House Bill 2094

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of Governor John A. Kitzhaber for Department of Consumer and Business Services)

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.**

Authorizes delay in reconsideration proceeding for notice of claim closure in workers' compensation claim under certain circumstances.

A BILL FOR AN ACT

Relating to reconsideration proceedings in workers' compensation claims; creating new provisions; and amending ORS 656.206, 656.247, 656.268 and 656.325.

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

SECTION 1. ORS 656.268 is amended to read:

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

(C) Is not with the employer at injury;

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

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

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

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

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

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

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

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

as the director may require; and

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

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

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

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

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

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

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

pared in time for use in the reconsideration proceeding.

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

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

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

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

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

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

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

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

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

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

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

(C) The parties agree to the delay; and

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

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

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

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

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

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

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

(e) The director may authorize only one delay period for each reconsideration proceeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[*(12)*] **(13)** An insurer or self-insured employer may take a credit or offset of previously paid workers' compensation benefits or payments against any further workers' compensation benefits or payments due a worker from that insurer or self-insured employer when the worker admits to having

obtained the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction is entered against the worker for having obtained the previously paid benefits through fraud. Benefits or payments obtained through fraud by a worker shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the director.

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

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

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

SECTION 2. ORS 656.206 is amended to read:

656.206. (1) As used in this section:

(a) "Essential functions" means the primary tasks associated with the job.

(b) "Materially improved medically" means an actual change for the better in the worker's medical condition that is supported by objective findings.

(c) "Materially improved vocationally" means an actual change for the better in the:

(A) Worker's vocational capability; or

(B) Likelihood that the worker can return to work in a gainful and suitable occupation.

(d) "Permanent total disability" means, notwithstanding ORS 656.225, the loss, including preexisting disability, of use or function of any portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation.

(e) "Regularly performing work" means the ability of the worker to discharge the essential functions of the job.

(f) "Suitable occupation" means one that the worker has the ability and the training or experience to perform, or an occupation that the worker is able to perform after rehabilitation.

(g) "Wages" means wages as determined under ORS 656.210.

(2) When permanent total disability results from the injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages not to exceed 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50, whichever amount is lesser.

(3) The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment.

(4) When requested by the Director of the Department of Consumer and Business Services, a worker who receives permanent total disability benefits shall file on a form provided by the director, a sworn statement of the worker's gross annual income for the preceding year along with such other information as the director considers necessary to determine whether the worker regularly performs work at a gainful and suitable occupation.

(5) Each insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker has materially improved, either medically or vocationally, and is no longer permanently incapacitated from regularly performing work at a gainful and suitable occupation. Reexamination shall be conducted every two years or at such other more frequent interval as the director may prescribe. Reexamination shall include such medical examinations, vocational evaluations, reports and other records as the insurer considers necessary or the director may require.

(6)(a) If a worker receiving permanent total disability benefits is found to be materially improved and capable of regularly performing work at a gainful and suitable occupation, the insurer or self-insured employer shall issue a notice of closure pursuant to ORS 656.268. Permanent total disability benefits shall be paid through the date of the notice of closure. Notwithstanding ORS 656.268 (5), if a worker objects to a notice of closure issued under this subsection, the worker must request a hearing. If the worker requests a hearing on the notice of closure before the Hearings Division of the Workers' Compensation Board within 30 days of the date of the notice of closure, the insurer or self-insured employer shall continue payment of permanent total disability benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the worker requests a hearing on the notice of closure more than 30 days from the date of the notice of closure but before the 60-day period for requesting a hearing expires, the insurer or self-insured employer shall resume paying permanent total disability benefits from the date the hearing is requested and shall continue payment of benefits until an order of the Hearings Division or a subsequent order affirms the notice of closure or until another order that terminates the worker's benefits becomes final. If the notice of closure is upheld by the Hearings Division, the insurer or self-insured employer shall be reimbursed from the Workers' Benefit Fund for the amount of permanent total disability benefits paid after the date of the notice of closure issued under this subsection.

(b) An insurer or self-insured employer must establish that the condition of a worker who is receiving permanent total disability benefits has materially improved by a preponderance of the evidence presented at hearing.

(c) Medical examinations or vocational evaluations used to support the issuance of a notice of closure under this subsection must include at least one report in which the author personally observed the worker.

(d) Notwithstanding section 54 (3), chapter 2, Oregon Laws 1990, the Hearings Division of the Workers' Compensation Board may request the director to order a medical arbiter examination of an injured worker who has requested a hearing under this subsection.

