

House Bill 3362

Sponsored by Representative WITT; Representatives D EDWARDS, GALIZIO, KOTEK, ROBLAN, SHIELDS (at the request of SEIU Local 503)

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**.

Requires Home Care Commission to elect workers' compensation coverage for certain home care workers. Allows termination of temporary total disability benefits of home care workers who refuse modified employment in certain circumstances.

A BILL FOR AN ACT

1
2 Relating to workers' compensation coverage for home care workers; amending ORS 656.039 and
3 656.268.

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

5 **SECTION 1.** ORS 656.039 is amended to read:

6 656.039. (1) An employer of one or more persons defined as nonsubject workers or not defined
7 as subject workers may elect to make them subject workers. If the employer is or becomes a
8 carrier-insured employer, the election shall be made by filing written notice thereof with the insurer
9 with a copy to the Director of the Department of Consumer and Business Services. The effective
10 date of coverage is governed by ORS 656.419 (3). If the employer is or becomes a self-insured em-
11 ployer, the election shall be made by filing written notice thereof with the director, the effective
12 date of coverage to be the date specified in the notice.

13 (2) Any election under subsection (1) of this section may be canceled by written notice thereof
14 to the insurer or, in the case of a self-insured employer, by notice thereof to the director. The can-
15 cellation is effective at 12 midnight ending the day the notice is received by the insurer or the di-
16 rector, unless a later date is specified in the notice. The insurer shall, within 10 days after receipt
17 of a notice of cancellation under this section, send a copy of the notice to the director.

18 (3) When necessary the insurer or the director shall fix assumed minimum or maximum wages
19 for persons made subject workers under this section.

20 (4) Notwithstanding any other provision of this section, a person or employer not subject to this
21 chapter who elects to become covered may apply to a guaranty contract insurer for coverage. An
22 insurer other than the State Accident Insurance Fund Corporation may provide such coverage.
23 However, the State Accident Insurance Fund Corporation shall accept any written notice filed and
24 provide coverage as provided in this section if all subject workers of the employers will be insured
25 with the State Accident Insurance Fund Corporation and the coverage of those subject workers is
26 not considered by the State Accident Insurance Fund Corporation to be a risk properly assignable
27 to the assigned risk pool.

28 **(5)(a) The Home Care Commission created by ORS 410.602 shall elect coverage on behalf**
29 **of clients of the Department of Human Services who employ home care workers to make**
30 **home care workers subject workers if the home care worker is paid by the state on behalf**

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 of the client.

2 (b) As used in this subsection, “home care worker” has the meaning given that term in
3 ORS 410.600.

4 **SECTION 2.** ORS 656.268 is amended to read:

5 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
6 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
7 insurer or self-insured employer shall close the worker’s claim, as prescribed by the Director of the
8 Department of Consumer and Business Services, and determine the extent of the worker’s permanent
9 disability, provided the worker is not enrolled and actively engaged in training according to rules
10 adopted by the director pursuant to ORS 656.340 and 656.726, when:

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

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

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

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

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

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

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

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

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

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

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

45 (B) Is at a work site more than 50 miles one way from where the worker was injured unless the

1 site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire
 2 or as established by the pattern of employment prior to the injury was that the employer had mul-
 3 tiple or mobile work sites and the worker could be assigned to any such site;

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

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

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

8 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
 9 gaining agreement; [or]

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

12 **(e) Notwithstanding paragraph (c) of this subsection, the attending physician or nurse**
 13 **practitioner who has authorized temporary disability benefits under ORS 656.245 for a home**
 14 **care worker who has been made a subject worker pursuant to ORS 656.039 advises the home**
 15 **care worker and documents in writing that the home care worker is released to return to**
 16 **modified employment, such employment is offered in writing to the home care worker by any**
 17 **client of the Department of Human Services who employs a home care worker and the home**
 18 **care worker fails to begin such employment.**

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

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

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

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

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

42 (c) If a worker, insurer or self-insured employer objects to the notice of closure, the objecting
 43 party first must request reconsideration by the director under this section. A worker's request for
 44 reconsideration must be made within 60 days of the date of the notice of closure. A request for re-
 45 consideration by an insurer or self-insured employer may be based only on disagreement with the

1 findings used to rate impairment and must be made within seven days of the date of the notice of
2 closure.

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

9 (e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
10 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
11 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
12 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
13 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
14 the claimant. If the increase in compensation results from information that the insurer or self-
15 insured employer demonstrates the insurer or self-insured employer could not reasonably have
16 known at the time of claim closure, from new information obtained through a medical arbiter ex-
17 amination or from the adoption of a temporary emergency rule, the penalty shall not be assessed.

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

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

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

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

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

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

42 (d) The reconsideration proceeding shall be completed within 18 working days from the date the
43 reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit
44 within the department. The deadline of 18 working days may be postponed by an additional 60 cal-
45 endar days if within the 18 working days the department mails notice of review by a medical arbiter.

1 If an order on reconsideration has not been mailed on or before 18 working days from the date the
 2 reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days
 3 where a notice for medical arbiter review was timely mailed or the director postponed the recon-
 4 sideration pursuant to paragraph (b) of this subsection, or within such additional time as provided
 5 in subsection (7) of this section when reconsideration is postponed further because the worker has
 6 failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and
 7 any further proceedings shall occur as though an order on reconsideration affirming the notice of
 8 closure was mailed on the date the order was due to issue.

