74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

House Bill 3085

Sponsored by COMMITTEE ON CONSUMER PROTECTION

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 **as introduced.**

Extends time limit on request for reconsideration of notice of closure in workers' compensation claim. Requires review by medical arbiter of rating of worker's disability based on impairment findings if requested by party. Allows consideration of certain nonmedical evidence at hearings conducted after reconsideration order has been issued.

1 **A BILL FOR AN ACT**

2 Relating to closure of workers' compensation claims; creating new provisions; and amending ORS
3 656.268, 656.283 and 656.295.

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

5 **SECTION 1.** ORS 656.268 is amended to read:

6 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
7 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
8 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
9 Department of Consumer and Business Services, and determine the extent of the worker's permanent
10 disability, provided the worker is not enrolled and actively engaged in training according to rules
11 adopted by the director pursuant to ORS 656.340 and 656.726, when:

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

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

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

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

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

30 (3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors

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.

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; or

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

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

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

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within [*60*] **120** days of the date of the notice of claim closure; of 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 claim closure; of the aggravation rights; and of such other information as the director may require; and

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

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

met or a notice of refusal to close if the requirements of this section have not been met. A notice of refusal to close shall advise the worker of the decision not to close; of the right of the worker to request a hearing pursuant to ORS 656.283 within 60 days of the date of the notice of refusal to close the claim; of the right to be represented by an attorney; and of such other information as the director may require.

(c) If a worker, insurer or 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*] **120** days of the date of the notice of closure. 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.

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

(e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for 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 the adoption of a temporary emergency rule, the penalty [*shall*] **may** not be assessed.

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

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

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

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

(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's request for reconsideration pursuant to subsection (5)(c) of this section. 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, the date of receipt of a waiver from the worker of the right to request reconsideration or the date of expiration of the right of the worker 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) 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 **if requested to do so by a party**.

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

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

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

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

(B) If the director determines that the worker failed to attend the examination without good

cause or failed to cooperate with the medical arbiter, or panel of medical arbiters, the director shall postpone the reconsideration proceedings for up to 60 days from the date of the determination that the worker failed to attend or cooperate, and shall suspend all disability benefits resulting from this or any prior opening of the claim until such time as the worker attends and cooperates with the examination or the request for reconsideration is withdrawn. Any additional evidence regarding good cause must be submitted prior to the conclusion of the 60-day postponement period.

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

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

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

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

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

(i)(A) When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the 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 prior to the completion of the reconsideration proceeding.

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

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

(9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due 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. 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 only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may

be appealed only in the same manner as are other notices of closure under this section.

(10) If the attending physician 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.

(11) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

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

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

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

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

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

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

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

(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, and there is sufficient information to determine permanent impair-

1 ment, the likely impairment and adaptability that would have been due to the current accepted
2 condition shall be estimated;
3 (c) Without the approval of the attending physician, the worker fails to seek medical treatment
4 for a period of 30 days or the worker fails to attend a closing examination, unless the worker
5 affirmatively establishes that such failure is attributable to reasons beyond the worker's control; or
6 (d) An insurer or self-insured employer finds that a worker who has been receiving permanent
7 total disability benefits has materially improved and is capable of regularly performing work at a
8 gainful and suitable occupation.
9 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
10 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-
11 duced by any sums earned during the training.
12 (3) A copy of all medical reports and reports of vocational rehabilitation agencies or counselors
13 shall be furnished to the worker, if requested by the worker.
14 (4) Temporary total disability benefits shall continue until whichever of the following events
15 first occurs:
16 (a) The worker returns to regular or modified employment;
17 (b) The attending physician advises the worker and documents in writing that the worker is
18 released to return to regular employment;
19 (c) The attending physician advises the worker and documents in writing that the worker is
20 released to return to modified employment, such employment is offered in writing to the worker and
21 the worker fails to begin such employment. However, an offer of modified employment may be re-
22 fused 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;
25 (B) Is at a work site more than 50 miles one way from where the worker was injured unless the
26 site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire
27 or as established by the pattern of employment prior to the injury was that the employer had mul-
28 tiple or mobile work sites and the worker could be assigned to any such site;
29 (C) Is not with the employer at injury;
30 (D) Is not at a work site of the employer at injury;
31 (E) Is not consistent with the existing written shift change policy or is not consistent with
32 common practice of the employer at injury or aggravation; or
33 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
34 gaining agreement; or
35 (d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld
36 or terminated under ORS 656.262 (4) or other provisions of this chapter.
37 (5)(a) Findings by the insurer or self-insured employer regarding the extent of the worker's dis-
38 ability in closure of the claim shall be pursuant to the standards prescribed by the director. The
39 insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the
40 worker's attorney if the worker is represented, and to the director. The notice must inform:
41 (A) The parties, in boldfaced type, of the proper manner in which to proceed if they are dissat-
42 isfied with the terms of the notice;
43 (B) The worker of the amount of any further compensation, including permanent disability
44 compensation to be awarded; of the duration of temporary total or temporary partial disability
45 compensation; of the right of the worker to request reconsideration by the director under this sec-

