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D R A F T

SUMMARY

Permits attending physician or authorized nurse practitioner to refer worker for treatment by chiropractic physician that is not member of managed care organization under specified circumstances.

A BILL FOR AN ACT

Relating to managed care organizations that provide managed care to injured workers; amending ORS 656.245 and 656.260.

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

SECTION 1. ORS 656.260 is amended to read:

656.260. (1) [*Any*] **A** health care provider or group of medical service providers may [*make written application*] **apply in writing** to the Director of the Department of Consumer and Business Services to become certified to provide managed care to injured workers for injuries and diseases compensable under this chapter, [*However, nothing in this section authorizes*] **but this section does not authorize** an organization that is formed, owned or operated by an insurer or employer other than a health care provider to become certified to provide managed care.

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

(3) **An** application for certification [*shall*] **must** be made in such form and manner and [*shall*] **must** set forth such information regarding the proposed plan for providing services as the director may prescribe. The information [*shall*] **must** include, but 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*] **that**
11 the 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*] **affects**
27 the provisions of ORS 441.055 relating to the granting of medical staff priv-
28 ileges.

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

31 (d) Provides adequate methods of peer review, service utilization review,

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

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

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

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

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

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

30 (e) Provides a program involving cooperative efforts by the workers, the
31 employer and the managed care organizations to promote workplace health

1 and safety consultative and other services and early return to work for in-
2 jured workers.

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

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

11 (i) **Except as provided in paragraph (h) of this subsection**, the pri-
12 mary care physician or chiropractic physician agrees to refer the worker to
13 the managed care organization for any specialized treatment, including
14 physical therapy, to be furnished by another provider that the worker may
15 require;

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

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

21 (B) [*Nothing in*] This paragraph [*is intended to*] **does not** limit the
22 worker's right to change primary care physicians or chiropractic physicians
23 [*prior to the*] **before** filing [*of*] a workers' compensation claim.

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

31 (D) As used in this paragraph, "primary care physician" means a physi-

1 cian who is qualified to be an attending physician, [*referred to*] **as defined**
2 in ORS 656.005 (12)(b)(A) and who is a family practitioner, a general practi-
3 tioner or an internal medicine practitioner.

4 **(h) Authorizes an attending physician or authorized nurse practi-**
5 **tioner to refer a worker for compensable medical treatment by a**
6 **chiropractic physician who is not a member of the managed care or-**
7 **ganization if:**

8 **(A) The worker has a documented history of treatment with the**
9 **chiropractic physician;**

10 **(B) The chiropractic physician agrees to comply with the rules,**
11 **terms and conditions for providing services that the managed care**
12 **organization provides; and**

13 **(C) The managed care organization's service utilization review pro-**
14 **cess determines that the treatment is medically appropriate.**

15 [*h*] **(i)** Provides a written explanation for denial of participation in the
16 managed care organization plan to any licensed health care provider that
17 has been denied participation in the managed care organization plan.

18 [*i*] **(j)** Does not prohibit the injured worker's attending physician from
19 advocating for medical services and temporary disability benefits for the in-
20 jured worker that are supported by the medical record.

21 [*j*] **(k)** Complies with any other requirement the director determines is
22 necessary to provide quality medical services and health care to injured
23 workers.

24 (5)(a) Notwithstanding ORS 656.245 (5) and subsection (4)(g) **and (h)** of
25 this section, a managed care organization may deny or terminate the au-
26 thorization of a primary care physician or chiropractic physician to serve
27 as an attending physician under subsection (4)(g) of this section, **of a**
28 **chiropractic physician to serve as a provider under subsection (4)(h)**
29 **of this section** or of a nurse practitioner to provide medical services as
30 provided in ORS 656.245 (5) if the physician or nurse practitioner, within two
31 years prior to the worker's enrollment in the plan:

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

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

7 (b) The director shall adopt by rule reporting standards for managed care
8 organizations to report denials and terminations of the authorization of pri-
9 mary care physicians, chiropractic physicians and nurse practitioners who
10 are not members of the managed care organization to provide compensable
11 medical treatment under ORS 656.245 (5) and subsection (4)(g) **and (h)** of this
12 section. The director shall annually report to the Workers' Compensation
13 Management-Labor Advisory Committee the information reported to the di-
14 rector by managed care organizations under this paragraph.

