House Bill 3212

Sponsored by Representative WITT; Representative KENNEMER, Senators GEORGE, MONNES ANDERSON (at the request of Beth Cooke)

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.**

Extends period in which nurse practitioner is authorized to provide compensable medical services in workers' compensation claim from 90 days to 180 days.

1 **A BILL FOR AN ACT**

2 Relating to the authority of nurse practitioners in workers' compensation claims; amending ORS
3 656.245.

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

5 **SECTION 1.** ORS 656.245 is amended to read:

6 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause
7 to be provided medical services for conditions caused in material part by the injury for such period
8 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS
9 656.225, including such medical services as may be required after a determination of permanent
10 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the
11 insurer or the self-insured employer shall cause to be provided only those medical services directed
12 to medical conditions caused in major part by the injury.

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

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

20 (A) Services provided to a worker who has been determined to be permanently and totally dis-
21 abled.

22 (B) Prescription medications.

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

25 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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.

(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, non-experimental 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

1 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
2 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.
3 (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an at-
4 tending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician
5 at the time of claim closure may make findings regarding the worker's impairment for the purpose
6 of evaluating the worker's disability.
7 (D) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed
8 under ORS 678.375 to 678.390:
9 (i) May provide compensable medical services for [*90*] **180** days from the date of the first visit
10 on the claim;
11 (ii) May authorize the payment of temporary disability benefits for a period not to exceed 60
12 days from the date of the first visit on the initial claim; and
13 (iii) When an injured worker treating with a nurse practitioner authorized to provide
14 compensable services under this section becomes medically stationary within the [*90-day*] **180-day**
15 period in which the nurse practitioner is authorized to treat the injured worker, shall refer the in-
16 jured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the
17 purpose of making findings regarding the worker's impairment for the purpose of evaluating the
18 worker's disability. If a worker returns to the nurse practitioner after initial claim closure for
19 evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the
20 worker to an attending physician and the insurer shall compensate the nurse practitioner for the
21 examination performed.
22 (3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice
23 of the committee created by ORS 656.794 and upon the advice of the professional licensing boards
24 of practitioners affected by the rule, may exclude from compensability any medical treatment the
25 director finds to be unscientific, unproven, outmoded or experimental. The decision of the director
26 is subject to review under ORS 656.704.
27 (4) Notwithstanding subsection (2)(a) of this section, when a self-insured employer or the insurer
28 of an employer contracts with a managed care organization certified pursuant to ORS 656.260 for
29 medical services required by this chapter to be provided to injured workers:
30 (a) Those workers who are subject to the contract shall receive medical services in the manner
31 prescribed in the contract. Workers subject to the contract include those who are receiving medical
32 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
33 jury or medically stationary status, on or after the effective date of the contract. If the managed
34 care organization determines that the change in provider would be medically detrimental to the
35 worker, the worker shall not become subject to the contract until the worker is found to be med-
36 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
37 ganization determines that the change in provider is no longer medically detrimental, whichever
38 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
39 notice of the worker's enrollment in the managed care organization, or upon the third day after the
40 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
41 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
42 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
43 vide compensable medical services under this section under an expired or terminated managed care
44 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
45 and conditions regarding services performed under any subsequent managed care organization con-

tract 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.

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

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

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