HB 3022-5
(LC 696)
4/26/19 (TSB/ps)

Requested by HOUSE COMMITTEE ON BUSINESS AND LABOR (at the request of the Management-Labor Advisory Committee)

PROPOSED AMENDMENTS TO
HOUSE BILL 3022

On page 1 of the printed bill, line 2, after "ORS" delete the rest of the line and lines 3 and 4 and insert "656.245, 656.266 and 656.704; and declaring an emergency.".

Delete lines 6 through 30 and delete pages 2 through 50 and insert:

"SECTION 1. ORS 656.245 is amended to read:

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

"(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) In addition to other benefits allowed under this chapter, after**

an industrial accident or occupational disease has been determined to be compensable, diagnostic services are compensable if the diagnostic services are reasonable and necessary to identify the nature or extent of a medical condition that might be related to the industrial accident or occupational disease. Surgery and surgical procedures are compensable diagnostic services only if other diagnostic services are inadequate for identifying the nature and extent of the effects of an industrial accident or occupational exposure and are sufficient to establish a treatment plan. For purposes of this subsection, a diagnostic injection is not surgery or a surgical procedure.

"[*(c)*] **(d)** 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)*] **(e)** 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)*] **(f)** 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 180 days from the date of the first visit on the initial claim;

"(ii) May authorize the payment of temporary disability benefits for a period not to exceed 180 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 180-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 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.

"(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) 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 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.

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

"(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.

"SECTION 2. ORS 656.266 is amended to read:

"656.266. (1) The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred.

"(2) Notwithstanding subsection (1) of this section, for the purpose of combined condition injury claims under ORS 656.005 (7)(a)(B) only:

"(a) Once the worker establishes an otherwise compensable injury, the employer shall bear the burden of proof to establish the otherwise compensable injury is not, or is no longer, the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

"(b) Notwithstanding ORS 656.804, paragraph (a) of this subsection does not apply to any occupational disease claim.

"**(3) For denials issued under ORS 656.262 (6)(c) or (7)(b), the employer bears the burden of proof to establish that the otherwise compensable condition and any other objective medical findings materially caused by the industrial accident are no longer the major contributing cause of the need for treatment and disability of the combined condition.**

"SECTION 3. ORS 656.704 is amended to read:

"656.704. (1) Actions and orders of the Director of the Department of Consumer and Business Services regarding matters concerning a claim under this chapter, and administrative and judicial review of those matters, are subject to the procedural provisions of this chapter and such procedural rules as the Workers' Compensation Board may prescribe.

"(2)(a) A party dissatisfied with an action or order regarding a matter other than a matter concerning a claim under this chapter may request a hearing on the matter in writing to the director. The director shall refer the request for hearing to the Workers' Compensation Board for a hearing before an Administrative Law Judge. Review of an order issued by the Administrative Law Judge shall be by the director and the director shall issue a final order that is subject to judicial review as provided by ORS 183.480 to 183.497.

"(b) The director shall prescribe the classes of orders issued under this subsection by Administrative Law Judges and other personnel that are final,

appealable orders and those orders that are preliminary orders subject to revision by the director.

"(3)(a) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, subject to paragraph (b) of this subsection, such matters do not include any disputes arising under ORS 656.245, 656.247, 656.248, 656.260 or 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide.

"(b) The respective authority of the board and the director to resolve medical service disputes shall be determined according to the following principles:

"(A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim.

"(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245 [*(1)(c)*] **(1)(d)**, is not a matter concerning a claim.

"(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.

"(c) Notwithstanding ORS 656.283 (3), if parties to a hearing scheduled before an Administrative Law Judge are involved in a dispute regarding both matters concerning a claim and matters not concerning a claim, the Admin-

istrative Law Judge may defer any action on the matter concerning a claim until the director has completed an administrative review of the matters other than those concerning a claim. The director shall mail a copy of the administrative order to the parties and to the Administrative Law Judge. A party may request a hearing on the order of the director. At the request of a party or by the own motion of the Administrative Law Judge, the hearings on the separate matters may be consolidated. The Administrative Law Judge shall issue an order for those matters concerning a claim and a separate order for matters other than those concerning a claim.

"(4) Hearings under ORS 656.740 shall be conducted by an Administrative Law Judge from the board's Hearings Division.

"(5) If a request for hearing or administrative review is filed with either the director or the board and it is determined that the request should have been filed with the other, the dispute shall be transferred. Filing a request will be timely filed if the original filing was completed within the prescribed time.

"SECTION 4. (1) Except as provided in subsection (2) of this section, the amendments to ORS 656.245, 656.266 and 656.704 by sections 1 to 3 of this 2019 Act apply to all claims or causes of action that exist or that arise on or after the effective date of this 2019 Act, regardless of the date of injury or the date the claim is presented.

"(2) The amendments to ORS 656.266 by section 2 of this 2019 Act apply to denials that are issued after the effective date of this 2019 Act.

"(3) This 2019 Act is retroactive unless a specific provision of this 2019 Act indicates otherwise.

"SECTION 5. This 2019 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2019 Act takes effect on its passage.".
