# Enrolled
# House Bill 2244

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

CHAPTER .....

AN ACT

Relating to permanent partial disability awards in workers' compensation claims; creating new provisions; and amending ORS 656.206, 656.214, 656.268, 656.307, 656.325, 656.726 and 656.790.

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

**SECTION 1.** ORS 656.214, as amended by section 2, chapter 657, Oregon Laws 2003, and section 4, chapter 653, Oregon Laws 2005, is amended to read:

656.214. (1) As used in this section:

**(a) "Impairment" means the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease determined in accordance with the standards provided under ORS 656.726, expressed as a percentage of the whole person.**

[*(a)*] **(b)** "Loss" includes permanent and complete or partial loss of use.

[*(b)*] **(c)** "Permanent partial disability" means**:** [*the loss of either one arm, one hand, one leg, one foot, loss of hearing in one or both ears, loss of one eye, one or more fingers, or any other injury known in surgery to be permanent partial disability.*]

[*(2) When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. The worker shall receive $511.29 for each degree stated against such disability in subsections (2) to (4) of this section as follows:*]

**(A) Permanent impairment resulting from the compensable industrial injury or occupational disease; or**

**(B) Permanent impairment and work disability resulting from the compensable industrial injury or occupational disease.**

**(d) "Regular work" means the job the worker held at injury.**

**(e) "Work disability" means impairment modified by age, education and adaptability to perform a given job.**

**(2) When permanent partial disability results from a compensable injury or occupational disease, benefits shall be awarded as follows:**

**(a) If the worker has been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has returned to regular work at the job held at the time of injury, the award shall be for impairment only. Impairment shall be determined in accordance with the standards provided by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726 (4). Impairment benefits are determined by multiplying the impairment value times 100 times the average weekly wage as defined by ORS 656.005.**

**(b) If the worker has not been released to regular work by the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 or has not returned to regular work at the job held at the time of injury, the award shall be for impairment and work disability. Work disability shall be determined in accordance with the standards provided by the director pursuant to ORS 656.726 (4). Impairment shall be determined as provided in paragraph (a) of this subsection. Work disability benefits shall be determined by multiplying the impairment value, as modified by the factors of age, education and adaptability to perform a given job, times 150 times the worker's weekly wage for the job at injury as calculated under ORS 656.210 (2). The factor for the worker's weekly wage used for the determination of the work disability may be no more than 133 percent or no less than 50 percent of the average weekly wage as defined in ORS 656.005.**

**(3) Impairment benefits awarded under subsection (2)(a) of this section shall be expressed as a percentage of the whole person. Impairment benefits for the following body parts may not exceed:**

(a) For the loss of one arm at or above the elbow joint, **60 percent** [*192 degrees, or a proportion thereof for losses less than a complete loss*].

(b) For the loss of one forearm at or above the wrist joint, or the loss of one hand, **47 percent** [*150 degrees, or a proportion thereof for losses less than a complete loss*].

(c) For the loss of one leg, at or above the knee joint, **47 percent** [*150 degrees, or a proportion thereof for losses less than a complete loss*].

(d) For the loss of one foot, **42 percent** [*135 degrees, or a proportion thereof for losses less than a complete loss*].

(e) For the loss of a great toe, **six percent; for loss of any other toe, one percent** [*18 degrees, or a proportion thereof for losses less than a complete loss; of any other toe, four degrees, or a proportion thereof for losses less than a complete loss*].

(f) For partial or complete loss of hearing in one ear, that **proportion** [*percentage*] of **19 percent** [*60 degrees*] which the loss bears to normal monaural hearing.

(g) For partial or complete loss of hearing in both ears, that proportion of [*192 degrees*] **60 percent** which the combined binaural hearing loss bears to normal combined binaural hearing. For the purpose of this paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. In the case of individuals with compensable hearing loss involving both ears, either the method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be used, depending upon which allows the greater award of [*disability*] **impairment**.

(h) For partial or complete loss of vision of one eye, that proportion of [*100 degrees*] **31 percent** which the loss of monocular vision bears to normal monocular vision. For the purposes of this paragraph, the term "normal monocular vision" shall be considered as Snellen 20/20 for distance and Snellen 14/14 for near vision with full sensory field.

