

SENATE AMENDMENTS TO SENATE BILL 504

By COMMITTEE ON COMMERCE

May 1

1 On page 1 of the printed bill, line 2, after “656.005” insert “and 656.245”.

2 On page 3, after line 1, insert:

3 “(c) Except as otherwise provided for workers subject to a managed care contract, ‘attending
4 physician’ does not include a physician who provides care in a hospital emergency room and refers
5 the injured worker to a primary care physician for follow-up care and treatment.”.

6 In line 2, delete “(c)” and insert “(d)”.

7 On page 6, after line 29, insert:

8 “(c) Except as otherwise provided for workers subject to a managed care contract, ‘attending
9 physician’ does not include a physician who provides care in a hospital emergency room and refers
10 the injured worker to a primary care physician for follow-up care and treatment.”.

11 In line 30, delete “(c)” and insert “(d)”.

12 On page 8, after line 26, insert:

13 “**SECTION 3.** ORS 656.245 is amended to read:

14 “656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall
15 cause to be provided medical services for conditions caused in material part by the injury for such
16 period as the nature of the injury or the process of the recovery requires, subject to the limitations
17 in ORS 656.225, including such medical services as may be required after a determination of per-
18 manent disability. In addition, for consequential and combined conditions described in ORS 656.005
19 (7), the insurer or the self-insured employer shall cause to be provided only those medical services
20 directed to medical conditions caused in major part by the injury.

21 “(b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances
22 and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and
23 supports and where necessary, physical restorative services. A pharmacist or dispensing physician
24 shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide
25 such medical services continues for the life of the worker.

26 “(c) Notwithstanding any other provision of this chapter, medical services after the worker’s
27 condition is medically stationary are not compensable except for the following:

28 “(A) Services provided to a worker who has been determined to be permanently and totally
29 disabled.

30 “(B) Prescription medications.

31 “(C) Services necessary to administer prescription medication or monitor the administration of
32 prescription medication.

33 “(D) Prosthetic devices, braces and supports.

34 “(E) Services necessary to monitor the status, replacement or repair of prosthetic devices,
35 braces and supports.

1 “(F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.
2 “(G) Services provided pursuant to an order issued under ORS 656.278.
3 “(H) Services that are necessary to diagnose the worker’s condition.
4 “(I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.
5 “(J) With the approval of the insurer or self-insured employer, palliative care that the worker’s
6 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
7 the worker to continue current employment or a vocational training program. If the insurer or
8 self-insured employer does not approve, the attending physician or the worker may request approval
9 from the Director of the Department of Consumer and Business Services for such treatment. The
10 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
11 (3) to aid in the review of such treatment. The decision of the director is subject to review under
12 ORS 656.704.
13 “(K) With the approval of the director, curative care arising from a generally recognized, non-
14 experimental advance in medical science since the worker’s claim was closed that is highly likely
15 to improve the worker’s condition and that is otherwise justified by the circumstances of the claim.
16 The decision of the director is subject to review under ORS 656.704.
17 “(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
18 of symptoms of the worker’s condition.
19 “(d) When the medically stationary date in a disabling claim is established by the insurer or
20 self-insured employer and is not based on the findings of the attending physician, the insurer or
21 self-insured employer is responsible for reimbursement to affected medical service providers for
22 otherwise compensable services rendered until the insurer or self-insured employer provides written
23 notice to the attending physician of the worker’s medically stationary status.
24 “(e) Except for services provided under a managed care contract, out-of-pocket expense re-
25 imbursement to receive care from the attending physician or nurse practitioner authorized to pro-
26 vide compensable medical services under this section shall not exceed the amount required to seek
27 care from an appropriate nurse practitioner or attending physician of the same specialty who is in
28 a medical community geographically closer to the worker’s home. For the purposes of this para-
29 graph, all physicians and nurse practitioners within a metropolitan area are considered to be part
30 of the same medical community.
31 “(2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
32 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
33 may subsequently change attending physician or nurse practitioner two times without approval from
34 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
35 insurer or self-insured employer may require the director’s approval of the selection and, if re-
36 quested, the director shall determine with the advice of one or more physicians, whether the se-
37 lection by the worker shall be approved. The decision of the director is subject to review under
38 ORS 656.704. The worker also may choose an attending doctor or physician in another country or
39 in any state or territory or possession of the United States with the prior approval of the insurer
40 or self-insured employer.
41 “(b) A medical service provider who is not a member of a managed care organization is subject
42 to the following provisions:
43 “(A) A medical service provider who is not qualified to be an attending physician may provide
44 compensable medical service to an injured worker for a period of 30 days from the date of injury
45 or occupational disease or for 12 visits, whichever first occurs, without the authorization of an at-

1 tending physician. Thereafter, medical service provided to an injured worker without the written
2 authorization of an attending physician is not compensable.

