House Bill 2706

Sponsored by COMMITTEE ON BUSINESS AND LABOR

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 insurer or self-insured employer to close workers' compensation claim if preponderance of medical evidence supports closure and attending physician fails to provide closing report after receiving request for report. Requires expedited reconsideration of claim closure unless waived by worker.

1 **A BILL FOR AN ACT**

2 Relating to closure of workers' compensation claims; amending ORS 656.268.

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

4 **SECTION 1.** ORS 656.268, as amended by sections 11 and 12, chapter 241, Oregon Laws 2007,
5 is amended to read:

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

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

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

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

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

28 **(e)(A) An insurer or self-insured employer concludes that a preponderance of the medical**
29 **evidence supports closure of the claim and the worker's attending physician has not sub-**
30 **mitted a closing report. Prior to closing a claim under this paragraph, the insurer or self-**

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.

LC 2210

insured employer shall notify the attending physician of the intention to close the claim and request a closing report from the attending physician. A copy of the notice and request shall be provided to the worker and the worker's attorney if the worker is represented. The attending physician shall respond to the request within 14 days of the request. If the attending physician provides a closing report that provides sufficient information for claim closure, the claim shall be closed using the findings of the attending physician. The insurer or self-insured shall consider the closing report of the attending physician in determining if a preponderance of the medical evidence supports a finding that the worker is medically stationary. However, the insurer or self-insured employer may determine the extent of the worker's permanent disability based on a preponderance of the medical evidence in the record and issue a notice of closure.

(B) If an insurer or self-insured employer closes a claim under this paragraph, a copy of the notice of closure shall be provided to the evaluation appellate unit of the department, which shall begin an expedited reconsideration of the claim closure. The expedited reconsideration shall include the appointment of a medical arbiter. The worker may waive reconsideration under this paragraph in accordance with rules adopted by the director.

(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 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

1 orders an increase by 25 percent or more of the amount of compensation to be paid to the worker
2 for permanent disability and the worker is found upon reconsideration to be at least 20 percent
3 permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and
4 paid to the worker in an amount equal to 25 percent of all compensation determined to be then due
5 the claimant. If the increase in compensation results from information that the insurer or self-
6 insured employer demonstrates the insurer or self-insured employer could not reasonably have
7 known at the time of claim closure, from new information obtained through a medical arbiter ex-
8 amination or from a determination order issued by the director that addresses the extent of the
9 worker's permanent disability that is not based on the standards adopted pursuant to ORS 656.726
10 (4)(f), the penalty shall not be assessed.
11 (6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be
12 held on each notice of closure. At the reconsideration proceeding:
13 (A) A deposition arranged by the worker, limited to the testimony and cross-examination of the
14 worker about the worker's condition at the time of claim closure, shall become part of the recon-
15 sideration record. The deposition must be conducted subject to the opportunity for cross-examination
16 by the insurer or self-insured employer and in accordance with rules adopted by the director. The
17 cost of the court reporter and one original of the transcript of the deposition for the Department
18 of Consumer and Business Services and one copy of the transcript of the deposition for each party
19 shall be paid by the insurer or self-insured employer. The reconsideration proceeding may not be
20 postponed to receive a deposition taken under this subparagraph. A deposition taken in accordance
21 with this subparagraph may be received as evidence at a hearing even if the deposition is not pre-
22 pared in time for use in the reconsideration proceeding.
23 (B) Pursuant to rules adopted by the director, the worker or the insurer or self-insured employer
24 may correct information in the record that is erroneous and may submit any medical evidence that
25 should have been but was not submitted by the attending physician or nurse practitioner authorized
26 to provide compensable medical services under ORS 656.245 at the time of claim closure.
27 (C) If the director determines that a claim was not closed in accordance with subsection (1) of
28 this section, the director may rescind the closure.
29 (b) If necessary, the director may require additional medical or other information with respect
30 to the claims and may postpone the reconsideration for not more than 60 additional calendar days.
31 (c) In any reconsideration proceeding under this section in which the worker was represented
32 by an attorney, the director shall order the insurer or self-insured employer to pay to the attorney,
33 out of the additional compensation awarded, an amount equal to 10 percent of any additional com-
34 pensation awarded to the worker.
35 (d) The reconsideration proceeding shall be completed within 18 working days from the date the
36 reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit
37 within the department. The deadline of 18 working days may be postponed by an additional 60 cal-
38 endar days if within the 18 working days the department mails notice of review by a medical arbiter.
39 If an order on reconsideration has not been mailed on or before 18 working days from the date the
40 reconsideration proceeding begins, or within 18 working days plus the additional 60 calendar days
41 where a notice for medical arbiter review was timely mailed or the director postponed the recon-
42 sideration pursuant to paragraph (b) of this subsection, or within such additional time as provided
43 in subsection (7) of this section when reconsideration is postponed further because the worker has
44 failed to cooperate in the medical arbiter examination, reconsideration shall be deemed denied and
45 any further proceedings shall occur as though an order on reconsideration affirming the notice of