tion within [*60*] **120** days of the date of the notice of claim closure; of 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 claim closure; of the aggravation rights; and of such other information as the director may require; and

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

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

(c) If a worker, insurer or 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*] **120** days of the date of the notice of closure. 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.

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

(e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from 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 the adoption of a temporary emergency rule, the penalty [*shall*] **may** not be assessed.

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

(A) A deposition arranged by the worker, limited to the testimony and cross-examination of the worker about the worker's condition at the time of claim closure, shall become part of the reconsideration record. The deposition must be conducted subject to the opportunity for cross-examination by the insurer or self-insured employer and in accordance with rules adopted by the director. The cost of the court reporter and one original of the transcript of the deposition for the Department of Consumer and Business Services and one copy of the transcript of the deposition for each party shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be

1 postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance
2 with this subparagraph may be received as evidence at a hearing even if the deposition is not pre-
3 pared in time for use in the reconsideration proceeding.
4 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
5 may correct information in the record that is erroneous and may submit any medical evidence that
6 should have been but was not submitted by the attending physician at the time of claim closure.
7 (C) If the director determines that a claim was not closed in accordance with subsection (1) of
8 this section, the director may rescind the closure.
9 (b) If necessary, the director may require additional medical or other information with respect
10 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.
11 (c) In any reconsideration proceeding under this section in which the worker was represented
12 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
13 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
14 pensation awarded to the worker.
15 (d) The reconsideration proceeding shall be completed within 18 working days from the date the
16 reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit
17 within the department. The deadline of 18 working days may be postponed by an additional 60 cal-
18 endar days if within the 18 working days the department mails notice of review by a medical arbiter.
19 If an order on reconsideration has not been mailed on or before 18 working days from the date the
20 reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days
21 where a notice for medical arbiter review was timely mailed or the director postponed the recon-
22 sideration pursuant to paragraph (b) of this subsection, or within such additional time as provided
23 in subsection (7) of this section when reconsideration is postponed further because the worker has
24 failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and
25 any further proceedings shall occur as though an order on reconsideration affirming the notice of
26 closure was mailed on the date the order was due to issue.
27 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
28 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
29 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
30 the period for reconsideration begins upon the earlier of the date of the request for reconsideration
31 by the worker, the date of receipt of a waiver from the worker of the right to request reconsider-
32 ation or the date of expiration of the right of the worker to request reconsideration. If a party elects
33 not to file a separate request for reconsideration, the party does not waive the right to fully par-
34 ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration
35 if the initiating party withdraws the request for reconsideration.
36 (f) Any medical arbiter report may be received as evidence at a hearing even if the report is
37 not prepared in time for use in the reconsideration proceeding.
38 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
39 656.283 within 30 days from the date of the reconsideration order.
40 (7)(a) If the basis for objection to a notice of closure issued under this section is disagreement
41 with the impairment used in rating of the worker's disability, the director shall refer the claim to
42 a medical arbiter appointed by the director **if requested to do so by a party**.
43 (b) If neither party requests a medical arbiter and the director determines that insufficient
44 medical information is available to determine disability, the director may refer the claim to a med-
45 ical arbiter appointed by the director.