15 (6) The director shall refuse to certify or may revoke or suspend the cer-
16 tification of any health care provider or group of medical service providers
17 to provide managed care if the director finds that:

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

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

22 (7) Any issue concerning the provision of medical services to injured
23 workers subject to a managed care contract and service utilization review,
24 quality assurance, dispute resolution, contract review and peer review ac-
25 tivities as well as authorization of medical services to be provided by other
26 than an attending physician pursuant to ORS 656.245 (2)(b) [*shall be*] **is**
27 subject to review by the director or the director's designated representatives.
28 The decision of the director is subject to review under ORS 656.704. Data
29 generated by or received in connection with these activities, including writ-
30 ten reports, notes or records of any such activities, or of any review thereof,
31 [*shall be*] **are** confidential, and [*shall*] **may** not be disclosed except as con-

1 sidered necessary by the director in the administration of this chapter. The
2 director may report professional misconduct to an appropriate licensing
3 board.

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

13 (9) A person participating in service utilization review, quality assurance,
14 dispute resolution or peer review activities pursuant to this section [shall]
15 **may** not be examined as to any communication made in the course of such
16 activities or the findings thereof, [nor shall any person be] **a person may**
17 **not be** subject to an action for civil damages for affirmative actions taken
18 or statements made in good faith.

19 (10) [No] **A** person who participates in forming consortiums, collectively
20 negotiating fees or otherwise solicits or enters into contracts in a good faith
21 effort to provide medical or health care services according to the provisions
22 of this section [shall] **may not** be examined or subject to administrative or
23 civil liability regarding any such participation except pursuant to the
24 director's active supervision of such activities and the managed care organ-
25 ization. Before engaging in such activities, the person shall provide notice
26 of intent to the director in a form prescribed by the director.

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

29 (12) In consultation with the committees referred to in ORS 656.790 and
30 656.794, the director shall adopt such rules as may be necessary to carry out
31 the provisions of this section.

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

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

8 (15) If a worker, insurer, self-insured employer, the attending physician
9 or an authorized health care provider is dissatisfied with an action of the
10 managed care organization regarding the provision of medical services pur-
11 suant to this chapter, peer review, service utilization review or quality as-
12 surance activities, that person or entity must first apply to the director for
13 administrative review of the matter before requesting a hearing. Such appli-
14 cation must be made not later than the 60th day after the date the managed
15 care organization has completed and issued *[its]* **the managed care**
16 **organization’s** final decision.

17 (16) Upon a request for administrative review, the director shall create
18 a documentary record sufficient for judicial review. The director shall
19 complete administrative review and issue a proposed order within a reason-
20 able time. The proposed order of the director issued pursuant to this section
21 *[shall become]* **is** final and not subject to further review unless a written
22 request for a hearing is filed with the director within 30 days of the mailing
23 of the order to all parties.

24 (17) At the contested case hearing, the order may be modified only if *[it]*
25 **the order** is not supported by substantial evidence in the record or reflects
26 an error of law. *[No]* New medical evidence or issues *[shall]* **may not** be
27 admitted. The dispute may also be remanded to the managed care organiza-
28 tion for further evidence taking, correction or other necessary action if the
29 Administrative Law Judge or director determines the record has been im-
30 properly, incompletely or otherwise insufficiently developed. Decisions by the
31 director regarding medical disputes are subject to review under ORS 656.704.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 656.245. (1)(a) For every compensable injury, [*the*] **an** insurer or [*the*] **a**
16 self-insured employer shall cause to be provided medical services for condi-
17 tions caused in material part by the injury for such period as the nature of
18 the injury or the process of the recovery requires, subject to the limitations
19 in ORS 656.225, including such medical services as may be required after a
20 determination of permanent disability. In addition, for consequential and
21 combined conditions described in ORS 656.005 (7), the insurer or the self-
22 insured employer shall cause to be provided only those medical services di-
23 rected to medical conditions caused in major part by the injury.