(i) For partial loss of vision in both eyes, that proportion of [*300 degrees*] **94 percent** which the combined binocular visual loss bears to normal combined binocular vision. In all cases of partial loss of sight, the percentage of said loss shall be measured with maximum correction. For the purpose of this paragraph, combined binocular visual loss shall be calculated by taking three times the visual loss in the less damaged eye plus the visual loss in the more damaged eye and dividing that amount by four. In the case of individuals with compensable visual loss involving both eyes, either the method of calculation for monocular visual loss or that for combined binocular visual loss shall be used, depending upon which allows the greater award of [*disability*] **impairment**.

(j) For the loss of a thumb, [*48 degrees, or a portion thereof for losses less than a complete loss*] **15 percent**.

(k) For the loss of a first finger, [*24 degrees, or a proportion thereof for losses less than a complete loss; of a second finger, 22 degrees, or a proportion thereof for losses less than a complete loss; of a third finger, 10 degrees, or a proportion thereof for losses less than a complete loss; of a fourth finger,*

*6 degrees, or a proportion thereof for losses less than a complete loss*] **eight percent; of a second finger, seven percent; of a third finger, three percent; of a fourth finger, two percent**.

[*(3)*] **(4)** The loss of one phalange of a thumb, including the adjacent epiphyseal region of the proximal phalange, is considered equal to the loss of one-half of a thumb. The loss of one phalange of a finger, including the adjacent epiphyseal region of the middle phalange, is considered equal to the loss of one-half of a finger. The loss of two phalanges of a finger, including the adjacent epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of 75 percent of a finger. The loss of more than one phalange of a thumb, excluding the epiphyseal region of the proximal phalange, is considered equal to the loss of an entire thumb. The loss of more than two phalanges of a finger, excluding the epiphyseal region of the proximal phalange of a finger, is considered equal to the loss of an entire finger. A proportionate loss of use may be allowed for an uninjured finger or thumb where there has been a loss of effective opposition.

[*(4)*] **(5)** A proportionate loss of the hand may be allowed where [*disability*] **impairment** extends to more than one digit, in lieu of ratings on the individual digits.

[*(5) In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726 (4)(f). The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability.*]

[*(6) For injuries for which the disability is determined pursuant to subsection (5) of this section, the worker shall receive an amount equal to:*]

[*(a) When the number of degrees stated against the disability is equal to or less than 64, $153.00 times the number of degrees.*]

[*(b) When the number of degrees stated against the disability is more than 64 but equal to or less than 160, $153.00 times 64 plus $267.44 times the number of degrees in excess of 64.*]

[*(c) When the number of degrees stated against the disability is more than 160, $153.00 times 64 plus $267.44 times 96 plus $709.79 times the number of degrees in excess of 160.*]

[*(7)*] **(6)** All permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning of symptoms may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization.

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

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

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

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

(b) Administer oaths.

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

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

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

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

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

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

(c) Administer oaths.

(d) Issue and serve by representatives of the director, or by any sheriff, subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony in any inquiry, investigation, proceeding or rulemaking hearing conducted by the director or the director's representatives. The director may require the attendance and testimony of employers, their officers and representatives in any inquiry under this chapter, and the production by employers of books, records, papers and documents without the payment or tender of witness fees on account of such attendance.

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

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

(A) The [*criteria*] **criterion** for evaluation of [*disabilities under ORS 656.214 (5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job*] **permanent impairment under ORS 656.214 is the loss of use or function of a body part or system due to the compensable industrial injury or occupational disease. Permanent impairment is expressed as a percentage of the whole person. The impairment value may not exceed 100 percent of the whole person**.

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

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

[*(C)*] **(D)** When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

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

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

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

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

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

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

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

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

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

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

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

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

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

**SECTION 3.** ORS 656.206, as amended by section 6, chapter 657, Oregon Laws 2003, and section 2, chapter 461, Oregon Laws 2005, 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 [*scheduled or unscheduled*] 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), 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 4.** ORS 656.268, as amended by section 8, chapter 657, Oregon Laws 2003, section 12, chapter 811, Oregon Laws 2003, section 2, chapter 221, Oregon Laws 2005, section 4, chapter 461, Oregon Laws 2005, and section 2, chapter 569, Oregon Laws 2005, is amended to read:

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

(a) The worker has become medically stationary and there is sufficient information to determine permanent [*impairment*] **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 [*impairment*] **disability**, the likely [*impairment and adaptability*] **permanent disability** that would have been due to the current accepted condition shall be estimated;

(c) Without the approval of the attending physician, 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.

(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 advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician 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;

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

(C) Is not with the employer at injury;

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

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

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

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

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

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

(B) The worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the duration of temporary total or temporary partial disability compensation; of the right of the worker to request reconsideration by the director under this section within 60 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 [*either a scheduled or unscheduled*] permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from information that the insurer or self-insured employer demonstrates the insurer or self-insured employer could not reasonably have known at the time of claim closure, from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed.

