LC 1486
2023 Regular Session
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D R A F T

SUMMARY

Removes limits on duration of medical service and number of visits and certain areas of practice for chiropractic physicians serving as attending physicians in workers' compensation claims.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to chiropractic physicians; amending ORS 656.005, 656.245 and 656.260; and declaring an emergency.

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

SECTION 1. ORS 656.005, as amended by section 5, chapter 6, Oregon Laws 2022, is amended to read:

656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered employment, as determined by the Employment Department, for the last quarter of the calendar year preceding the fiscal year in which the injury occurred.

(2)(a) "Beneficiary" means an injured worker, and the spouse in a marriage, child or dependent of a worker, who is entitled to receive payments under this chapter.

(b) "Beneficiary" does not include a person who intentionally causes the compensable injury to or death of an injured worker.

(3) "Board" means the Workers' Compensation Board.

(4) "Carrier-insured employer" means an employer who provides workers' compensation coverage with the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state.

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.

(5) "Child" means a child of an injured worker, including:

(a) A posthumous child;

(b) A child legally adopted before the injury;

(c) A child toward whom the worker stands in loco parentis;

(d) A child born out of wedlock;

(e) A stepchild, if the stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support; and

(f) A child of any age who was incapacitated at the time of the accident and thereafter remains incapacitated and substantially dependent on the worker for support.

(6) "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge.

(7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death. An injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

(A) An injury or disease is not compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is 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) "Compensable injury" does not include:

(A) Injury to any active participant in assaults or combats that are not

connected to the job assignment and that amount to a deviation from customary duties;

(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

(C) Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or cannabis or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption.

(c) A "disabling compensable injury" is an injury that entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury.

(d) A "nondisabling compensable injury" is any injury that requires medical services only.

(8) "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Dependent" means any of the following individuals who, at the time of an accident, depended in whole or in part for the individual's support on the earnings of a worker who dies as a result of an injury:

(a) A parent of a worker or the parent's spouse or domestic partner;

(b) A grandparent of a worker or the grandparent's spouse or domestic partner;

(c) A grandchild of a worker or the grandchild's spouse or domestic partner;

(d) A sibling or stepsibling of a worker or the sibling's or stepsibling's spouse or domestic partner; and

(e) Any individual related by blood or affinity whose close association with a worker is the equivalent of a family relationship.

(11) "Director" means the Director of the Department of Consumer and Business Services.

(12)(a) "Doctor" or "physician" means a person duly licensed to practice one or more of the healing arts in any country or in any state, territory or possession of the United States within the limits of the license of the licensee.

(b) Except as otherwise provided for workers subject to a managed care contract, "attending physician" means a doctor, physician or physician assistant who is primarily responsible for the treatment of a worker's compensable injury and who is:

(A)**(i)** A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(ii) A doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States; or

(B) For a cumulative total of 60 days from the first visit on the initial claim or for a cumulative total of 18 visits, whichever occurs first, to any of the medical service providers listed in this subparagraph, a:

[*(i) Doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon under ORS chapter 684 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States;*]

[*(ii)*] **(i)** Physician assistant licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly licensed physician as-

sistant in any country or in any state, territory or possession of the United States; or

[*(iii)*] **(ii)** Doctor of naturopathy or naturopathic physician licensed by the Oregon Board of Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

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

(d) "Consulting physician" means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician or nurse practitioner authorized to provide compensable medical services under ORS 656.245 regarding treatment of a worker's compensable injury.

(13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and the state, state agencies, counties, municipal corporations, school districts and other public corporations or political subdivisions, that contracts to pay a remuneration for the services of any worker.

(b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of a temporary service provider is not the employer of temporary workers provided by the temporary service provider.

(c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning for that term provided in ORS 656.850.

(d) For the purposes of this chapter, "subject employer" means an employer that is subject to this chapter as provided in ORS 656.023.

(14) "Insurer" means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in this state or an assigned claims agent selected by the director under ORS 656.054.

(15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.

(16) "Incapacitated" means an individual is physically or mentally unable to earn a livelihood.

(17) "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time.

(18) "Noncomplying employer" means a subject employer that has failed to comply with ORS 656.017.

(19) "Objective findings" in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. "Objective findings" does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable.

(20) "Palliative care" means medical service rendered to reduce or moderate temporarily the intensity of an otherwise stable medical condition, but does not include those medical services rendered to diagnose, heal or permanently alleviate or eliminate a medical condition.

(21) "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of the employer.

(22) "Payroll" means a record of wages payable to workers for their services and includes commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. However, "payroll" does not include overtime pay, vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments to reward workers for safe working practices. Bonus pay is limited to payments that are not anticipated under the contract of employment and that are paid at the sole discretion of the employer. The exclusion from payroll of bonus payments to reward workers for safe working practices is only for the purpose of calculations based on payroll to determine premium for workers' compensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter.

(23) "Person" includes a partnership, joint venture, association, limited

liability company and corporation.

