A-Engrossed
House Bill 2092

Ordered by the House March 10
Including House Amendments dated March 10

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

SUMMARY

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

[*Clarifies exclusive remedy provisions of workers' compensation laws. Provides for administrative review of certain matters arising under workers' compensation laws and rules.*]
Modifies manner in which notice of compliance is made available to subject employers.
Eliminates requirement for consultation with certain professional licensing boards when rules are adopted concerning appropriateness of certain types of medical treatment. [*Allows medical service providers to seek resolution of medical service disputes through same process as workers, employers and insurers.*]
Restores authority of Director of Department of Consumer and Business Services to extend temporary disability compensation paid to workers in vocational training.

1 **A BILL FOR AN ACT**

2 Relating to workers' compensation; creating new provisions; and amending ORS 656.056, 656.245 and
3 656.340.

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

5 **SECTION 1.** ORS 656.056 is amended to read:

6 656.056. (1) All subject employers shall display in a conspicuous manner about their works, and
7 in a sufficient number of places reasonably to inform their workers of the fact, [*printed notices fur-*
8 *nished by the Director of the Department of Consumer and Business Services*] **a notice** stating that
9 they are subject to this chapter and the manner of their compliance with this chapter.

10 (2) [*No*] **An** employer who is not currently a subject employer [*shall*] **may not** post**,** or permit
11 to remain on or about the place of business or premises of the employer**,** any notice that the em-
12 ployer is subject to, and complying with, this chapter.

13 **(3) The Director of the Department of Consumer and Business Services shall prescribe**
14 **by rule the manner by which the notice required under subsection (1) of this section shall**
15 **be provided to subject employers.**

16 **SECTION 2.** ORS 656.245 is amended to read:

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

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.

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

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

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

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

(H) Services that are necessary to diagnose the worker's condition.

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

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

(K) With the approval of the director, curative care arising from a generally recognized, nonexperimental advance in medical science since the worker's claim was closed that is highly likely to improve the worker's condition and that is otherwise justified by the circumstances of the claim. The decision of the director is subject to review under ORS 656.704.

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

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

(e) Except for services provided under a managed care contract, out-of-pocket expense reimbursement to receive care from the attending physician or nurse practitioner authorized to provide compensable medical services under this section shall not exceed the amount required to seek care from an appropriate nurse practitioner or attending physician of the same specialty who is in a medical community geographically closer to the worker's home. For the purposes of this paragraph, all physicians and nurse practitioners within a metropolitan area are considered to be part of the same medical community.

(2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the State of Oregon. The worker may choose the initial attending physician or nurse practitioner and may subsequently change attending physician or nurse practitioner two times without approval from the director. If the worker thereafter selects another attending physician or nurse practitioner, the insurer or self-insured employer may require the director's approval of the selection. The decision of the director is subject to review under ORS 656.704. The worker also may choose an attending doctor or physician in another country or in any state or territory or possession of the United States with the prior approval of the insurer or self-insured employer.

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

(A) A medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of the first visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable.

(B) A medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation. However, an emergency room physician who is not authorized to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim.

(C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.

(D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed under ORS 678.375 to 678.390:

(i) May provide compensable medical services for 90 days from the date of the first visit on the claim;

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

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

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

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the physician or nurse practitioner agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

(b)(A) For initial or aggravation claims filed after June 7, 1995, the insurer or self-insured employer may require an injured worker, on a case-by-case basis, immediately to receive medical services from the managed care organization.

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

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

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

6 (5) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the
7 managed care organization, is authorized to provide the same level of services as a primary care
8 physician as established by ORS 656.260 (4), if at the time the worker is enrolled in the managed
9 care organization, the nurse practitioner maintains the worker's medical records and with whom the
10 worker has a documented history of treatment, if that nurse practitioner agrees to refer the worker
11 to the managed care organization for any specialized treatment, including physical therapy, to be
12 furnished by another provider that the worker may require and if that nurse practitioner agrees to
13 comply with all the rules, terms and conditions regarding services performed by the managed care
14 organization.

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

18 **SECTION 3.** ORS 656.340 is amended to read:

19 656.340. (1)(a) The insurer or self-insured employer shall cause vocational assistance to be pro-
20 vided to an injured worker who is eligible for assistance in returning to work.

