

# House Bill 2756

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

## 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**.

Changes time frame for provision of compensable medical treatment by certain medical service providers in workers' compensation system.

## A BILL FOR AN ACT

1  
2 Relating to authority of medical service providers in workers' compensation system; amending ORS  
3 656.245.

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

5 **SECTION 1.** ORS 656.245 is amended to read:

6 656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause  
7 to be provided medical services for conditions caused in material part by the injury for such period  
8 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS  
9 656.225, including such medical services as may be required after a determination of permanent  
10 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the  
11 insurer or the self-insured employer shall cause to be provided only those medical services directed  
12 to medical conditions caused in major part by the injury.

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

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

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

22 (B) Prescription medications.

23 (C) Services necessary to administer prescription medication or monitor the administration of  
24 prescription medication.

25 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

**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 (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 and, if re-  
 32 quested, the director shall determine with the advice of one or more physicians, whether the se-  
 33 lection by the worker shall be approved. The decision of the director is subject to review under  
 34 ORS 656.704. The worker also may choose an attending doctor or physician in another country or  
 35 in any state or territory or possession of the United States with the prior approval of the insurer  
 36 or self-insured employer.

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

39 (A) A medical service provider who is not qualified to be an attending physician may provide  
 40 compensable medical service to an injured worker for a period of 30 days from the date of [*injury*  
 41 *or occupational disease*] **the first visit on the initial claim** or for 12 visits, whichever first occurs,  
 42 without the authorization of an attending physician. Thereafter, medical service provided to an in-  
 43 jured worker without the written authorization of an attending physician is not compensable.

44 (B) A medical service provider who is not an attending physician cannot authorize the payment  
 45 of temporary disability compensation. Except as otherwise provided in this chapter, only the at-

1 tending physician at the time of claim closure may make findings regarding the worker's impairment  
2 for the purpose of evaluating the worker's disability.

3 (C) Notwithstanding subparagraphs (A) and (B) of this paragraph, a nurse practitioner licensed  
4 under ORS 678.375 to 678.390 may:

5 (i) Provide compensable medical services for 90 days from the date of the first visit on the claim;

6 (ii) Authorize the payment of temporary disability benefits for a period not to exceed 60 days  
7 from the date of the first visit on the initial claim; and

8 (iii) When an injured worker treating with a nurse practitioner authorized to provide  
9 compensable services under this section becomes medically stationary within the 90-day period in  
10 which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker  
11 to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of  
12 making findings regarding the worker's impairment for the purpose of evaluating the worker's disa-  
13 bility. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a  
14 possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an  
15 attending physician and the insurer shall compensate the nurse practitioner for the examination  
16 performed.

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

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

25 (a) Those workers who are subject to the contract shall receive medical services in the manner  
26 prescribed in the contract. Workers subject to the contract include those who are receiving medical  
27 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-  
28 jury or medically stationary status, on or after the effective date of the contract. If the managed  
29 care organization determines that the change in provider would be medically detrimental to the  
30 worker, the worker shall not become subject to the contract until the worker is found to be med-  
31 ically stationary, the worker changes physicians or nurse practitioners, or the managed care or-  
32 ganization determines that the change in provider is no longer medically detrimental, whichever  
33 event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual  
34 notice of the worker's enrollment in the managed care organization, or upon the third day after the  
35 notice was sent by regular mail by the insurer or self-insured employer, whichever event first oc-  
36 curs. A worker shall not be subject to a contract after it expires or terminates without renewal. A  
37 worker may continue to treat with the attending physician or nurse practitioner authorized to pro-  
38 vide compensable medical services under this section under an expired or terminated managed care  
39 organization contract if the physician or nurse practitioner agrees to comply with the rules, terms  
40 and conditions regarding services performed under any subsequent managed care organization con-  
41 tract to which the worker is subject. A worker shall not be subject to a contract if the worker's  
42 primary residence is more than 100 miles outside the managed care organization's certified ge-  
43 ographical area. Each such contract must comply with the certification standards provided in ORS  
44 656.260. However, a worker may receive immediate emergency medical treatment that is  
45 compensable from a medical service provider who is not a member of the managed care organization.

1 Insurers or self-insured employers who contract with a managed care organization for medical ser-  
2 vices shall give notice to the workers of eligible medical service providers and such other informa-  
3 tion regarding the contract and manner of receiving medical services as the director may prescribe.  
4 Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer  
5 is considered to be subject to a contract between the State Accident Insurance Fund Corporation  
6 as a processing agent or the assigned claims agent and a managed care organization.

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

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

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

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

27 (5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize  
28 physician assistants licensed by the Board of Medical Examiners for the State of Oregon who prac-  
29 tice in areas served by Type A or Type B rural hospitals described in ORS 442.470 to authorize the  
30 payment of temporary disability compensation for injured workers for a period not to exceed 30 days  
31 from the date of the first visit on the claim. In addition, the director, by rule, may authorize such  
32 assistants who practice in areas served by a Type C rural hospital described in ORS 442.470 to au-  
33 thorize such payment.

