

A-Engrossed
Senate Bill 533

Ordered by the Senate March 28
Including Senate Amendments dated March 28

Sponsored by COMMITTEE ON BUSINESS AND TRANSPORTATION

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.

Extends period during which nurse practitioner may provide services to injured worker. Modifies authority of nurse practitioner and chiropractic physician to provide services to injured worker enrolled in managed care organization. [*Requires managed care organization to provide dispute resolution process for resolution of disputes between managed care organization and health care provider.*] Specifies conditions under which managed care organization may deny or terminate participation of primary care physician, chiropractic physician or nurse practitioner in managed care organization.

A BILL FOR AN ACT

1
2 Relating to the authority of certain medical service providers to provide services to injured workers;
3 amending ORS 656.245 and 656.260.

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.

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.

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

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

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

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

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

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

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

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

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

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

33 (2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
34 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
35 may subsequently change attending physician or nurse practitioner two times without approval from
36 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
37 insurer or self-insured employer may require the director's approval of the selection. The decision
38 of the director is subject to review under ORS 656.704. The worker also may choose an attending
39 doctor or physician in another country or in any state or territory or possession of the United
40 States with the prior approval of the insurer 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 the first
45 visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an

1 attending 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 authorized
5 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
6 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
7 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
8 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

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

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

15 (i) May provide compensable medical services for [90] **180** days from the date of the first visit
16 on the **initial** claim;

17 (ii) May authorize the payment of temporary disability benefits for a period not to exceed [60]
18 **180** days from the date of the first visit on the initial claim; and

19 (iii) When an injured worker treating with a nurse practitioner authorized to provide
20 compensable services under this section becomes medically stationary within the [90-day] **180-day**
21 period in which the nurse practitioner is authorized to treat the injured worker, shall refer the in-
22 jured worker to a physician qualified to be an attending physician as defined in ORS 656.005 for the
23 purpose of making findings regarding the worker's impairment for the purpose of evaluating the
24 worker's disability. If a worker returns to the nurse practitioner after initial claim closure for
25 evaluation of a possible worsening of the worker's condition, the nurse practitioner shall refer the
26 worker to an attending physician and the insurer shall compensate the nurse practitioner for the
27 examination performed.

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

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

36 (a) Those workers who are subject to the contract shall receive medical services in the manner
37 prescribed in the contract. Workers subject to the contract include those who are receiving medical
38 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
39 jury or medically stationary status, on or after the effective date of the contract. If the managed
40 care organization determines that the change in provider would be medically detrimental to the
41 worker, the worker shall not become subject to the contract until the worker is found to be med-
42 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
43 ganization determines that the change in provider is no longer medically detrimental, whichever
44 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
45 notice of the worker's enrollment in the managed care organization, or upon the third day after the

1 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
2 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
3 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
4 vide compensable medical services under this section under an expired or terminated managed care
5 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
6 and conditions regarding services performed under any subsequent managed care organization con-
7 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
8 primary residence is more than 100 miles outside the managed care organization's certified ge-
9 ographical area. Each such contract must comply with the certification standards provided in ORS
10 656.260. However, a worker may receive immediate emergency medical treatment that is
11 compensable from a medical service provider who is not a member of the managed care organization.
12 Insurers or self-insured employers who contract with a managed care organization for medical ser-
13 vices shall give notice to the workers of eligible medical service providers and such other informa-
14 tion regarding the contract and manner of receiving medical services as the director may prescribe.
15 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
16 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
17 as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

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

1 organization.

2 **(b) A nurse practitioner authorized to provide medical services to a worker enrolled in**
3 **the managed care organization may provide medical treatment to the worker if the treat-**
4 **ment is determined to be medically appropriate according to the service utilization review**
5 **process of the managed care organization and may authorize temporary disability payments**
6 **as provided in subsection (2)(b)(D) of this section. However, the managed care organization**
7 **may authorize the nurse practitioner to provide medical services and authorize temporary**
8 **disability payments beyond the periods established in subsection (2)(b)(D) of this section.**

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

12 **SECTION 2.** ORS 656.260 is amended to read:

13 656.260. (1) Any health care provider or group of medical service providers may make written
14 application to the Director of the Department of Consumer and Business Services to become certi-
15 fied to provide managed care to injured workers for injuries and diseases compensable under this
16 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
17 erated by an insurer or employer other than a health care provider to become certified to provide
18 managed care.

19 (2) Each application for certification shall be accompanied by a reasonable fee prescribed by the
20 director. A certificate is valid for such period as the director may prescribe unless sooner revoked
21 or suspended.