9 (e) The period for completing the reconsideration proceeding described in paragraph (d) of this
 10 subsection begins upon receipt by the director of a worker's request for reconsideration pursuant
 11 to subsection (5)(c) of this section. If the insurer or self-insured employer requests reconsideration,
 12 the period for reconsideration begins upon the earlier of the date of the request for reconsideration
 13 by the worker, the date of receipt of a waiver from the worker of the right to request reconsider-
 14 ation or the date of expiration of the right of the worker to request reconsideration. If a party elects
 15 not to file a separate request for reconsideration, the party does not waive the right to fully par-
 16 ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration
 17 if the initiating party withdraws the request for reconsideration.

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

20 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
 21 656.283 within 30 days from the date of the reconsideration order.

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

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

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

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

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

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

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

1 upon the existing record.

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

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

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

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

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

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

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

23 (9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
 24 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
 25 any permanent disability payments due for work disability under the closure shall be suspended, and
 26 the worker shall receive temporary disability compensation and any permanent disability payments
 27 due for impairment while the worker is enrolled and actively engaged in the training. When the
 28 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
 29 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
 30 if the worker's accepted injury is no longer the major contributing cause of the worker's combined
 31 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
 32 duration of temporary total or temporary partial disability compensation. Permanent disability
 33 compensation shall be redetermined for work disability only. If the worker has returned to work or
 34 the worker's attending physician has released the worker to return to regular or modified employ-
 35 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
 36 be appealed only in the same manner as are other notices of closure under this section.

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

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

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

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

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

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

21 **SECTION 3.** ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12,
 22 chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461,
 23 Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

24 656.268. (1) One purpose of this chapter is to restore the injured worker as soon as possible and
 25 as near as possible to a condition of self support and maintenance as an able-bodied worker. The
 26 insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the
 27 Department of Consumer and Business Services, and determine the extent of the worker's permanent
 28 disability, provided the worker is not enrolled and actively engaged in training according to rules
 29 adopted by the director pursuant to ORS 656.340 and 656.726, when:

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

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

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

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

44 (2) If the worker is enrolled and actively engaged in training according to rules adopted pursu-
 45 ant to ORS 656.340 and 656.726, the temporary disability compensation shall be proportionately re-

1 duced by any sums earned during the training.

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

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

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

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

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

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

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

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

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

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

23 (F) Is not consistent with an existing shift change provision of an applicable collective bar-
24 gaining agreement; [*or*]

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

27 **(e) Notwithstanding paragraph (c) of this subsection, the attending physician or nurse**
28 **practitioner who has authorized temporary disability benefits under ORS 656.245 for a home**
29 **care worker who has been made a subject worker pursuant to ORS 656.039 advises the home**
30 **care worker and documents in writing that the home care worker is released to return to**
31 **modified employment, such employment is offered in writing to the home care worker by any**
32 **client of the Department of Human Services who employs a home care worker and the home**
33 **care worker fails to begin such employment.**

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

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

40 (B) The worker of the amount of any further compensation, including permanent disability
41 compensation to be awarded; of the duration of temporary total or temporary partial disability
42 compensation; of the right of the worker to request reconsideration by the director under this sec-
43 tion within 60 days of the date of the notice of claim closure; of the right of the insurer or self-
44 insured employer to request reconsideration by the director under this section within seven days
45 of the date of the notice of claim closure; of the aggravation rights; and of such other information

1 as the director may require; and

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

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

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

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

24 (e) If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director
25 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
26 for either a scheduled or unscheduled permanent disability and the worker is found upon reconsid-
27 eration to be at least 20 percent permanently disabled, a penalty shall be assessed against the
28 insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all
29 compensation determined to be then due the claimant. If the increase in compensation results from
30 information that the insurer or self-insured employer demonstrates the insurer or self-insured em-
31 ployer could not reasonably have known at the time of claim closure, from new information obtained
32 through a medical arbiter examination or from the adoption of a temporary emergency rule, the
33 penalty shall not be assessed.

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

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

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

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

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

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

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

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

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

35 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
 36 656.283 within 30 days from the date of the reconsideration order.

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

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

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

44 (d) The arbiter, or panel of medical arbiters, shall be chosen from among a list of physicians
 45 qualified to be attending physicians referred to in ORS 656.005 (12)(b)(A) who were selected by the

1 director in consultation with the Board of Medical Examiners for the State of Oregon and the
 2 committee referred to in ORS 656.790.

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

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

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

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

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

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

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

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

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

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

38 (9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
 39 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
 40 any permanent disability payments due under the closure shall be suspended, and the worker shall
 41 receive temporary disability compensation while the worker is enrolled and actively engaged in the
 42 training. When the worker ceases to be enrolled and actively engaged in the training, the insurer
 43 or self-insured employer shall again close the claim pursuant to this section if the worker is med-
 44 ically stationary or if the worker's accepted injury is no longer the major contributing cause of the
 45 worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7). The closure

1 shall include the duration of temporary total or temporary partial disability compensation. Perma-
 2 nent disability compensation shall be redetermined for unscheduled disability only. If the worker has
 3 returned to work or the worker's attending physician has released the worker to return to regular
 4 or modified employment, the insurer or self-insured employer shall again close the claim. This notice
 5 of closure may be appealed only in the same manner as are other notices of closure under this
 6 section.

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

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

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

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

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

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

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