(7) A worker who has had permanent total disability benefits terminated under this section by an order that has become final is eligible for vocational assistance pursuant to ORS 656.340. Notwithstanding ORS 656.268 [*(9)*] **(10)**, if a worker has enrolled in and is actively engaged in a training program, when vocational assistance provided under this section ends or the worker ceases to be enrolled and actively engaged in the training program, the insurer or the self-insured employer shall determine the extent of disability pursuant to ORS 656.214.

(8) A worker receiving permanent total disability benefits is required, if requested by the director, the insurer or the self-insured employer, to submit to a vocational evaluation at a time reasonably convenient to the worker as may be provided by the rules of the director. No more than three evaluations may be requested except after notification to and authorization by the director. If the worker refuses to submit to or obstructs a vocational evaluation, the rights of the worker to

compensation shall be suspended with the consent of the director until the evaluation has taken place, and no compensation shall be payable for the period during which the worker refused to submit to or obstructed the evaluation. The insurer or self-insured employer shall pay the costs of the evaluation and related services that are reasonably necessary to allow the worker to attend the evaluation requested under this subsection. As used in this subsection, "related services" includes, but is not limited to, wages, child care, travel, meals and lodging.

(9) Notwithstanding any other provisions of this chapter, if a worker receiving permanent total disability incurs a new compensable injury, the worker's entitlement to compensation for the new injury shall be limited to medical benefits pursuant to ORS 656.245 and permanent partial disability benefits for impairment, as determined in the manner set forth in ORS 656.214 (2).

(10) When a worker eligible for benefits under this section returns to work, if the combined total of the worker's post-injury wages plus permanent total disability benefit exceeds the worker's wage at the time of injury, the worker's permanent total disability benefit shall be reduced by the amount the worker's wages plus statutory permanent total disability benefit exceeds the worker's wage at injury.

(11) For purposes of this section:

(a) A gainful occupation for workers with a date of injury prior to January 1, 2006, who were:

(A) Employed continuously for 52 weeks prior to the injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wages from all employment for the 52 weeks prior to the date of injury.

(B) Not employed continuously for the 52 weeks prior to the date of injury, but who were employed for at least four weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wage from all employment for the 52 weeks prior to the date of injury based on weeks of actual employment, excluding any extended periods of unemployment.

(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire.

(b) A gainful occupation for workers with a date of injury on or after January 1, 2006, who were:

(A) Employed continuously for 52 weeks prior to the injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wages from all employment for the 52 weeks prior to the date of injury adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

(B) Not employed continuously for the 52 weeks prior to the date of injury, but who were employed for at least four weeks prior to the date of injury, is an occupation that provides weekly

wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the worker's average weekly wage from all employment for the 52 weeks prior to the date of injury based on weeks of actual employment, excluding any extended periods of unemployment and as adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

(C) Employed for less than four weeks prior to the date of injury with no other employment during the 52 weeks prior to the date of injury, is an occupation that provides weekly wages that are the lesser of the most recent federal poverty guidelines for a family of three that are applicable to Oregon residents and that are published annually in the Federal Register by the United States Department of Health and Human Services or 66-2/3 percent of the average weekly wages intended by the parties at the time of initial hire adjusted by the percentage of change in the applicable federal poverty guidelines for a family of three from the date of injury to the date of evaluation of the extent of the worker's disability.

SECTION 3. ORS 656.247 is amended to read:

656.247. (1) Except for medical services provided to workers subject to ORS 656.245 (4)(b)(B), payment for medical services provided to a subject worker in response to an initial claim for a work-related injury or occupational disease from the date of the employer's notice or knowledge of the claim until the date the claim is accepted or denied shall be payable in accordance with subsection (4) of this section if the expenses are for:

(a) Diagnostic services required to identify appropriate treatment or to prevent disability;

(b) Medication required to alleviate pain; or

(c) Services required to stabilize the worker's claimed condition and to prevent further disability.

(2) Notwithstanding subsection (1) of this section, no payment shall be due from the insurer or self-insured employer if the insurer or self-insured employer denies the claim within 14 days of the date of the employer's notice or knowledge of the claim.

(3)(a) Disputes about whether the medical services provided to treat the claimed work-related injury or occupational disease under subsection (1) of this section are excessive, inappropriate or ineffectual or are consistent with the criteria in subsection (1) of this section shall be resolved by the Director of the Department of Consumer and Business Services. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327 (3) to aid in the review of such services. If a party is dissatisfied with the order of the director, the dissatisfied party may request review under ORS 656.704 within 60 days of the date of the director's order. The order of the director may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(b) Disputes about the amount of the fee or nonpayment of bills for medical treatment and services pursuant to this section shall be resolved pursuant to ORS 656.248.