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

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

1       **SECTION 2.** ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and section  
 2 4, chapter 26, Oregon Laws 2005, is amended to read:

3       656.245. (1)(a) For every compensable injury, the insurer or the self-insured employer shall cause  
 4 to be provided medical services for conditions caused in material part by the injury for such period  
 5 as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS  
 6 656.225, including such medical services as may be required after a determination of permanent  
 7 disability. In addition, for consequential and combined conditions described in ORS 656.005 (7), the  
 8 insurer or the self-insured employer shall cause to be provided only those medical services directed  
 9 to medical conditions caused in major part by the injury.

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

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

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

19       (B) Prescription medications.

20       (C) Services necessary to administer prescription medication or monitor the administration of  
 21 prescription medication.

22       (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

43       (d) When the medically stationary date in a disabling claim is established by the insurer or  
 44 self-insured employer and is not based on the findings of the attending physician, the insurer or  
 45 self-insured employer is responsible for reimbursement to affected medical service providers for

1 otherwise compensable services rendered until the insurer or self-insured employer provides written  
2 notice to the attending physician of the worker's medically stationary status.

3 (e) Except for services provided under a managed care contract, out-of-pocket expense re-  
4 imbursement to receive care from the attending physician shall not exceed the amount required to  
5 seek care from an appropriate attending physician of the same specialty who is in a medical com-  
6 munity geographically closer to the worker's home. For the purposes of this paragraph, all physi-  
7 cians within a metropolitan area are considered to be part of the same medical community.

8 (2)(a) The worker may choose an attending doctor or physician within the State of Oregon. The  
9 worker may choose the initial attending physician and may subsequently change attending physician  
10 two times without approval from the director. If the worker thereafter selects another attending  
11 physician, the insurer or self-insured employer may require the director's approval of the selection  
12 and, if requested, the director shall determine with the advice of one or more physicians, whether  
13 the selection by the worker shall be approved. The decision of the director is subject to review un-  
14 der ORS 656.704. The worker also may choose an attending doctor or physician in another country  
15 or in any state or territory or possession of the United States with the prior approval of the insurer  
16 or self-insured employer.

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

19 (A) A medical service provider who is not qualified to be an attending physician may provide  
20 compensable medical service to an injured worker for a period of 30 days from the date of [*injury*  
21 *or occupational disease*] **the first visit on the initial claim** or for 12 visits, whichever first occurs,  
22 without the authorization of an attending physician. Thereafter, medical service provided to an in-  
23 jured worker without the written authorization of an attending physician is not compensable.

24 (B) A medical service provider who is not an attending physician cannot authorize the payment  
25 of temporary disability compensation. Except as otherwise provided in this chapter, only the at-  
26 tending physician at the time of claim closure may make findings regarding the worker's impairment  
27 for the purpose of evaluating the worker's disability.

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

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

36 (a) Those workers who are subject to the contract shall receive medical services in the manner  
37 prescribed in the contract. Workers subject to the contract include those who are receiving medical  
38 treatment for an accepted compensable injury or occupational disease, regardless of the date of in-  
39 jury or medically stationary status, on or after the effective date of the contract. If the managed  
40 care organization determines that the change in provider would be medically detrimental to the  
41 worker, the worker shall not become subject to the contract until the worker is found to be med-  
42 ically stationary, the worker changes physicians or the managed care organization determines that  
43 the change in provider is no longer medically detrimental, whichever event first occurs. A worker  
44 becomes subject to the contract upon the worker's receipt of actual notice of the worker's enroll-  
45 ment in the managed care organization, or upon the third day after the notice was sent by regular

1 mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be  
2 subject to a contract after it expires or terminates without renewal. A worker may continue to treat  
3 with the attending physician under an expired or terminated managed care organization contract if  
4 the physician agrees to comply with the rules, terms and conditions regarding services performed  
5 under any subsequent managed care organization contract to which the worker is subject. A worker  
6 shall not be subject to a contract if the worker's primary residence is more than 100 miles outside  
7 the managed care organization's certified geographical area. Each such contract must comply with  
8 the certification standards provided in ORS 656.260. However, a worker may receive immediate  
9 emergency medical treatment that is compensable from a medical service provider who is not a  
10 member of the managed care organization. Insurers or self-insured employers who contract with a  
11 managed care organization for medical services shall give notice to the workers of eligible medical  
12 service providers and such other information regarding the contract and manner of receiving med-  
13 ical services as the director may prescribe. Notwithstanding any provision of law or rule to the  
14 contrary, a worker of a noncomplying employer is considered to be subject to a contract between  
15 the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent  
16 and a managed care organization.

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

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

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

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

36 (5) Notwithstanding any other provision of this chapter, the director, by rule, shall authorize  
37 nurse practitioners certified by the Oregon State Board of Nursing and physician assistants licensed  
38 by the Board of Medical Examiners for the State of Oregon who practice in areas served by Type  
39 A or Type B rural hospitals described in ORS 442.470 to authorize the payment of temporary disa-  
40 bility compensation for injured workers for a period not to exceed 30 days from the date of the first  
41 visit on the claim. In addition, the director, by rule, may authorize such practitioners and assistants  
42 who practice in areas served by a Type C rural hospital described in ORS 442.470 to authorize such  
43 payment.

44 (6) Subject to the provisions of ORS 656.704, if a claim for medical services is disapproved, the  
45 injured worker, insurer or self-insured employer may request administrative review by the director

1 pursuant to ORS 656.260 or 656.327.

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