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

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

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

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

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

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

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

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

ticipate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws the request for reconsideration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**SECTION 5.** ORS 656.307, as amended by section 10, chapter 657, Oregon Laws 2003, is amended to read:

656.307. (1)(a) Where there is an issue regarding:

(A) Which of several subject employers is the true employer of a claimant worker;

(B) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(C) Responsibility between two or more employers or their insurers involving payment of compensation for one or more accidental injuries; or

(D) Joint employment by two or more employers,

the Director of the Department of Consumer and Business Services shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262 (4).

(b) At the time of claim closure, all parties to an order issued pursuant to paragraph (a) of this subsection shall have reconsideration and appeal rights.

(2) The director then shall request the Workers' Compensation Board chairperson to appoint an Administrative Law Judge to determine the responsible paying party. The proceedings shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298.

(3) When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. Any monetary adjustment not reimbursed by an insurer or self-insured employer shall be recovered from the Consumer and Business Services Fund. Any stipulation or agreement under subsection (6) of this section shall not obligate the Consumer and Business Services Fund for reimbursement without prior approval of the Director of the Department of Consumer and Business Services.

(4) No self-insured employer or an insurer shall be joined in any proceeding under this section regarding its responsibility for any claim subject to ORS 656.273 unless the issue is entitled to hearing on application of the worker.

(5) The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim.

(6)(a) Notwithstanding subsection (2) of this section, parties to a responsibility proceeding under this section may agree to resolution of the dispute by mediation or arbitration by a private party. Any settlement stipulation, arbitration decision or other resolution of matters in dispute resulting from mediation or arbitration proceedings shall be filed with the Hearings Division and shall be given the same force and effect as an order of an Administrative Law Judge made pursuant to subsection (2) of this section. However, any such settlement stipulation, arbitration decision or other resolution is binding on the parties and is not subject to review by the director, an Administrative Law Judge, the board or any court or other administrative body, unless required pursuant to paragraph (d) of this subsection or subsection (3) of this section.

(b) For purposes of this subsection, mediation is a process of discussion and negotiation, with the mediator playing a central role in seeking a consensus among the parties. Such consensus may be reflected in a final mediation settlement stipulation, signed by all the parties and fully binding upon the parties with the same effect as a final order of an Administrative Law Judge, when the signed mediation settlement stipulation is filed with the Hearings Division of the Workers' Compensation Board.

(c) For purposes of this subsection, arbitration is an agreement to submit the matter to a binding decision by an arbitrator, through a process mutually agreed upon in advance. Once all the parties have agreed in writing to proceed with arbitration, no party may withdraw from the arbitration process except as provided in the written arbitration agreement.

(d) A mediation settlement stipulation may include matters beyond the responsibility issues. If other matters are included, the settlement agreement shall be submitted to the Hearings Division of the Workers' Compensation Board for review and approval, under this chapter, as to such additional matters beyond the responsibility issues.

(e) Any arbitration decision shall be limited to a decision as to responsibility and, where appropriate, the payment of associated costs and attorney fees. The arbitrator's decision shall have the same effect as a final order of an Administrative Law Judge when the signed decision is filed with the Hearings Division.

(f) When the parties have reported to the Hearings Division that they have agreed upon a mediation or arbitration process, the hearing shall be deferred for 90 days to allow the mediation or

arbitration process to occur. Once 90 days have passed, the matter shall again be docketed for hearing unless the parties advise the Hearings Division in writing that progress has been made and request an extension of time of up to 90 days, which extension of time shall be granted as a matter of right. Once the second 90 days have passed, the matter shall again be docketed for hearing, and the hearing shall proceed before an Administrative Law Judge as though there had been no mediation or arbitration process, unless the parties present a mediation settlement stipulation or signed arbitration decision before the hearing begins.

(g) All parties must agree in writing to pursue mediation or arbitration and must agree upon the selection of the mediator or arbitrator. The mediator or arbitrator shall not be an employee of any insurer or self-insured employer that is a party to the proceedings. The mediator or arbitrator must be an attorney admitted to practice law in the State of Oregon. The mediator or arbitrator may serve as a mediator or arbitrator, even if the mediator or arbitrator separately represents any insurer or self-insured employer in other proceedings, provided that all parties are advised of such representation and consent in writing that the mediator or arbitrator may so serve despite such other representation. Such written consent supersedes any legal ethics restrictions otherwise provided for in law or regulation.

