within any three-month period. Each violation, or each day a violation continues,
39 shall be considered a separate violation.

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

42