21 (b) For this purpose the insurer or self-insured employer shall contact a worker with a claim for
22 a disabling compensable injury or claim for aggravation for evaluation of the worker's eligibility for
23 vocational assistance within five days of:

24 (A) Having knowledge of the worker's likely eligibility for vocational assistance, from a medical
25 or investigation report, notification from the worker, or otherwise; or

26 (B) The time the worker is medically stationary, if the worker has not returned to or been re-
27 leased for the worker's regular employment or has not returned to other suitable employment with
28 the employer at the time of injury or aggravation and the worker is not receiving vocational as-
29 sistance.

30 (c) Eligibility may be redetermined by the insurer or self-insured employer upon receipt of new
31 information that would change the eligibility determination.

32 (2) Contact under subsection (1) of this section shall include informing the worker about reem-
33 ployment rights, the responsibility of the worker to request reemployment, and wage subsidy and job
34 site modification assistance and the provisions of the preferred worker program pursuant to rules
35 adopted by the Director of the Department of Consumer and Business Services.

36 (3) Within five days after notification that the attending physician or nurse practitioner au-
37 thorized to provide compensable medical services under ORS 656.245 has released a worker to re-
38 turn to work, the insurer or self-insured employer shall inform the worker about the opportunity to
39 seek reemployment or reinstatement under ORS 659A.043 and 659A.046. The insurer shall inform the
40 employer of the worker's reemployment rights, wage subsidy and the job site modification assistance
41 and the provisions of the preferred worker program.

42 (4) As soon as possible, and not more than 30 days after the contact required by subsection (1)
43 of this section, the insurer or self-insured employer shall cause an individual certified by the direc-
44 tor to provide vocational assistance to determine whether the worker is eligible for vocational as-
45 sistance. The insurer or self-insured employer shall notify the worker of the decision regarding the

worker's eligibility for vocational assistance. If the insurer or self-insured employer decides that the worker is not eligible, the worker may apply to the director for review of the decision as provided in subsection (16) of this section. A worker determined ineligible upon evaluation under subsection (1)(b)(B) of this section, or because the worker's eligibility has fully and finally expired under standards prescribed by the director, may not be found eligible thereafter unless that eligibility determination is rejected by the director under subsection (16) of this section or the worker's condition worsens so as to constitute an aggravation claim under ORS 656.273. A worker is not entitled to vocational assistance benefits when possible eligibility for such benefits arises from a worsening of the worker's condition that occurs after the expiration of the worker's aggravation rights under ORS 656.273.

(5) The objectives of vocational assistance are to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the weekly wage currently being paid for employment which was the worker's regular employment even though the wage available following employment may be less than the wage prescribed by subsection (6) of this section. As used in this subsection and subsection (6) of this section, "regular employment" means the employment the worker held at the time of the injury or the claim for aggravation under ORS 656.273, whichever gave rise to the potential eligibility for vocational assistance; or, for a worker not employed at the time of the aggravation, the employment the worker held on the last day of work prior to the aggravation.

(6)(a) A worker is eligible for vocational assistance if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury or aggravation, and the worker has a substantial handicap to employment.

(b) As used in this subsection:

(A) A "substantial handicap to employment" exists when the worker, because of the injury or aggravation, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in suitable employment.

(B) "Suitable employment" means:

(i) Employment of the kind for which the worker has the necessary physical capacity, knowledge, skills and abilities;

(ii) Employment that is located where the worker customarily worked or is within reasonable commuting distance of the worker's residence; and

(iii) Employment that produces a weekly wage within 20 percent of that currently being paid for employment that was the worker's regular employment as defined in subsection (5) of this section. The director shall adopt rules providing methods of calculating the weekly wage currently being paid for the worker's regular employment for use in determining eligibility and for providing assistance to eligible workers. If the worker's regular employment was seasonal or temporary, the worker's wage shall be averaged based on a combination of the worker's earned income and any unemployment insurance payments. Only earned income evidenced by verifiable documentation such as federal or state tax returns shall be used in the calculation. Earned income does not include fringe benefits or reimbursement of the worker's employment expenses.

(7) Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employ-

ment assistance over training.

(8) An insurer or self-insured employer may utilize its own staff or may engage any other individual certified by the director to perform the vocational evaluation required by subsection (4) of this section.