22 (3) Application for certification shall be made in such form and manner and shall set forth such
23 information regarding the proposed plan for providing services as the director may prescribe. The
24 information shall include, but not be limited to:

25 (a) A list of the names of all individuals who will provide services under the managed care plan,
26 together with appropriate evidence of compliance with any licensing or certification requirements
27 for that individual to practice in this state.

28 (b) A description of the times, places and manner of providing services under the plan.

29 (c) A description of the times, places and manner of providing other related optional services
30 the applicants wish to provide.

31 (d) Satisfactory evidence of ability to comply with any financial requirements to insure delivery
32 of service in accordance with the plan which the director may prescribe.

33 (4) The director shall certify a health care provider or group of medical service providers to
34 provide managed care under a plan if the director finds that the plan:

35 (a) Proposes to provide medical and health care services required by this chapter in a manner
36 that:

37 (A) Meets quality, continuity and other treatment standards adopted by the health care provider
38 or group of medical service providers in accordance with processes approved by the director; and

39 (B) Is timely, effective and convenient for the worker.

40 (b) Subject to any other provision of law, does not discriminate against or exclude from partic-
41 ipation in the plan any category of medical service providers and includes an adequate number of
42 each category of medical service providers to give workers adequate flexibility to choose medical
43 service providers from among those individuals who provide services under the plan. However,
44 nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to
45 the granting of medical staff privileges.

1 (c) Provides appropriate financial incentives to reduce service costs and utilization without
2 sacrificing the quality of service.

3 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
4 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
5 or excessive treatment, to exclude from participation in the plan those individuals who violate these
6 treatment standards and to provide for the resolution of such medical disputes as the director con-
7 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
8 zation and contract review committee shall be physicians licensed to practice medicine by the
9 Oregon Medical Board. As used in this paragraph:

10 (A) "Peer review" means evaluation or review of the performance of colleagues by a panel with
11 similar types and degrees of expertise. Peer review requires participation of at least three physicians
12 prior to final determination.

13 (B) "Service utilization review" means evaluation and determination of the reasonableness, ne-
14 cessity and appropriateness of a worker's use of medical care resources and the provision of any
15 needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service
16 utilization review" includes prior authorization, concurrent review, retrospective review, discharge
17 planning and case management activities.

18 (C) "Quality assurance" means activities to safeguard or improve the quality of medical care
19 by assessing the quality of care or service and taking action to improve it.

20 (D) "Dispute resolution" includes the resolution of disputes arising under peer review, service
21 utilization review and quality assurance activities between insurers, self-insured employers, workers
22 and medical and health care service providers, as required under the certified plan.

23 (E) "Contract review" means the methods and processes whereby the managed care organization
24 monitors and enforces its contracts with participating providers for matters other than matters
25 enumerated in subparagraphs (A), (B) and (C) of this paragraph.

26 (e) Provides a program involving cooperative efforts by the workers, the employer and the
27 managed care organizations to promote workplace health and safety consultative and other services
28 and early return to work for injured workers.

29 (f) Provides a timely and accurate method of reporting to the director necessary information
30 regarding medical and health care service cost and utilization to enable the director to determine
31 the effectiveness of the plan.

32 *[(g) Authorizes workers to receive compensable medical treatment from a primary care physician
33 who is not a member of the managed care organization, but who maintains the worker's medical re-
34 cords and with whom the worker has a documented history of treatment, if that primary care physician
35 agrees to refer the worker to the managed care organization for any specialized treatment, including
36 physical therapy, to be furnished by another provider that the worker may require and if that primary
37 care physician agrees to comply with all the rules, terms and conditions regarding services performed
38 by the managed care organization. Nothing in this paragraph is intended to limit the worker's right
39 to change primary care physicians prior to the filing of a workers' compensation claim. As used in this
40 paragraph, "primary care physician" means a physician who is qualified to be an attending physician
41 referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a general practitioner or an
42 internal medicine practitioner.]*

43 **(g)(A) Authorizes workers to receive compensable medical treatment from a primary
44 care physician or chiropractic physician who is not a member of the managed care organ-
45 ization, but who maintains the worker's medical records and is a physician with whom the**

1 worker has a documented history of treatment, if:

2 (i) The primary care physician or chiropractic physician agrees to refer the worker to
3 the managed care organization for any specialized treatment, including physical therapy, to
4 be furnished by another provider that the worker may require;

5 (ii) The primary care physician or chiropractic physician agrees to comply with all the
6 rules, terms and conditions regarding services performed by the managed care organization;
7 and

8 (iii) The treatment is determined to be medically appropriate according to the service
9 utilization review process of the managed care organization.