3 “(B) A medical service provider who is not an attending physician cannot authorize the payment
4 of temporary disability compensation. **However, an emergency room physician who is not au-**
5 **thorized to serve as an attending physician under ORS 656.005 (12)(c) may authorize tempo-**
6 **rary disability benefits for a maximum of 14 days.** Except as otherwise provided in this chapter,
7 only the attending physician at the time of claim closure may make findings regarding the worker’s
8 impairment for the purpose of evaluating the worker’s disability.

9 “(C) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed
10 under ORS 678.375 to 678.390 may:

11 “(i) Provide compensable medical services for 90 days from the date of the first visit on the
12 claim;

13 “(ii) Authorize the payment of temporary disability benefits for a period not to exceed 60 days
14 from the date of the first visit on the initial claim; and

15 “(iii) When an injured worker treating with a nurse practitioner authorized to provide
16 compensable services under this section becomes medically stationary within the 90-day period in
17 which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker
18 to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of
19 making findings regarding the worker’s impairment for the purpose of evaluating the worker’s disa-
20 bility. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a
21 possible worsening of the worker’s condition, the nurse practitioner shall refer the worker to an
22 attending physician and the insurer shall compensate the nurse practitioner for the examination
23 performed.

24 “(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice
25 of the committee created by ORS 656.794 and upon the advice of the professional licensing boards
26 of practitioners affected by the rule, may exclude from compensability any medical treatment the
27 director finds to be unscientific, unproven, outmoded or experimental. The decision of the director
28 is subject to review under ORS 656.704.

29 “(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the
30 insurer of an employer contracts with a managed care organization certified pursuant to ORS
31 656.260 for medical services required by this chapter to be provided to injured workers:

32 “(a) Those workers who are subject to the contract shall receive medical services in the manner
33 prescribed in the contract. Workers subject to the contract include those who are receiving medical
34 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
35 jury or medically stationary status, on or after the effective date of the contract. If the managed
36 care organization determines that the change in provider would be medically detrimental to the
37 worker, the worker shall not become subject to the contract until the worker is found to be med-
38 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
39 ganization determines that the change in provider is no longer medically detrimental, whichever
40 event first occurs. A worker becomes subject to the contract upon the worker’s receipt of actual
41 notice of the worker’s enrollment in the managed care organization, or upon the third day after the
42 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
43 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
44 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
45 vide compensable medical services under this section under an expired or terminated managed care

1 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
2 and conditions regarding services performed under any subsequent managed care organization con-
3 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
4 primary residence is more than 100 miles outside the managed care organization's certified ge-
5 ographical area. Each such contract must comply with the certification standards provided in ORS
6 656.260. However, a worker may receive immediate emergency medical treatment that is
7 compensable from a medical service provider who is not a member of the managed care organization.
8 Insurers or self-insured employers who contract with a managed care organization for medical ser-
9 vices shall give notice to the workers of eligible medical service providers and such other informa-
10 tion regarding the contract and manner of receiving medical services as the director may prescribe.
11 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
12 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
13 as a processing agent or the assigned claims agent and a managed care organization.

14 “(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-
15 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
16 vices from the managed care organization.

17 “(B) If the insurer or self-insured employer gives notice that the worker is required to receive
18 treatment from the managed care organization, the insurer or self-insured employer must guarantee
19 that any reasonable and necessary services so received, that are not otherwise covered by health
20 insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker
21 receives actual notice of the denial or until three days after the denial is mailed, whichever event
22 first occurs. The worker may elect to receive care from a primary care physician or nurse practi-
23 tioner authorized to provide compensable medical services under this section who agrees to the
24 conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or
25 self-insured employer if this election is made.

26 “(C) If the insurer or self-insured employer does not give notice that the worker is required to
27 receive treatment from the managed care organization, the insurer or self-insured employer is under
28 no obligation to pay for services received by the worker unless the claim is later accepted.

29 “(D) If the claim is denied, the worker may receive medical services after the date of denial from
30 sources other than the managed care organization until the denial is reversed. Reasonable and
31 necessary medical services received from sources other than the managed care organization after
32 the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured em-
33 ployer if the claim is finally determined to be compensable.

34 “(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize
35 physician assistants licensed by the Board of Medical Examiners for the State of Oregon who prac-
36 tice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the
37 payment of temporary disability compensation for injured workers for a period not to exceed 30 days
38 from the date of the first visit on the claim. In addition, the director, by rule, may authorize such
39 assistants who practice in areas served by a Type C rural hospital described in ORS 442.470 to au-
40 thorize such payment.