(9) The director shall adopt rules providing:

(a) Standards for and methods of certifying individuals qualified by education, training and experience to provide vocational assistance to injured workers;

(b) Standards for registration of vocational assistance providers;

(c) Conditions and procedures under which the certification of an individual to provide vocational assistance services or the registration of a vocational assistance provider may be suspended or revoked for failure to maintain compliance with the certification or registration standards;

(d) Standards for the nature and extent of services a worker may receive, for plans for return to work and for determining when the worker has returned to work; and

(e) Procedures, schedules and conditions relating to the payment for services performed by a vocational assistance provider, that are based on payment for specific services performed and not fees for services performed on an hourly basis. Fee schedules shall reflect a reasonable rate for direct worker purchases and for all vocational assistance providers and shall be the same within suitable geographic areas.

(10) Insurers and self-insured employers shall maintain records and make reports to the director of vocational assistance actions at times and in the manner as the director may prescribe. The requirements prescribed shall be for the purpose of assisting the Department of Consumer and Business Services in monitoring compliance with this section to insure that workers receive timely and appropriate vocational assistance. The director shall minimize to the greatest extent possible the number, extent and kinds of reports required. The director shall compile a list of organizations or agencies registered to provide vocational assistance. A current list shall be distributed by the director to all insurers and self-insured employers. The insurer shall send the list to each worker with the notice of eligibility.

(11) When a worker is eligible to receive vocational assistance, the worker and the insurer or self-insured employer shall attempt to agree on the choice of a vocational assistance provider. If the worker agrees, the insurer or self-insured employer may utilize its own staff to provide vocational assistance. If they are unable to agree on a vocational assistance provider, the insurer or self-insured employer shall notify the director and the director shall select a provider. Any change in the choice of vocational assistance provider is subject to the approval of the director.

(12) Notwithstanding ORS 656.268, a worker actively engaged in training may receive temporary disability compensation for a maximum of 16 months. The insurer or self-insured employer may voluntarily extend the payment of temporary disability compensation to a maximum of 21 months. **The director may order the payment of temporary disability compensation for up to 21 months upon good cause shown by the injured worker.** The costs related to vocational assistance training programs may be paid for periods longer than 21 months, but in no event may temporary disability benefits be paid for a period longer than 21 months.

(13) As used in this section, "vocational assistance provider" means a public or private organization or agency that provides vocational assistance to injured workers.

(14)(a) Determination of eligibility for vocational assistance does not entitle all workers to the same type or extent of assistance.

(b) Training shall not be provided to an eligible worker solely because the worker cannot obtain

employment, otherwise suitable, that will produce the wage prescribed in subsection (6) of this section unless such training will enable the worker to find employment which will produce a wage significantly closer to that prescribed in subsection (6) of this section.

(c) Nothing in this section shall be interpreted to expand the availability of training under this section.

(15) A physical capacities evaluation shall be performed in conjunction with vocational assistance or determination of eligibility for such assistance at the request of the insurer or self-insured employer or worker. The request shall be made to the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245. The attending physician or nurse practitioner, within 20 days of the request, shall perform a physical capacities evaluation or refer the worker for such evaluation or advise the insurer or self-insured employer and the worker in writing that the injured worker is incapable of participating in a physical capacities evaluation.

(16)(a) The Legislative Assembly finds that vocational rehabilitation of injured workers requires a high degree of cooperation between all of the participants in the vocational assistance process. Based on this finding, the Legislative Assembly concludes that disputes regarding eligibility for and extent of vocational assistance services should be resolved through nonadversarial procedures to the greatest extent possible consistent with constitutional principles. The director shall adopt by rule a procedure for resolving vocational assistance disputes in the manner provided in this subsection.

(b) If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must apply to the director for administrative review of the matter. Application for review must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time.

(c) If the worker's dissatisfaction is resolved by agreement of the parties, the agreement shall be reduced to writing, and the director and the parties shall review the agreement and either approve or disapprove it. The agreement is subject to reconsideration by the director under limitations prescribed by the director, but is not subject to review by any other forum.

(d) If the worker's dissatisfaction is not resolved by agreement of the parties, the director shall resolve the matter in a written order based on a record sufficient to permit review. The order is subject to review under ORS 656.704. The request for a hearing must be filed within 60 days of the date the order was issued. At the hearing, the order of the director shall be modified only if it:

(A) Violates a statute or rule;

(B) Exceeds the statutory authority of the agency;

(C) Was made upon unlawful procedure; or

(D) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(e) For purposes of this subsection, the term "parties" does not include a noncomplying employer.

SECTION 4. The amendments to ORS 656.340 by section 3 of this 2011 Act apply to all claims by workers who are eligible for or actively engaged in vocational training on or after the effective date of this 2011 Act.