10 (B) Nothing in this paragraph is intended to limit the worker's right to change primary
11 care physicians or chiropractic physicians prior to the filing of a workers' compensation
12 claim.

13 (C) A chiropractic physician authorized to provide compensable medical treatment under
14 this paragraph may provide services and authorize temporary disability compensation as
15 provided in ORS 656.005 (12)(b)(B) and 656.245 (2)(b). However, the managed care organization
16 may authorize chiropractic physicians to provide medical services and authorize temporary
17 disability payments beyond the periods established in ORS 656.005 (12)(b)(B) and ORS 656.245
18 (2)(b).

19 (D) As used in this paragraph, "primary care physician" means a physician who is qual-
20 ified to be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family
21 practitioner, a general practitioner or an internal medicine practitioner.

22 (h) Provides a written explanation for denial of participation in the managed care organization
23 plan to any licensed health care provider that has been denied participation in the managed care
24 organization plan.

25 (i) Does not prohibit the injured worker's attending physician from advocating for medical ser-
26 vices and temporary disability benefits for the injured worker that are supported by the medical
27 record.

28 (j) Complies with any other requirement the director determines is necessary to provide quality
29 medical services and health care to injured workers.

30 (5)(a) Notwithstanding ORS 656.245 (5) and subsection (4)(g) of this section, a managed
31 care organization may deny or terminate the authorization of a primary care physician or
32 chiropractic physician to serve as an attending physician under subsection (4)(g) of this
33 section or of a nurse practitioner to provide medical services as provided in ORS 656.245 (5)
34 if the physician or nurse practitioner, within two years prior to the worker's enrollment in
35 the plan:

36 (A) Has been terminated from serving as an attending physician or nurse practitioner for
37 a worker enrolled in the plan for failure to meet the requirements of subsection (4)(g) of this
38 section or of ORS 656.245 (5); or

39 (B) Has failed to satisfy the credentialing standards for participating in the managed care
40 organization.

41 (b) The director shall adopt by rule reporting standards for managed care organizations
42 to report denials and terminations of the authorization of primary care physicians,
43 chiropractic physicians and nurse practitioners who are not members of the managed care
44 organization to provide compensable medical treatment under ORS 656.245 (5) and subsection
45 (4)(g) of this section. The director shall annually report to the Workers' Compensation

1 **Management-Labor Advisory Committee the information reported to the director by man-**
2 **aged care organizations under this paragraph.**

3 [(5)] (6) The director shall refuse to certify or may revoke or suspend the certification of any
4 health care provider or group of medical service providers to provide managed care if the director
5 finds that:

6 (a) The plan for providing medical or health care services fails to meet the requirements of this
7 section.

8 (b) Service under the plan is not being provided in accordance with the terms of a certified plan.

9 [(6)] (7) Any issue concerning the provision of medical services to injured workers subject to a
10 managed care contract and service utilization review, quality assurance, dispute resolution, contract
11 review and peer review activities as well as authorization of medical services to be provided by
12 other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the
13 director or the director's designated representatives. The decision of the director is subject to re-
14 view under ORS 656.704. Data generated by or received in connection with these activities, includ-
15 ing written reports, notes or records of any such activities, or of any review thereof, shall be
16 confidential, and shall not be disclosed except as considered necessary by the director in the ad-
17 ministration of this chapter. The director may report professional misconduct to an appropriate li-
18 censing board.

19 [(7)] (8) No data generated by service utilization review, quality assurance, dispute resolution
20 or peer review activities and no physician profiles or data used to create physician profiles pursuant
21 to this section or a review thereof shall be used in any action, suit or proceeding except to the ex-
22 tent considered necessary by the director in the administration of this chapter. The confidentiality
23 provisions of this section shall not apply in any action, suit or proceeding arising out of or related
24 to a contract between a managed care organization and a health care provider whose confidentiality
25 is protected by this section.

26 [(8)] (9) A person participating in service utilization review, quality assurance, dispute resol-
27 ution or peer review activities pursuant to this section shall not be examined as to any communi-
28 cation made in the course of such activities or the findings thereof, nor shall any person be subject
29 to an action for civil damages for affirmative actions taken or statements made in good faith.

30 [(9)] (10) No person who participates in forming consortiums, collectively negotiating fees or
31 otherwise solicits or enters into contracts in a good faith effort to provide medical or health care
32 services according to the provisions of this section shall be examined or subject to administrative
33 or civil liability regarding any such participation except pursuant to the director's active super-
34 vision of such activities and the managed care organization. Before engaging in such activities, the
35 person shall provide notice of intent to the director in a form prescribed by the director.