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

30 (c) Notwithstanding any other provision of this chapter, medical services
31 after the worker's condition is medically stationary are not compensable ex-

1 cept for the following:

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

4 (B) Prescription medications.

5 (C) Services necessary to administer prescription medication or monitor
6 the administration of prescription medication.

7 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

16 (J) With the approval of the insurer or self-insured employer, palliative
17 care that the worker's attending physician referred to in ORS 656.005
18 (12)(b)(A) prescribes and that is necessary to enable the worker to continue
19 current employment or a vocational training program. If the insurer or self-
20 insured employer does not approve, the attending physician or the worker
21 may request approval from the Director of the Department of Consumer and
22 Business Services for such treatment. The director may order a medical re-
23 view by a physician or panel of physicians pursuant to ORS 656.327 (3) to
24 aid in the review of such treatment. The decision of the director is subject
25 to review under ORS 656.704.

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

31 (L) Curative care provided to a worker to stabilize a temporary and acute

1 waxing and waning of symptoms of the worker's condition.

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

9 (e) Except for services provided under a managed care contract, out-of-
10 pocket expense reimbursement to receive care from the attending physician
11 or nurse practitioner authorized to provide compensable medical services
12 under this section [*shall*] **may** not exceed the amount required to seek care
13 from an appropriate nurse practitioner or attending physician of the same
14 specialty who is in a medical community geographically closer to the
15 worker's home. For the purposes of this paragraph, all physicians and nurse
16 practitioners within a metropolitan area are [*considered to be*] part of the
17 same medical community.

18 (2)(a) The worker may choose an attending doctor, physician or nurse
19 practitioner within the State of Oregon. The worker may choose the initial
20 attending physician or nurse practitioner and may subsequently change at-
21 tending physician or nurse practitioner two times without approval from the
22 director. If the worker thereafter selects another attending physician or
23 nurse practitioner, the insurer or self-insured employer may require the
24 director's approval of the selection. The decision of the director is subject
25 to review under ORS 656.704. The worker also may choose an attending
26 doctor or physician in another country or in any state or territory or pos-
27 session of the United States with the prior approval of the insurer or self-
28 insured employer.

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

31 (A) A medical service provider who is not qualified to be an attending

1 physician may provide compensable medical [*service*] **services** to an injured
2 worker for a period of 30 days from the date of the first visit on the initial
3 claim or for 12 visits, whichever first occurs, without the authorization of
4 an attending physician. Thereafter, medical service provided to an injured
5 worker without the written authorization of an attending physician is not
6 compensable.

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

15 (C) Except as otherwise provided in this chapter, only a physician quali-
16 fied to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i)
17 who is serving as the attending physician at the time of claim closure may
18 make findings regarding the worker's impairment for the purpose of evalu-
19 ating the worker's disability.

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

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

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

27 (iii) When an injured worker treating with a nurse practitioner author-
28 ized to provide compensable services under this section becomes medically
29 stationary within the 180-day period in which the nurse practitioner is au-
30 thorized to treat the injured worker, shall refer the injured worker to a
31 physician qualified to be an attending physician as defined in ORS 656.005

1 for the purpose of making findings regarding the worker's impairment for the
2 purpose of evaluating the worker's disability. If a worker returns to the
3 nurse practitioner after initial claim closure for evaluation of a possible
4 worsening of the worker's condition, the nurse practitioner shall refer the
5 worker to an attending physician and the insurer shall compensate the nurse
6 practitioner for the examination performed.