41 “(6) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the
42 managed care organization, is authorized to provide the same level of services as a primary care
43 physician as established by ORS 656.260 (4), if at the time the worker is enrolled in the managed
44 care organization, the nurse practitioner maintains the worker's medical records and with whom the
45 worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker

1 to the managed care organization for any specialized treatment, including physical therapy, to be
2 furnished by another provider that the worker may require and if that nurse practitioner agrees to
3 comply with all the rules, terms and conditions regarding services performed by the managed care
4 organization.

5 “(7) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the
6 injured worker, insurer or self-insured employer may request administrative review by the director
7 pursuant to ORS 656.260 or 656.327.

8 “**SECTION 4.** ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and sec-
9 tion 4, chapter 26, Oregon Laws 2005, is amended to read:

10 “656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall
11 cause to be provided medical services for conditions caused in material part by the injury for such
12 period as the nature of the injury or the process of the recovery requires, subject to the limitations
13 in ORS 656.225, including such medical services as may be required after a determination of per-
14 manent disability. In addition, for consequential and combined conditions described in ORS 656.005
15 (7), the insurer or the self-insured employer shall cause to be provided only those medical services
16 directed to medical conditions caused in major part by the injury.

17 “(b) Compensable medical services shall include medical, surgical, hospital, nursing, ambulances
18 and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and
19 supports and where necessary, physical restorative services. A pharmacist or dispensing physician
20 shall dispense generic drugs to the worker in accordance with ORS 689.515. The duty to provide
21 such medical services continues for the life of the worker.

22 “(c) Notwithstanding any other provision of this chapter, medical services after the worker’s
23 condition is medically stationary are not compensable except for the following:

24 “(A) Services provided to a worker who has been determined to be permanently and totally
25 disabled.

26 “(B) Prescription medications.

27 “(C) Services necessary to administer prescription medication or monitor the administration of
28 prescription medication.

29 “(D) Prosthetic devices, braces and supports.

30 “(E) Services necessary to monitor the status, replacement or repair of prosthetic devices,
31 braces and supports.

32 “(F) Services provided pursuant to an accepted claim for aggravation under ORS 656.273.

33 “(G) Services provided pursuant to an order issued under ORS 656.278.

34 “(H) Services that are necessary to diagnose the worker’s condition.

35 “(I) Life-preserving modalities similar to insulin therapy, dialysis and transfusions.

36 “(J) With the approval of the insurer or self-insured employer, palliative care that the worker’s
37 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
38 the worker to continue current employment or a vocational training program. If the insurer or
39 self-insured employer does not approve, the attending physician or the worker may request approval
40 from the Director of the Department of Consumer and Business Services for such treatment. The
41 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
42 (3) to aid in the review of such treatment. The decision of the director is subject to review under
43 ORS 656.704.

44 “(K) With the approval of the director, curative care arising from a generally recognized, non-
45 experimental advance in medical science since the worker’s claim was closed that is highly likely

1 to improve the worker's condition and that is otherwise justified by the circumstances of the claim.
2 The decision of the director is subject to review under ORS 656.704.

3 "(L) Curative care provided to a worker to stabilize a temporary and acute waxing and waning
4 of symptoms of the worker's condition.

5 "(d) When the medically stationary date in a disabling claim is established by the insurer or
6 self-insured employer and is not based on the findings of the attending physician, the insurer or
7 self-insured employer is responsible for reimbursement to affected medical service providers for
8 otherwise compensable services rendered until the insurer or self-insured employer provides written
9 notice to the attending physician of the worker's medically stationary status.

10 "(e) Except for services provided under a managed care contract, out-of-pocket expense re-
11 imbursement to receive care from the attending physician shall not exceed the amount required to
12 seek care from an appropriate attending physician of the same specialty who is in a medical com-
13 munity geographically closer to the worker's home. For the purposes of this paragraph, all physi-
14 cians within a metropolitan area are considered to be part of the same medical community.

15 "(2)(a) The worker may choose an attending doctor or physician within the State of Oregon. The
16 worker may choose the initial attending physician and may subsequently change attending physician
17 two times without approval from the director. If the worker thereafter selects another attending
18 physician, the insurer or self-insured employer may require the director's approval of the selection
19 and, if requested, the director shall determine with the advice of one or more physicians, whether
20 the selection by the worker shall be approved. The decision of the director is subject to review un-
21 der ORS 656.704. The worker also may choose an attending doctor or physician in another country
22 or in any state or territory or possession of the United States with the prior approval of the insurer
23 or self-insured employer.

