

LC 1486
2023 Regular Session
10/25/22 (ASD/ps)

DRAFT

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

1
2 Relating to chiropractic physicians; amending ORS 656.005, 656.245 and
3 656.260; and declaring an 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
6 Laws 2022, is amended to read:

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

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

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

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

17 (4) "Carrier-insured employer" means an employer who provides workers'
18 compensation coverage with the State Accident Insurance Fund Corporation
19 or an insurer authorized under ORS chapter 731 to transact workers' com-
20 pensation 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.

1 (5) “Child” means a child of an injured worker, including:

2 (a) A posthumous child;

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

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

5 (d) A child born out of wedlock;

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

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

12 (6) “Claim” means a written request for compensation from a subject
13 worker or someone on the worker’s behalf, or any compensable injury of
14 which a subject employer has notice or knowledge.

15 (7)(a) A “compensable injury” is an accidental injury, or accidental injury
16 to prosthetic appliances, arising out of and in the course of employment re-
17 quiring medical services or resulting in disability or death. An injury is ac-
18 cidental if the result is an accident, whether or not due to accidental means,
19 if it is established by medical evidence supported by objective findings, sub-
20 ject to the following limitations:

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

24 (B) If an otherwise compensable injury combines at any time with a pre-
25 existing condition to cause or prolong disability or a need for treatment, the
26 combined condition is compensable only if, so long as and to the extent that
27 the otherwise compensable injury is the major contributing cause of the
28 disability of the combined condition or the major contributing cause of the
29 need for treatment of the combined condition.

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

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

1 connected to the job assignment and that amount to a deviation from cus-
2 tomary duties;

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

6 (C) Injury the major contributing cause of which is demonstrated to be
7 by a preponderance of the evidence the injured worker's consumption of al-
8 coholic beverages or cannabis or the unlawful consumption of any controlled
9 substance, unless the employer permitted, encouraged or had actual knowl-
10 edge of such consumption.

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

15 (d) A "nondisabling compensable injury" is any injury that requires med-
16 ical services only.

17 (8) "Compensation" includes all benefits, including medical services, pro-
18 vided for a compensable injury to a subject worker or the worker's benefi-
19 ciaries by an insurer or self-insured employer pursuant to this chapter.

20 (9) "Department" means the Department of Consumer and Business Ser-
21 vices.

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

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

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

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

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

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

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

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

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

13 (A)(i) A physician licensed under ORS 677.100 to 677.228 by the Oregon
14 Medical Board, or a podiatric physician and surgeon licensed under ORS
15 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial
16 surgeon licensed by the Oregon Board of Dentistry or a similarly licensed
17 doctor in any country or in any state, territory or possession of the United
18 States; or

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

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

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

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

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

3 [(iii)] (ii) Doctor of naturopathy or naturopathic physician licensed by the
4 Oregon Board of Naturopathic Medicine under ORS chapter 685 or a simi-
5 larly licensed doctor or physician in any country or in any state, territory
6 or possession of the United States.

7 (c) Except as otherwise provided for workers subject to a managed care
8 contract, “attending physician” does not include a physician who provides
9 care in a hospital emergency room and refers the injured worker to a pri-
10 mary care physician for follow-up care and treatment.

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

15 (13)(a) “Employer” means any person, including receiver, administrator,
16 executor or trustee, and the state, state agencies, counties, municipal corpo-
17 rations, school districts and other public corporations or political subdi-
18 visions, that contracts to pay a remuneration for the services of any worker.

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

22 (c) As used in paragraph (b) of this subsection, “temporary service pro-
23 vider” has the meaning for that term provided in ORS 656.850.

24 (d) For the purposes of this chapter, “subject employer” means an em-
25 ployer that is subject to this chapter as provided in ORS 656.023.

26 (14) “Insurer” means the State Accident Insurance Fund Corporation or
27 an insurer authorized under ORS chapter 731 to transact workers’ compen-
28 sation insurance in this state or an assigned claims agent selected by the
29 director under ORS 656.054.

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

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

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

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

7 (19) “Objective findings” in support of medical evidence are verifiable
8 indications of injury or disease that may include, but are not limited to,
9 range of motion, atrophy, muscle strength and palpable muscle spasm. “Ob-
10 jective findings” does not include physical findings or subjective responses
11 to physical examinations that are not reproducible, measurable or observa-
12 ble.

13 (20) “Palliative care” means medical service rendered to reduce or mod-
14 erate temporarily the intensity of an otherwise stable medical condition, but
15 does not include those medical services rendered to diagnose, heal or per-
16 manently alleviate or eliminate a medical condition.