(c) Except as provided in subsection (2) of this section, when a claim is settled pursuant to ORS 656.289 (4), all medical services payable under subsection (1) of this section that are provided on or before the date of denial shall be paid in accordance with subsection (4) of this section. The insurer or self-insured employer shall notify each affected service provider of the results of the settlement.

(4)(a) If the claim in which medical services are provided under subsection (1) of this section is accepted, the insurer or self-insured employer shall make payment for such medical services subject

to the limitations and conditions of this chapter.

(b) If the claim in which medical services are provided under subsection (1) of this section is denied and a health benefit plan provides benefits to the worker, the health benefit plan shall be the first payer of the expenses for medical services according to the terms, conditions and benefits of the plan. Except as provided by subsection (2) of this section, after payment by the health benefit plan, the workers' compensation insurer or self-insured employer shall pay any balance remaining for such services subject to the limitations and conditions of this chapter.

(c) As used in this subsection, "health benefit plan" has the meaning given that term in ORS 743.730.

(5) An insurer or self-insured employer may recover expenses for medical services paid under subsection (1) of this section as an overpayment as provided by ORS 656.268 [*(13)(a)*] **(14)**.

SECTION 4. ORS 656.325 is amended to read:

656.325. (1)(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. No more than three independent medical examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

(b) When a worker is requested by the director, the insurer or self-insured employer to attend an independent medical examination, the examination must be conducted by a physician selected from a list of qualified physicians established by the director under ORS 656.328.

(c) The director shall adopt rules applicable to independent medical examinations conducted pursuant to paragraph (a) of this subsection that:

(A) Provide a worker the opportunity to request review by the director of the reasonableness of the location selected for an independent medical examination. Upon receipt of the request for review, the director shall conduct an expedited review of the location selected for the independent medical examination and issue an order on the reasonableness of the location of the examination. The director shall determine if there is substantial evidence for the objection to the location for the independent medical examination based on a conclusion that the required travel is medically contraindicated or other good cause establishing that the required travel is unreasonable. The determinations of the director about the location of independent medical examinations are not subject to review.

(B) Impose a monetary penalty against a worker who fails to attend an independent medical examination without prior notification or without justification for not attending the examination. A penalty imposed under this subparagraph may be imposed only on a worker who is not receiving temporary disability benefits under ORS 656.210 or 656.212. An insurer or self-insured employer may offset any future compensation payable to the worker to recover any penalty imposed under this subparagraph from a claim with the same insurer or self-insured employer. When a penalty is recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment may not exceed 25 percent of the benefit payment without prior authorization from the worker.

(C) Impose a sanction against a medical service provider that unreasonably fails to provide in

a timely manner diagnostic records required for an independent medical examination.

(d) Notwithstanding ORS 656.262 (6), if the director determines that the location selected for an independent medical examination is unreasonable, the insurer or self-insured employer shall accept or deny the claim within 90 days after the employer has notice or knowledge of the claim.

(e) If the worker has made a timely request for a hearing on a denial of compensability as required by ORS 656.319 (1)(a) that is based on one or more reports of examinations conducted pursuant to paragraph (a) of this subsection and the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 does not concur with the report or reports, the worker may request an examination to be conducted by a physician selected by the director from the list described in ORS 656.328. The cost of the examination and the examination report shall be paid by the insurer or self-insured employer.

(f) The insurer or self-insured employer shall pay the costs of the medical examination and related services which are reasonably necessary to allow the worker to submit to any examination requested under this section. As used in this paragraph, "related services" includes, but is not limited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages for the period during which the worker is absent if the worker does not receive benefits pursuant to ORS 656.210 (4) during the period of absence. A claim for "related services" described in this paragraph shall be made in the manner prescribed by the director.

(g) A worker who objects to the location of an independent medical examination must request review by the director under paragraph (c)(A) of this subsection within six business days of the date the notice of the independent medical examination was mailed.

(2) For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal.

(3) A worker who has received an award for permanent total or permanent partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268.

(4) When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to this chapter, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate.

(5)(a) Except as provided by ORS 656.268 (4)(c) and [*(10)*] **(11)**, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured

worker is capable of performing the employment offered.

(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers.

(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 approves employment in a modified job whether or not such a job is available.

(6) Any party may request a hearing on any dispute under this section pursuant to ORS 656.283.

SECTION 5. The amendments to ORS 656.206, 656.247, 656.268 and 656.325 by sections 1 to 4 of this 2011 Act apply to requests for reconsideration made on or after the effective date of this 2011 Act.