

House Bill 3150

Sponsored by COMMITTEE ON BUSINESS AND LABOR (at the request of Oregon Chiropractic Association)

SUMMARY

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

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

1
2 Relating to chiropractic physicians; amending ORS 656.005, 656.245 and 656.260; and declaring an
3 emergency.

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

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

7 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
8 ployment, as determined by the Employment Department, for the last quarter of the calendar year
9 preceding the fiscal year in which the injury occurred.

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

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

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

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

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

19 (a) A posthumous child;

20 (b) A child legally adopted before the injury;

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

22 (d) A child born out of wedlock;

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

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

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

29 (7)(a) A "compensable injury" is an accidental injury, or accidental injury to prosthetic appli-
30 ances, arising out of and in the course of employment requiring medical services or resulting in
31 disability or death. An injury is accidental if the result is an accident, whether or not due to acci-

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 dental means, if it is established by medical evidence supported by objective findings, subject to the
 2 following limitations:

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

5 (B) If an otherwise compensable injury combines at any time with a preexisting condition to
 6 cause or prolong disability or a need for treatment, the combined condition is compensable only if,
 7 so long as and to the extent that the otherwise compensable injury is the major contributing cause
 8 of the disability of the combined condition or the major contributing cause of the need for treatment
 9 of the combined condition.

10 (b) “Compensable injury” does not include:

11 (A) Injury to any active participant in assaults or combats that are not connected to the job
 12 assignment and that amount to a deviation from customary duties;

13 (B) Injury incurred while engaging in or performing, or as the result of engaging in or per-
 14 forming, any recreational or social activities primarily for the worker’s personal pleasure; or

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

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

22 (d) A “nondisabling compensable injury” is any injury that requires medical services only.

23 (8) “Compensation” includes all benefits, including medical services, provided for a compensable
 24 injury to a subject worker or the worker’s beneficiaries by an insurer or self-insured employer pur-
 25 suant to this chapter.

26 (9) “Department” means the Department of Consumer and Business Services.

27 (10) “Dependent” means any of the following individuals who, at the time of an accident, de-
 28 pended in whole or in part for the individual’s support on the earnings of a worker who dies as a
 29 result of an injury:

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

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

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

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

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

37 (11) “Director” means the Director of the Department of Consumer and Business Services.

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

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

44 (A)(i) A physician licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a
 45 podiatric physician and surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical

1 Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly
 2 licensed doctor in any country or in any state, territory or possession of the United States; or

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

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

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

12 *[(ii)]* (i) Physician assistant licensed by the Oregon Medical Board in accordance with ORS
 13 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory
 14 or possession of the United States; or

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

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

21 (d) “Consulting physician” means a doctor or physician who examines a worker or the worker’s
 22 medical record to advise the attending physician or nurse practitioner authorized to provide
 23 compensable medical services under ORS 656.245 regarding treatment of a worker’s compensable
 24 injury.

25 (13)(a) “Employer” means any person, including receiver, administrator, executor or trustee, and
 26 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
 27 rations or political subdivisions, that contracts to pay a remuneration for the services of any
 28 worker.

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

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

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

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

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

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

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

43 (18) “Noncomplying employer” means a subject employer that has failed to comply with ORS
 44 656.017.

45 (19) “Objective findings” in support of medical evidence are verifiable indications of injury or

1 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
2 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
3 sponses to physical examinations that are not reproducible, measurable or observable.

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

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

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

19 (23) "Person" includes a partnership, joint venture, association, limited liability company and
20 corporation.

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

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

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

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

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

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

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

39 (25) "Self-insured employer" means an employer or group of employers certified under ORS
40 656.430 as meeting the qualifications set out by ORS 656.407.

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

43 (27) "Wages" means the money rate at which the service rendered is recompensed under the
44 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
45 housing, lodging or similar advantage received from the employer, and includes the amount of tips

1 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
 2 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
 3 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
 4 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
 5 which any worker shall be carried upon the payroll of the employer for the purpose of determining
 6 the premium of the employer.

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

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

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

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

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

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

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

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

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

36 (B) Prescription medications.

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

39 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (B) A medical service provider who is not an attending physician cannot authorize the payment
 43 of temporary disability compensation. However, an emergency room physician who is not authorized
 44 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
 45 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending

1 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
 2 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

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

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

9 (i) May provide compensable medical services for 180 days from the date of the first visit on the
 10 initial claim;

11 (ii) May authorize the payment of temporary disability benefits for a period not to exceed 180
 12 days from the date of the first visit on the initial claim; and

13 (iii) When an injured worker treating with a nurse practitioner authorized to provide
 14 compensable services under this section becomes medically stationary within the 180-day period in
 15 which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker
 16 to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of
 17 making findings regarding the worker's impairment for the purpose of evaluating the worker's disa-
 18 bility. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a
 19 possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an
 20 attending physician and the insurer shall compensate the nurse practitioner for the examination
 21 performed.