17 (21) “Party” means a claimant for compensation, the employer of the in-
18 jured worker at the time of injury and the insurer, if any, of the employer.

19 (22) “Payroll” means a record of wages payable to workers for their ser-
20 vices and includes commissions, value of exchange labor and the reasonable
21 value of board, rent, housing, lodging or similar advantage received from the
22 employer. However, “payroll” does not include overtime pay, vacation pay,
23 bonus pay, tips, amounts payable under profit-sharing agreements or bonus
24 payments to reward workers for safe working practices. Bonus pay is limited
25 to payments that are not anticipated under the contract of employment and
26 that are paid at the sole discretion of the employer. The exclusion from
27 payroll of bonus payments to reward workers for safe working practices is
28 only for the purpose of calculations based on payroll to determine premium
29 for workers’ compensation insurance, and does not affect any other calcu-
30 lation or determination based on payroll for the purposes of this chapter.

31 (23) “Person” includes a partnership, joint venture, association, limited

1 liability company and corporation.

2 (24)(a) “Preexisting condition” means, for all industrial injury claims, any
3 injury, disease, congenital abnormality, personality disorder or similar con-
4 dition that contributes to disability or need for treatment, provided that:

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

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

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

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

15 (b) “Preexisting condition” means, for all occupational disease claims, any
16 injury, disease, congenital abnormality, personality disorder or similar con-
17 dition that contributes to disability or need for treatment and that precedes
18 the onset of the claimed occupational disease, or precedes a claim for wors-
19 ening in such claims pursuant to ORS 656.273 or 656.278.

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

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

26 (26) “State Accident Insurance Fund Corporation” and “corporation”
27 mean the State Accident Insurance Fund Corporation created under ORS
28 656.752.

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

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

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

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

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

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

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

25 656.245. (1)(a) For every compensable injury, the insurer or the self-
26 insured employer shall cause to be provided medical services for conditions
27 caused in material part by the injury for such period as the nature of the
28 injury or the process of the recovery requires, subject to the limitations in
29 ORS 656.225, including such medical services as may be required after a de-
30 termination of permanent disability. In addition, for consequential and com-
31 bined conditions described in ORS 656.005 (7), the insurer or the self-insured

1 employer shall cause to be provided only those medical services directed to
2 medical conditions caused in major part by the injury.

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

9 (c) Notwithstanding any other provision of this chapter, medical services
10 after the worker's condition is medically stationary are not compensable ex-
11 cept for the following:

12 (A) Services provided to a worker who has been determined to be perma-
13 nently and totally disabled.

14 (B) Prescription medications.

15 (C) Services necessary to administer prescription medication or monitor
16 the administration of prescription medication.

17 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

26 (J) With the approval of the insurer or self-insured employer, palliative
27 care that the worker's attending physician referred to in ORS 656.005
28 (12)(b)(A) prescribes and that is necessary to enable the worker to continue
29 current employment or a vocational training program. If the insurer or self-
30 insured employer does not approve, the attending physician or the worker
31 may request approval from the Director of the Department of Consumer and

1 Business Services for such treatment. The director may order a medical re-
2 view by a physician or panel of physicians pursuant to ORS 656.327 (3) to
3 aid in the review of such treatment. The decision of the director is subject
4 to review under ORS 656.704.

5 (K) With the approval of the director, curative care arising from a gen-
6 erally recognized, nonexperimental advance in medical science since the
7 worker's claim was closed that is highly likely to improve the worker's
8 condition and that is otherwise justified by the circumstances of the claim.
9 The decision of the director is subject to review under ORS 656.704.

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

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

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

28 (2)(a) The worker may choose an attending doctor, physician or nurse
29 practitioner within the State of Oregon. The worker may choose the initial
30 attending physician or nurse practitioner and may subsequently change at-
31 tending physician or nurse practitioner two times without approval from the

1 director. If the worker thereafter selects another attending physician or
2 nurse practitioner, the insurer or self-insured employer may require the
3 director's approval of the selection. The decision of the director is subject
4 to review under ORS 656.704. The worker also may choose an attending
5 doctor or physician in another country or in any state or territory or pos-
6 session of the United States with the prior approval of the insurer or self-
7 insured employer.

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

10 (A) A medical service provider who is not qualified to be an attending
11 physician may provide compensable medical service to an injured worker for
12 a period of 30 days from the date of the first visit on the initial claim or for
13 12 visits, whichever first occurs, without the authorization of an attending
14 physician. Thereafter, medical service provided to an injured worker without
15 the written authorization of an attending physician is not compensable.