(24)(a) "Preexisting condition" means, for all industrial injury claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment, provided that:

(A) Except for claims in which a preexisting condition is arthritis or an arthritic condition, the worker has been diagnosed with the condition, or has obtained medical services for the symptoms of the condition regardless of diagnosis; and

(B)(i) In claims for an initial injury or omitted condition, the diagnosis or treatment precedes the initial injury;

(ii) In claims for a new medical condition, the diagnosis or treatment precedes the onset of the new medical condition; or

(iii) In claims for a worsening pursuant to ORS 656.273 or 656.278, the diagnosis or treatment precedes the onset of the worsened condition.

(b) "Preexisting condition" means, for all occupational disease claims, any injury, disease, congenital abnormality, personality disorder or similar condition that contributes to disability or need for treatment and that precedes the onset of the claimed occupational disease, or precedes a claim for worsening in such claims pursuant to ORS 656.273 or 656.278.

(c) For the purposes of industrial injury claims, a condition does not contribute to disability or need for treatment if the condition merely renders the worker more susceptible to the injury.

(25) "Self-insured employer" means an employer or group of employers certified under ORS 656.430 as meeting the qualifications set out by ORS 656.407.

(26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident Insurance Fund Corporation created under ORS 656.752.

(27) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar ad-

vantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

(28)(a) "Worker" means any person, other than an independent contractor, who engages to furnish services for a remuneration, including a minor whether lawfully or unlawfully employed and salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an adult in custody or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant.

(b) For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

(c) For the purposes of this chapter, "subject worker" means a worker who is subject to this chapter as provided in ORS 656.027.

(29) "Independent contractor" has the meaning for that term provided in ORS 670.600.

SECTION 2. 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) 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 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 fur-

nished 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 3. ORS 656.260 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Provides adequate methods of peer review, service utilization review, quality assurance, contract review and dispute resolution to ensure appro-

priate treatment or to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate. A majority of the members of each peer review, quality assurance, service utilization and contract review committee shall be physicians licensed to practice medicine by the Oregon Medical Board. As used in this paragraph:

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

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

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

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

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

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

jured workers.

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

(g)(A) Authorizes workers to receive compensable medical treatment from a primary care physician or chiropractic physician who is not a member of the managed care organization, but who maintains the worker's medical records and is a physician with whom the worker has a documented history of treatment, if:

(i) The primary care physician or chiropractic physician 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;

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

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

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

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

(D) As used in this paragraph, "primary care physician" means a physician who is qualified to be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a general practitioner or an

internal medicine practitioner.

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

(i) Does not prohibit the injured worker's attending physician from advocating for medical services and temporary disability benefits for the injured worker that are supported by the medical record.

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

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

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

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

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

(6) The director shall refuse to certify or may revoke or suspend the cer-

tification of any health care provider or group of medical service providers to provide managed care if the director finds that:

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

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

(7) Any issue concerning the provision of medical services to injured workers subject to a managed care contract and service utilization review, quality assurance, dispute resolution, contract review and peer review activities as well as authorization of medical services to be provided by other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the director or the director's designated representatives. The decision of the director is subject to review under ORS 656.704. Data generated by or received in connection with these activities, including written reports, notes or records of any such activities, or of any review thereof, shall be confidential, and shall not be disclosed except as considered necessary by the director in the administration of this chapter. The director may report professional misconduct to an appropriate licensing board.

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

(9) A person participating in service utilization review, quality assurance, dispute resolution or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil

damages for affirmative actions taken or statements made in good faith.

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

(11) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(12) In consultation with the committees referred to in ORS 656.790 and 656.794, the director shall adopt such rules as may be necessary to carry out the provisions of this section.

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

(14) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care organization contract may designate any medical service provider or category of providers as attending physicians.

(15) If a worker, insurer, self-insured employer, the attending physician or an authorized health care provider is dissatisfied with an action of the managed care organization regarding the provision of medical services pursuant to this chapter, peer review, service utilization review or quality assurance activities, that person or entity must first apply to the director for administrative review of the matter before requesting a hearing. Such application must be made not later than the 60th day after the date the managed care organization has completed and issued its final decision.

(16) Upon a request for administrative review, the director shall create a documentary record sufficient for judicial review. The director shall

complete administrative review and issue a proposed order within a reasonable time. The proposed order of the director issued pursuant to this section shall become final and not subject to further review unless a written request for a hearing is filed with the director within 30 days of the mailing of the order to all parties.

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

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

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

(20) The director shall conduct such investigations, audits and other administrative oversight in regard to managed care as the director deems necessary to carry out the purposes of this chapter.

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

(A) Restrict the choice of a health care provider or medical service provider by a worker;

(B) Restrict the access of a worker to any category of medical service providers;

(C) Restrict the ability of a medical service provider to refer a worker to another provider;

(D) Require preauthorization or precertification to determine the necessity of medical services or treatment; or

(E) Restrict treatment provided to a worker by a medical service provider to specific treatment guidelines, protocols or standards.

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

(A) A medical service provider who refers a worker to another medical service provider;

(B) Use of an on-site medical service facility by the employer to assess the nature or extent of a worker's injury; or

(C) Treatment provided by a medical service provider or transportation of a worker in an emergency or trauma situation.

(c) Except as provided in paragraph (b) of this subsection, if the director finds that a person has violated a provision of paragraph (a) of this subsection, the director may impose a sanction that may include a civil penalty not to exceed $2,000 for each violation.

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

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

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

SECTION 4. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.