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

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

30 (a) Those workers who are subject to the contract shall receive medical services in the manner
 31 prescribed in the contract. Workers subject to the contract include those who are receiving medical
 32 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-
 33 jury or medically stationary status, on or after the effective date of the contract. If the managed
 34 care organization determines that the change in provider would be medically detrimental to the
 35 worker, the worker shall not become subject to the contract until the worker is found to be med-
 36 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-
 37 ganization determines that the change in provider is no longer medically detrimental, whichever
 38 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual
 39 notice of the worker's enrollment in the managed care organization, or upon the third day after the
 40 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-
 41 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A
 42 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-
 43 vide compensable medical services under this section under an expired or terminated managed care
 44 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms
 45 and conditions regarding services performed under any subsequent managed care organization con-

1 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's
2 primary residence is more than 100 miles outside the managed care organization's certified ge-
3 ographical area. Each such contract must comply with the certification standards provided in ORS
4 656.260. However, a worker may receive immediate emergency medical treatment that is
5 compensable from a medical service provider who is not a member of the managed care organization.
6 Insurers or self-insured employers who contract with a managed care organization for medical ser-
7 vices shall give notice to the workers of eligible medical service providers and such other informa-
8 tion regarding the contract and manner of receiving medical services as the director may prescribe.
9 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer
10 is considered to be subject to a contract between the State Accident Insurance Fund Corporation
11 as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

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

40 (b) A nurse practitioner authorized to provide medical services to a worker enrolled in the
41 managed care organization may provide medical treatment to the worker if the treatment is deter-
42 mined to be medically appropriate according to the service utilization review process of the man-
43 aged care organization and may authorize temporary disability payments as provided in subsection
44 (2)(b)(D) of this section. However, the managed care organization may authorize the nurse practi-
45 tioner to provide medical services and authorize temporary disability payments beyond the periods

1 established in subsection (2)(b)(D) of this section.

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

5 **SECTION 3.** ORS 656.260 is amended to read:

6 656.260. (1) Any health care provider or group of medical service providers may make written
 7 application to the Director of the Department of Consumer and Business Services to become certi-
 8 fied to provide managed care to injured workers for injuries and diseases compensable under this
 9 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
 10 erated by an insurer or employer other than a health care provider to become certified to provide
 11 managed care.

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

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

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

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

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

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

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

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

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

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

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

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

41 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
 42 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
 43 or excessive treatment, to exclude from participation in the plan those individuals who violate these
 44 treatment standards and to provide for the resolution of such medical disputes as the director con-
 45 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-

1 zation and contract review committee shall be physicians licensed to practice medicine by the
2 Oregon Medical Board. As used in this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

38 (C) A chiropractic physician authorized to provide compensable medical treatment under this
39 paragraph may provide services and authorize temporary disability compensation as provided in ORS
40 656.005 (12)(b)(A) [(12)(b)(B) and 656.245 (2)(b)]. *However, the managed care organization may au-*
41 *thorize chiropractic physicians to provide medical services and authorize temporary disability payments*
42 *beyond the periods established in ORS 656.005 (12)(b)(B) and 656.245 (2)(b)].*

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

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

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

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

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

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

17 (B) Has failed to satisfy the credentialing standards for participating in the managed care or-
 18 ganization.

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

25 (6) The director shall refuse to certify or may revoke or suspend the certification of any health
 26 care provider or group of medical service providers to provide managed care if the director finds
 27 that:

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

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

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

41 (8) No data generated by service utilization review, quality assurance, dispute resolution or peer
 42 review activities and no physician profiles or data used to create physician profiles pursuant to this
 43 section or a review thereof shall be used in any action, suit or proceeding except to the extent
 44 considered necessary by the director in the administration of this chapter. The confidentiality pro-
 45 visions of this section shall not apply in any action, suit or proceeding arising out of or related to

1 a contract between a managed care organization and a health care provider whose confidentiality
2 is protected by this section.

3 (9) A person participating in service utilization review, quality assurance, dispute resolution or
4 peer review activities pursuant to this section shall not be examined as to any communication made
5 in the course of such activities or the findings thereof, nor shall any person be subject to an action
6 for civil damages for affirmative actions taken or statements made in good faith.

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

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

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

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

20 (14) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care or-
21 ganization contract may designate any medical service provider or category of providers as attend-
22 ing physicians.

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

29 (16) Upon a request for administrative review, the director shall create a documentary record
30 sufficient for judicial review. The director shall complete administrative review and issue a pro-
31 posed order within a reasonable time. The proposed order of the director issued pursuant to this
32 section shall become final and not subject to further review unless a written request for a hearing
33 is filed with the director within 30 days of the mailing of the order to all parties.

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

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

43 (19) Notwithstanding any other provision of law, original jurisdiction over contract review dis-
44 putes is with the director. The director may resolve the matter by issuing an order subject to re-
45 view under ORS 656.704, or the director may determine that the matter in dispute would be best

1 addressed in another forum and so inform the parties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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