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

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

17 (a) Those workers who are subject to the contract [*shall*] **must** receive
18 medical services in the manner prescribed in the contract. Workers subject
19 to the contract include those who are receiving medical treatment for an
20 accepted compensable injury or occupational disease, regardless of the date
21 of injury or medically stationary status, on or after the effective date of the
22 contract. If the managed care organization determines that the change in
23 provider would be medically detrimental to the worker, the worker [*shall not*
24 *become*] **is not** subject to the contract until the worker is found to be med-
25 ically stationary, the worker changes physicians or nurse practitioners, or
26 the managed care organization determines that the change in provider is no
27 longer medically detrimental, whichever event first occurs. A worker be-
28 comes subject to the contract upon the worker's receipt of actual notice of
29 the worker's enrollment in the managed care organization, or upon the third
30 day after the notice was sent by regular mail by the insurer or self-insured
31 employer, whichever event first occurs. A worker [*shall not be*] **is not** subject

1 to a contract after *[it]* **the contract** expires or terminates without renewal.
2 A worker may continue to treat with the attending physician or nurse
3 practitioner authorized to provide compensable medical services under this
4 section under an expired or terminated managed care organization contract
5 if the physician or nurse practitioner agrees to comply with the rules, terms
6 and conditions regarding services performed under any subsequent managed
7 care organization contract to which the worker is subject. A worker *[shall*
8 *not be]* **is not** subject to a contract if the worker's primary residence is more
9 than 100 miles outside the managed care organization's certified geographical
10 area. Each such contract must comply with the certification standards pro-
11 vided in ORS 656.260. However, a worker may receive immediate emergency
12 medical treatment that is compensable from a medical service provider who
13 is not a member of the managed care organization. Insurers or self-insured
14 employers who contract with a managed care organization for medical ser-
15 vices shall give notice to the workers of eligible medical service providers
16 and such other information regarding the contract and manner of receiving
17 medical services as the director may prescribe. Notwithstanding any pro-
18 vision of law or rule to the contrary, a worker of a noncomplying employer
19 is *[considered to be]* subject to a contract between the State Accident Insur-
20 ance Fund Corporation as a processing agent or the assigned claims agent
21 and a managed care organization.

22 (b)(A) For initial or aggravation claims filed after June 7, 1995, the
23 insurer or self-insured employer may require an injured worker, on a case-
24 by-case basis, immediately to receive medical services from the managed care
25 organization.

26 (B) If the insurer or self-insured employer gives notice that the worker
27 is required to receive treatment from the managed care organization, the
28 insurer or self-insured employer must guarantee that any reasonable and
29 necessary services so received, that are not otherwise covered by health in-
30 surance, will be paid as provided in ORS 656.248, even if the claim is denied,
31 until the worker receives actual notice of the denial or until three days after

1 the denial is mailed, whichever event first occurs. The worker may elect to
2 receive care from a primary care physician or nurse practitioner authorized
3 to provide compensable medical services under this section who agrees to the
4 conditions of ORS 656.260 (4)(g) **and (h)**. However, guarantee of payment is
5 not required by the insurer or self-insured employer if this election is made.

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

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

16 (5)(a) A nurse practitioner licensed under ORS 678.375 to 678.390 who is
17 not a member of the managed care organization is authorized to provide the
18 same level of services as a primary care physician as established by ORS
19 656.260 (4) if the nurse practitioner maintains the worker's medical records
20 and [*with whom*] **if** the worker has a documented history of treatment **with**
21 **the nurse practitioner**, if [*that*] **the** nurse practitioner agrees to refer the
22 worker to the managed care organization for any specialized treatment, in-
23 cluding physical therapy, **subject to the provisions of ORS 656.260 (4)(h)**,
24 [*to be*] **that will be** furnished by another provider that the worker may re-
25 quire and if [*that*] **the** nurse practitioner agrees to comply with all the rules,
26 terms and conditions regarding services performed by the managed care or-
27 ganization.

28 (b) A nurse practitioner authorized to provide medical services to a
29 worker enrolled in the managed care organization may provide medical
30 treatment to the worker if the treatment is determined to be medically ap-
31 propriate according to the service utilization review process of the managed

1 care organization and may authorize temporary disability payments as pro-
2 vided in subsection (2)(b)(D) of this section. However, the managed care or-
3 ganization may authorize the nurse practitioner to provide medical services
4 and authorize temporary disability payments beyond the periods established
5 in subsection (2)(b)(D) of this section.

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

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