

A-Engrossed
Senate Bill 158

Ordered by the Senate March 29
Including Senate Amendments dated March 29

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SUMMARY

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

Permits 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

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 to the assigned risk pool.

2 **(5)(a) The Home Care Commission, as created by ORS 410.602, may elect coverage on**
3 **behalf of clients of the Department of Human Services who employ home care workers to**
4 **make home care workers subject workers if the home care worker is paid by the state on**
5 **behalf of the client.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending**
17 **physician or nurse practitioner who has authorized temporary disability benefits under ORS**
18 **656.245 for a home care worker who has been made a subject worker pursuant to ORS 656.039**
19 **advises the home care worker and documents in writing that the home care worker is re-**
20 **leased to return to modified employment, appropriate modified employment is offered in**
21 **writing by the Home Care Commission or a designee of the commission to the home care**
22 **worker for any client of the Department of Human Services who employs a home care**
23 **worker and the home care worker fails to begin the employment.**

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

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

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

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

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

1 director may require.

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

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

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

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

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

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

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

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

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

1 pensation awarded to the worker.

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

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

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

25 (g) If any party objects to the reconsideration order, the party may request a hearing under ORS
26 656.283 within 30 days from the date of the reconsideration order.

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

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

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

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

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

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

1 good cause must be submitted prior to the conclusion of the 60-day postponement period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 **(e) Notwithstanding paragraph (c)(C), (D), (E) and (F) of this subsection, the attending**
33 **physician or nurse practitioner who has authorized temporary disability benefits under ORS**
34 **656.245 for a home care worker who has been made a subject worker pursuant to ORS 656.039**
35 **advises the home care worker and documents in writing that the home care worker is re-**
36 **leased to return to modified employment, appropriate modified employment is offered in**
37 **writing by the Home Care Commission or a designee of the commission to the home care**
38 **worker for any client of the Department of Human Services who employs a home care**
39 **worker and the home care worker fails to begin the employment.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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