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

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

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

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

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

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

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

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

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

(i)(A) When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the 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 prior to the completion of the reconsideration proceeding.

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

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

(9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the insurer

or self-insured employer shall again close the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for unscheduled disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer shall again close the claim. This notice of closure may be appealed only in the same manner as are other notices of closure under this section.

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

(11) Any notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid.

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

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

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

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

SECTION 3. ORS 656.283 is amended to read:

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

(2)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and

extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director is hereby charged with the duty of creating a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

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

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

(A) Violates a statute or rule;

(B) Exceeds the statutory authority of the agency;

(C) Was made upon unlawful procedure; or

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

(d) An appeal of the director's administrative review under paragraph (b) of this subsection must be made within 60 days of the review issue date.

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

(4)(a) The board shall refer the request for hearing to an Administrative Law Judge for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing may not be postponed:

(A) Except in extraordinary circumstances beyond the control of the requesting party; and

(B) For more than 120 days after the date of the postponed hearing.

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

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

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

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

(ii) Make prehearing rulings necessary to promote full discovery and completion of the medical

record required for determination of the issues arising from the claim; and

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

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

(d) If a hearing has been postponed in accordance with paragraph (b) of this subsection:

(A) The director may not consider the timeliness of a denial issued in the claim that is the subject of the hearing for the purpose of imposing a penalty against an insurer or self-insured employer that is potentially responsible for the claim; and

(B) The 120-day maximum postponement established under paragraph (a) of this subsection for rescheduling a hearing does not apply.

(5)(a) At least 60 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. Hearings shall be held in the county where the worker resided at the time of the injury or such other place selected by the Administrative Law Judge.

(b) The 60-day prior notice required by paragraph (a) of this subsection:

(A) May be waived by agreement of the parties and the board if waiver of the notice will result in an earlier date for the hearing.

(B) Does not apply to hearings in cases assigned to the Expedited Claim Service under ORS 656.291, cases involving stayed compensation under ORS 656.313 (1)(b) and requests for hearing that are consolidated with an existing case with an existing hearing date.

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

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

a preponderance of that evidence **establishes** that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. If the Administrative Law Judge finds that the claim has been closed prematurely, the Administrative Law Judge shall issue an order rescinding the notice of closure.

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

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

SECTION 4. ORS 656.295 is amended to read:

656.295. (1) The request for review by the Workers' Compensation Board of an order of an Administrative Law Judge need only state that the party requests a review of the order.

(2) The requests for review shall be mailed to the board and copies of the request shall be mailed to all parties to the proceeding before the Administrative Law Judge.

(3) When review has been requested, the record of such oral proceedings at the hearings before the Administrative Law Judge as may be necessary for purposes of the review shall be transcribed at the expense of the board. The original transcript shall be certified to be true, accurate and complete by the transcriber. A list of all exhibits received by the Administrative Law Judge shall be furnished to the parties in interest along with a copy of the transcribed record.

(4) Notice of the review shall be given to the parties by mail. The board shall set a date for review as expeditiously as possible. Review shall be scheduled for a date not later than 90 days after receipt by the board of the request for review. Review shall not be postponed except in extraordinary circumstances beyond the control of the requesting party.

(5) The review by the board shall be based upon the record submitted to it under subsection (3) of this section and such oral or written argument as it may receive. Evaluation of the worker's disability by the board shall be **by a preponderance of the evidence** as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. If the board finds that the claim has been closed prematurely, the board shall issue an order rescinding the notice of closure. The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268. However, if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Administrative Law Judge, it may remand the case to the Administrative Law Judge for further evidence taking, correction or other necessary action.

(6) The board may affirm, reverse, modify or supplement the order of the Administrative Law Judge and make such disposition of the case as it determines to be appropriate. It shall make its decision within 30 days after the review.

(7) The order of the board shall be filed and a copy thereof sent by mail to the director and to the parties.

(8) An order of the board is final unless within 30 days after the date of mailing of copies of such

order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298.

SECTION 5. The amendments to ORS 656.268, 656.283 and 656.295 by sections 1 to 4 of this 2007 Act apply to all claims for injury or disease existing on the effective date of this 2007 Act.