24 "(b) A medical service provider who is not a member of a managed care organization is subject
25 to the following provisions:

26 "(A) A medical service provider who is not qualified to be an attending physician may provide
27 compensable medical service to an injured worker for a period of 30 days from the date of injury
28 or occupational disease or for 12 visits, whichever first occurs, without the authorization of an at-
29 tending physician. Thereafter, medical service provided to an injured worker without the written
30 authorization of an attending physician is not compensable.

31 "(B) A medical service provider who is not an attending physician cannot authorize the payment
32 of temporary disability compensation. **However, an emergency room physician who is not au-**
33 **thorized to serve as an attending physician under ORS 656.005 (12)(c) may authorize tempo-**
34 **rary disability benefits for a maximum of 14 days.** Except as otherwise provided in this chapter,
35 only the attending physician at the time of claim closure may make findings regarding the worker's
36 impairment for the purpose of evaluating the worker's disability.

37 "(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice
38 of the committee created by ORS 656.794 and upon the advice of the professional licensing boards
39 of practitioners affected by the rule, may exclude from compensability any medical treatment the
40 director finds to be unscientific, unproven, outmoded or experimental. The decision of the director
41 is subject to review under ORS 656.704.

42 "(4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the
43 insurer of an employer contracts with a managed care organization certified pursuant to ORS
44 656.260 for medical services required by this chapter to be provided to injured workers:

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3 jury or medically stationary status, on or after the effective date of the contract. If the managed
4 care organization determines that the change in provider would be medically detrimental to the
5 worker, the worker shall not become subject to the contract until the worker is found to be med-
6 ically stationary, the worker changes physicians or the managed care organization determines that
7 the change in provider is no longer medically detrimental, whichever event first occurs. A worker
8 becomes subject to the contract upon the worker's receipt of actual notice of the worker's enroll-
9 ment in the managed care organization, or upon the third day after the notice was sent by regular
10 mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be
11 subject to a contract after it expires or terminates without renewal. A worker may continue to treat
12 with the attending physician under an expired or terminated managed care organization contract if
13 the physician agrees to comply with the rules, terms and conditions regarding services performed
14 under any subsequent managed care organization contract to which the worker is subject. A worker
15 shall not be subject to a contract if the worker's primary residence is more than 100 miles outside
16 the managed care organization's certified geographical area. Each such contract must comply with
17 the certification standards provided in ORS 656.260. However, a worker may receive immediate
18 emergency medical treatment that is compensable from a medical service provider who is not a
19 member of the managed care organization. Insurers or self-insured employers who contract with a
20 managed care organization for medical services shall give notice to the workers of eligible medical
21 service providers and such other information regarding the contract and manner of receiving med-
22 ical services as the director may prescribe. Notwithstanding any provision of law or rule to the
23 contrary, a worker of a noncomplying employer is considered to be subject to a contract between
24 the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent
25 and a managed care organization.

26 “(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured em-
27 ployer may require an injured worker, on a case-by-case basis, immediately to receive medical ser-
28 vices from the managed care organization.

29 “(B) If the insurer or self-insured employer gives notice that the worker is required to receive
30 treatment from the managed care organization, the insurer or self-insured employer must guarantee
31 that any reasonable and necessary services so received, that are not otherwise covered by health
32 insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker
33 receives actual notice of the denial or until three days after the denial is mailed, whichever event
34 first occurs. The worker may elect to receive care from a primary care physician who agrees to the
35 conditions of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or
36 self-insured employer if this election is made.

37 “(C) If the insurer or self-insured employer does not give notice that the worker is required to
38 receive treatment from the managed care organization, the insurer or self-insured employer is under
39 no obligation to pay for services received by the worker unless the claim is later accepted.

40 “(D) If the claim is denied, the worker may receive medical services after the date of denial from
41 sources other than the managed care organization until the denial is reversed. Reasonable and
42 necessary medical services received from sources other than the managed care organization after
43 the date of claim denial must be paid as provided in ORS 656.248 by the insurer or self-insured em-
44 ployer if the claim is finally determined to be compensable.

45 “(5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize

1 nurse practitioners certified by the Oregon State Board of Nursing and physician assistants licensed
2 by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type
3 A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disa-
4 bility compensation for injured workers for a period not to exceed 30 days from the date of the first
5 visit on the claim. In addition, the director, by rule, may authorize such practitioners and assistants
6 who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such
7 payment.

8 “(6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the
9 injured worker, insurer or self-insured employer may request administrative review by the director
10 pursuant to ORS 656.260 or 656.327.”.

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