(h) If the claimant is represented by an attorney, the other parties must arrange for payment of a reasonable attorney fee for the claimant's attorney's services during the mediation or arbitration. Any mediation or arbitration agreement shall specify the terms of the fee arrangement.

(i) If the claimant is not represented by an attorney, the mediation process cannot include any issue other than responsibility. A nonrepresented claimant must be advised in writing of the following before the mediation or arbitration proceeds:

(A) The claimant's right to refuse to participate in mediation or arbitration proceedings and to, instead, proceed to a hearing before an Administrative Law Judge;

(B) The present rate of temporary total disability benefits for each alleged date of injury;

(C) The present rate of [*unscheduled and scheduled*] permanent partial disability benefits for each alleged date of injury;

(D) The estimated date of expiration of aggravation rights for each alleged date of injury; and

(E) The claimant's right to be represented by counsel of the claimant's choice at no expense to the claimant.

(j) Notwithstanding any other provision of law, any insurer or self-insured employer may be represented by a certified claims examiner rather than by an attorney in any mediation or arbitration hereunder. Any separate insured for the same insurer shall be represented by a separate claims examiner, if the insured has a continuing financial exposure as to the claim; where no continuing financial exposure exists, a single certified claims examiner may represent more than one insured for the same insurer in the mediation or arbitration proceeding.

(k) Any other procedures as to mediation or arbitration shall be subject to agreement among the parties. The Workers' Compensation Board may adopt rules as to the process for deferral and docketing of hearings where mediation or arbitration occurs, the filing of arbitration decisions as orders of the Hearings Division, the filing of mediation settlement stipulations regarding responsibility as orders of the Hearings Division, and review and approval of mediation settlement stipulations that extend beyond the issues of responsibility and associated attorney fees and costs. The Workers' Compensation Board shall not enact rules that restrict the mediation or arbitration process except to the extent provided within this section.

**SECTION 6.** ORS 656.325, as amended by section 12, chapter 657, Oregon Laws 2003, section 14, chapter 811, Oregon Laws 2003, and section 2, chapter 675, Oregon Laws 2005, 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 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 [*unscheduled*] permanent total or [*unscheduled*] **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 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), 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, 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 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 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 7.** ORS 656.790 is amended to read:

656.790. (1) The Governor shall appoint a Workers' Compensation Management-Labor Advisory Committee composed of 10 appointed members. Five members from organized labor shall represent subject workers and five members shall represent subject employers. In addition to the appointed members, the Director of the Department of Consumer and Business Services shall serve ex officio as a member of the committee. The appointment of members of the committee is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(2) The director may recommend areas of the law which the director desires to have studied or the committee may study such aspects of the law as the committee shall determine require their consideration. The committee [*periodically*] shall **biennially** review the standards for evaluation of permanent disability adopted under ORS 656.726 and shall recommend to the director factors to be included or such other modification of application of the standards as the committee considers appropriate. **The committee shall biennially review and make recommendations about permanent partial disability benefits.** The committee shall advise the director regarding any proposed changes in the operation of programs funded by the Workers' Benefit Fund. The committee shall report its findings to the director for such action as the director deems appropriate.

(3) The committee shall report to the Legislative Assembly such findings and recommendations as the committee considers appropriate, including a report on the following matters:

(a) Decisions of the Supreme Court and Court of Appeals that have significant impact on the workers' compensation system.

(b) Adequacy of workers' compensation benefits.

(c) Medical and legal system costs.

(d) Adequacy of assessments for reserve programs and administrative costs.

(e) The operation of programs funded by the Workers' Benefit Fund.

(4) The members of the committee shall be appointed for a term of two years and shall serve without compensation, but shall be entitled to travel expenses. The committee may hire, subject to approval of the director, such experts as it may require to discharge its duties. All expenses of the committee shall be paid out of the Consumer and Business Services Fund.

**SECTION 8. The amendments to ORS 656.206, 656.214, 656.268, 656.307, 656.325 and 656.726 by sections 1 to 6 of this 2007 Act apply to injuries occurring on or after January 1, 2008.**

---

**Passed by House April 10, 2007**

.....
Chief Clerk of House

.....
Speaker of House

**Passed by Senate May 15, 2007**

.....
President of Senate

**Received by Governor:**

.....M.,....., 2007

**Approved:**

.....M.,....., 2007

.....
Governor

**Filed in Office of Secretary of State:**

.....M.,....., 2007

.....
Secretary of State