16 (B) A medical service provider who is not an attending physician cannot
17 authorize the payment of temporary disability compensation. However, an
18 emergency room physician who is not authorized to serve as an attending
19 physician under ORS 656.005 (12)(c) may authorize temporary disability ben-
20 efits for a maximum of 14 days. A medical service provider qualified to serve
21 as an attending physician under ORS 656.005 (12)(b)(B) may authorize the
22 payment of temporary disability compensation for a period not to exceed 30
23 days from the date of the first visit on the initial claim.

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

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

31 (i) May provide compensable medical services for 180 days from the date

1 of the first visit on the initial claim;

2 (ii) May authorize the payment of temporary disability benefits for a pe-
3 riod not to exceed 180 days from the date of the first visit on the initial
4 claim; and

5 (iii) When an injured worker treating with a nurse practitioner author-
6 ized to provide compensable services under this section becomes medically
7 stationary within the 180-day period in which the nurse practitioner is au-
8 thorized to treat the injured worker, shall refer the injured worker to a
9 physician qualified to be an attending physician as defined in ORS 656.005
10 for the purpose of making findings regarding the worker's impairment for the
11 purpose of evaluating the worker's disability. If a worker returns to the
12 nurse practitioner after initial claim closure for evaluation of a possible
13 worsening of the worker's condition, the nurse practitioner shall refer the
14 worker to an attending physician and the insurer shall compensate the nurse
15 practitioner for the examination performed.

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

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

26 (a) Those workers who are subject to the contract shall receive medical
27 services in the manner prescribed in the contract. Workers subject to the
28 contract include those who are receiving medical treatment for an accepted
29 compensable injury or occupational disease, regardless of the date of injury
30 or medically stationary status, on or after the effective date of the contract.
31 If the managed care organization determines that the change in provider

1 would be medically detrimental to the worker, the worker shall not become
2 subject to the contract until the worker is found to be medically stationary,
3 the worker changes physicians or nurse practitioners, or the managed care
4 organization determines that the change in provider is no longer medically
5 detrimental, whichever event first occurs. A worker becomes subject to the
6 contract upon the worker's receipt of actual notice of the worker's enroll-
7 ment in the managed care organization, or upon the third day after the no-
8 tice was sent by regular mail by the insurer or self-insured employer,
9 whichever event first occurs. A worker shall not be subject to a contract
10 after it expires or terminates without renewal. A worker may continue to
11 treat with the attending physician or nurse practitioner authorized to pro-
12 vide compensable medical services under this section under an expired or
13 terminated managed care organization contract if the physician or nurse
14 practitioner agrees to comply with the rules, terms and conditions regarding
15 services performed under any subsequent managed care organization contract
16 to which the worker is subject. A worker shall not be subject to a contract
17 if the worker's primary residence is more than 100 miles outside the managed
18 care organization's certified geographical area. Each such contract must
19 comply with the certification standards provided in ORS 656.260. However,
20 a worker may receive immediate emergency medical treatment that is
21 compensable from a medical service provider who is not a member of the
22 managed care organization. Insurers or self-insured employers who contract
23 with a managed care organization for medical services shall give notice to
24 the workers of eligible medical service providers and such other information
25 regarding the contract and manner of receiving medical services as the di-
26 rector may prescribe. Notwithstanding any provision of law or rule to the
27 contrary, a worker of a noncomplying employer is considered to be subject
28 to a contract between the State Accident Insurance Fund Corporation as a
29 processing agent or the assigned claims agent and a managed care organ-
30 ization.

31 (b)(A) For initial or aggravation claims filed after June 7, 1995, the

1 insurer or self-insured employer may require an injured worker, on a case-
2 by-case basis, immediately to receive medical services from the managed care
3 organization.

4 (B) If the insurer or self-insured employer gives notice that the worker
5 is required to receive treatment from the managed care organization, the
6 insurer or self-insured employer must guarantee that any reasonable and
7 necessary services so received, that are not otherwise covered by health in-
8 surance, will be paid as provided in ORS 656.248, even if the claim is denied,
9 until the worker receives actual notice of the denial or until three days after
10 the denial is mailed, whichever event first occurs. The worker may elect to
11 receive care from a primary care physician or nurse practitioner authorized
12 to provide compensable medical services under this section who agrees to the
13 conditions of ORS 656.260 (4)(g). However, guarantee of payment is not re-
14 quired by the insurer or self-insured employer if this election is made.