36 [(10)] (11) The provisions of this section shall not affect the confidentiality or admission in evi-
37 dence of a claimant's medical treatment records.

38 [(11)] (12) In consultation with the committees referred to in ORS 656.790 and 656.794, the di-
39 rector shall adopt such rules as may be necessary to carry out the provisions of this section.

40 [(12)] (13) As used in this section, ORS 656.245, 656.248 and 656.327, "medical service provider"
41 means a person duly licensed to practice one or more of the healing arts in any country or in any
42 state or territory or possession of the United States.

43 [(13)] (14) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care
44 organization contract may designate any medical service provider or category of providers as at-
45 tending physicians.

1 [(14)] (15) If a worker, insurer, self-insured employer [or], the attending physician **or an au-**
 2 **thorized health care provider** is dissatisfied with an action of the managed care organization re-
 3 garding the provision of medical services pursuant to this chapter, peer review, service utilization
 4 review or quality assurance activities, that person or entity must first apply to the director for ad-
 5 ministrative review of the matter before requesting a hearing. Such application must be made not
 6 later than the 60th day after the date the managed care organization has completed and issued its
 7 final decision.

8 [(15)] (16) Upon a request for administrative review, the director shall create a documentary
 9 record sufficient for judicial review. The director shall complete administrative review and issue a
 10 proposed order within a reasonable time. The proposed order of the director issued pursuant to this
 11 section shall become final and not subject to further review unless a written request for a hearing
 12 is filed with the director within 30 days of the mailing of the order to all parties.

13 [(16)] (17) At the contested case hearing, the order may be modified only if it is not supported
 14 by substantial evidence in the record or reflects an error of law. No new medical evidence or issues
 15 shall be admitted. The dispute may also be remanded to the managed care organization for further
 16 evidence taking, correction or other necessary action if the Administrative Law Judge or director
 17 determines the record has been improperly, incompletely or otherwise insufficiently developed. De-
 18 cisions by the director regarding medical disputes are subject to review under ORS 656.704.

19 [(17)] (18) Any person who is dissatisfied with an action of a managed care organization other
 20 than regarding the provision of medical services pursuant to this chapter, peer review, service
 21 utilization review or quality assurance activities may request review under ORS 656.704.

22 [(18)] (19) Notwithstanding any other provision of law, original jurisdiction over contract review
 23 disputes is with the director. The director may resolve the matter by issuing an order subject to
 24 review under ORS 656.704, or the director may determine that the matter in dispute would be best
 25 addressed in another forum and so inform the parties.

26 [(19)] (20) The director shall conduct such investigations, audits and other administrative over-
 27 sight in regard to managed care as the director deems necessary to carry out the purposes of this
 28 chapter.

29 [(20)(a)] (21)(a) Except as otherwise provided in this chapter, only a managed care organization
 30 certified by the director may:

- 31 (A) Restrict the choice of a health care provider or medical service provider by a worker;
- 32 (B) Restrict the access of a worker to any category of medical service providers;
- 33 (C) Restrict the ability of a medical service provider to refer a worker to another provider;
- 34 (D) Require preauthorization or precertification to determine the necessity of medical services
 35 or treatment; or
- 36 (E) Restrict treatment provided to a worker by a medical service provider to specific treatment
 37 guidelines, protocols or standards.

38 (b) The provisions of paragraph (a) of this subsection do not apply to:

- 39 (A) A medical service provider who refers a worker to another medical service provider;
- 40 (B) Use of an on-site medical service facility by the employer to assess the nature or extent of
 41 a worker's injury; or
- 42 (C) Treatment provided by a medical service provider or transportation of a worker in an
 43 emergency or trauma situation.

44 (c) Except as provided in paragraph (b) of this subsection, if the director finds that a person has
 45 violated a provision of paragraph (a) of this subsection, the director may impose a sanction that may

1 include a civil penalty not to exceed \$2,000 for each violation.

2 (d) If violation of paragraph (a) of this subsection is repeated or willful, the director may order
3 the person committing the violation to cease and desist from making any future communications
4 with injured workers or medical service providers or from taking any other actions that directly or
5 indirectly affect the delivery of medical services provided under this chapter.

6 (e)(A) Penalties imposed under this subsection are subject to ORS 656.735 (4) to (6) and 656.740.

7 (B) Cease and desist orders issued under this subsection are subject to ORS 656.740.

8