closure was mailed on the date the order was due to issue.

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

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

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

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

(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

1 director for reconsideration of the notice of closure.
2 (h) After reconsideration, no subsequent medical evidence of the worker's impairment is admis-
3 sible before the director, the Workers' Compensation Board or the courts for purposes of making
4 findings of impairment on the claim closure.
5 (i)(A) When the basis for objection to a notice of closure issued under this section is a disa-
6 greement with the impairment used in rating the worker's disability, and the director determines
7 that the worker is not medically stationary at the time of the reconsideration or that the closure
8 was not made pursuant to this section, the director is not required to appoint a medical arbiter prior
9 to the completion of the reconsideration proceeding.
10 (B) If the worker's condition has substantially changed since the notice of closure, upon the
11 consent of all the parties to the claim, the director shall postpone the proceeding until the worker's
12 condition is appropriate for claim closure under subsection (1) of this section.
13 (8) No hearing shall be held on any issue that was not raised and preserved before the director
14 at reconsideration. However, issues arising out of the reconsideration order may be addressed and
15 resolved at hearing.
16 (9) If, after the notice of closure issued pursuant to this section, the worker becomes enrolled
17 and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726,
18 any permanent disability payments due for work disability under the closure shall be suspended, and
19 the worker shall receive temporary disability compensation and any permanent disability payments
20 due for impairment while the worker is enrolled and actively engaged in the training. When the
21 worker ceases to be enrolled and actively engaged in the training, the insurer or self-insured em-
22 ployer shall again close the claim pursuant to this section if the worker is medically stationary or
23 if the worker's accepted injury is no longer the major contributing cause of the worker's combined
24 or consequential condition or conditions pursuant to ORS 656.005 (7). The closure shall include the
25 duration of temporary total or temporary partial disability compensation. Permanent disability
26 compensation shall be redetermined for work disability only. If the worker has returned to work or
27 the worker's attending physician has released the worker to return to regular or modified employ-
28 ment, the insurer or self-insured employer shall again close the claim. This notice of closure may
29 be appealed only in the same manner as are other notices of closure under this section.
30 (10) If the attending physician or nurse practitioner authorized to provide compensable medical
31 services under ORS 656.245 has approved the worker's return to work and there is a labor dispute
32 in progress at the place of employment, the worker may refuse to return to that employment without
33 loss of reemployment rights or any vocational assistance provided by this chapter.
34 (11) Any notice of closure made under this section may include necessary adjustments in com-
35 pensation paid or payable prior to the notice of closure, including disallowance of permanent disa-
36 bility payments prematurely made, crediting temporary disability payments against current or future
37 permanent or temporary disability awards or payments and requiring the payment of temporary
38 disability payments which were payable but not paid.
39 (12) An insurer or self-insured employer may take a credit or offset of previously paid workers'
40 compensation benefits or payments against any further workers' compensation benefits or payments
41 due a worker from that insurer or self-insured employer when the worker admits to having obtained
42 the previously paid benefits or payments through fraud, or a civil judgment or criminal conviction
43 is entered against the worker for having obtained the previously paid benefits through fraud. Bene-
44 fits or payments obtained through fraud by a worker shall not be included in any data used for
45 ratemaking or individual employer rating or dividend calculations by an insurer, a rating organiza-

tion 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.