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

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

25 (5)(a) A nurse practitioner licensed under ORS 678.375 to 678.390 who is
26 not a member of the managed care organization is authorized to provide the
27 same level of services as a primary care physician as established by ORS
28 656.260 (4) if the nurse practitioner maintains the worker's medical records
29 and with whom the worker has a documented history of treatment, if that
30 nurse practitioner agrees to refer the worker to the managed care organiza-
31 tion for any specialized treatment, including physical therapy, to be fur-

1 nished by another provider that the worker may require and if that nurse
2 practitioner agrees to comply with all the rules, terms and conditions re-
3 garding services performed by the managed care organization.

4 (b) A nurse practitioner authorized to provide medical services to a
5 worker enrolled in the managed care organization may provide medical
6 treatment to the worker if the treatment is determined to be medically ap-
7 propriate according to the service utilization review process of the managed
8 care organization and may authorize temporary disability payments as pro-
9 vided in subsection (2)(b)(D) of this section. However, the managed care or-
10 ganization may authorize the nurse practitioner to provide medical services
11 and authorize temporary disability payments beyond the periods established
12 in subsection (2)(b)(D) of this section.

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

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

18 656.260. (1) Any health care provider or group of medical service providers
19 may make written application to the Director of the Department of Consumer
20 and Business Services to become certified to provide managed care to injured
21 workers for injuries and diseases compensable under this chapter. However,
22 nothing in this section authorizes an organization that is formed, owned or
23 operated by an insurer or employer other than a health care provider to be-
24 come certified to provide managed care.

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

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

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

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

7 (c) A description of the times, places and manner of providing other re-
8 lated optional services the applicants wish to provide.

9 (d) Satisfactory evidence of ability to comply with any financial require-
10 ments to insure delivery of service in accordance with the plan which the
11 director may prescribe.

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

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

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

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

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

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

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

1 puate treatment or to prevent inappropriate or excessive treatment, to ex-
2 clude from participation in the plan those individuals who violate these
3 treatment standards and to provide for the resolution of such medical dis-
4 putes as the director considers appropriate. A majority of the members of
5 each peer review, quality assurance, service utilization and contract review
6 committee shall be physicians licensed to practice medicine by the Oregon
7 Medical Board. As used in this paragraph:

8 (A) "Peer review" means evaluation or review of the performance of col-
9 leagues by a panel with similar types and degrees of expertise. Peer review
10 requires participation of at least three physicians prior to final determi-
11 nation.

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

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

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

25 (E) "Contract review" means the methods and processes whereby the
26 managed care organization monitors and enforces its contracts with partic-
27 ipating providers for matters other than matters enumerated in subpara-
28 graphs (A), (B) and (C) of this paragraph.

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

1 jured workers.

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

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

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

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

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

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

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

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

1 internal medicine practitioner.

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

5 (i) Does not prohibit the injured worker's attending physician from ad-
6 vocating for medical services and temporary disability benefits for the in-
7 jured worker that are supported by the medical record.

8 (j) Complies with any other requirement the director determines is nec-
9 essary to provide quality medical services and health care to injured work-
10 ers.

11 (5)(a) Notwithstanding ORS 656.245 (5) and subsection (4)(g) of this sec-
12 tion, a managed care organization may deny or terminate the authorization
13 of a primary care physician or chiropractic physician to serve as an attend-
14 ing physician under subsection (4)(g) of this section or of a nurse practi-
15 tioner to provide medical services as provided in ORS 656.245 (5) if the
16 physician or nurse practitioner, within two years prior to the worker's en-
17 rollment in the plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (12) In consultation with the committees referred to in ORS 656.790 and
13 656.794, the director shall adopt such rules as may be necessary to carry out
14 the provisions of this section.

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

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

22 (15) If a worker, insurer, self-insured employer, the attending physician
23 or an authorized health care provider is dissatisfied with an action of the
24 managed care organization regarding the provision of medical services pur-
25 suant 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
27 administrative review of the matter before requesting a hearing. Such appli-
28 cation must be made not later than the 60th day after the date the managed
29 care organization has completed and issued its final decision.

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

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

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

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

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

23 (20) The director shall conduct such investigations, audits and other ad-
24 ministrative oversight in regard to managed care as the director deems nec-
25 essary to carry out the purposes of this chapter.

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

28 (A) Restrict the choice of a health care provider or medical service pro-
29 vider by a worker;

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

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

3 (D) Require preauthorization or precertification to determine the neces-
4 sity of medical services or treatment; or

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

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

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

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

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

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

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

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

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

27 **SECTION 4. This 2023 Act being necessary for the immediate pres-**
28 **ervation of the public peace, health and safety, an emergency is de-**
29 **clared to exist, and this 2023 Act takes effect on its passage.**

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