74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

House Bill 2840

Sponsored by Representative OLSON (at the request of Chiropractic Association of Oregon)

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.**

Modifies period of treatment and number of patient visits for which chiropractor may serve as attending physician in workers' compensation claim. Authorizes chiropractor to serve as primary care physician for injured worker enrolled in managed care plan. Allows worker who becomes subject to managed care organization contract to continue to treat with chiropractor under certain circumstances.

1 **A BILL FOR AN ACT**

2 Relating to provision of medical services in workers' compensation claim; amending ORS 656.005,
3 656.245 and 656.260.

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

5 **SECTION 1.** ORS 656.005 is amended to read:

6 656.005. (1) "Average weekly wage" means the Oregon average weekly wage in covered em-
7 ployment, as determined by the Employment Department, for the last quarter of the calendar year
8 preceding the fiscal year in which the injury occurred.

9 (2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a
10 worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

11 (a) A spouse of an injured worker living in a state of abandonment for more than one year at
12 the time of the injury or subsequently. A spouse who has lived separate and apart from the worker
13 for a period of two years and who has not during that time received or attempted by process of law
14 to collect funds for support or maintenance is considered living in a state of abandonment.

15 (b) A person who intentionally causes the 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' compensation cover-
18 age with a guaranty contract insurer.

19 (5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child to-
20 ward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such
21 stepchild was, at the time of the injury, a member of the worker's family and substantially dependent
22 upon the worker for support. An invalid dependent child is a child, for purposes of benefits, re-
23 gardless of age, so long as the child was an invalid at the time of the accident and thereafter re-
24 mains an invalid substantially dependent on the worker for support. For purposes of this chapter,
25 an invalid dependent child is considered to be a child under 18 years of age.

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

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

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.
New sections are in **boldfaced** type.

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

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

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

(b) "Compensable injury" does not include:

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

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

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

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

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

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

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

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

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

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

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

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a period of [*30*] **60** days from the date of first visit on the initial claim or for [*12*] **24**

1 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic
2 Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in
3 any state, territory or possession of the United States.
4 (c) "Consulting physician" means a doctor or physician who examines a worker or the worker's
5 medical record to advise the attending physician or nurse practitioner authorized to provide
6 compensable medical services under ORS 656.245 regarding treatment of a worker's compensable
7 injury.
8 (13)(a) "Employer" means any person, including receiver, administrator, executor or trustee, and
9 the state, state agencies, counties, municipal corporations, school districts and other public corpo-
10 rations or political subdivisions, who contracts to pay a remuneration for and secures the right to
11 direct and control the services of any person.
12 (b) Notwithstanding paragraph (a) of this subsection, for purposes of this chapter, the client of
13 a temporary service provider is not the employer of temporary workers provided by the temporary
14 service provider.
15 (c) As used in paragraph (b) of this subsection, "temporary service provider" has the meaning
16 for that term provided in ORS 656.850.
17 (14) "Guaranty contract insurer" and "insurer" mean the State Accident Insurance Fund Cor-
18 poration or an insurer authorized under ORS chapter 731 to transact workers' compensation insur-
19 ance in this state or an assigned claims agent selected by the director under ORS 656.054.
20 (15) "Consumer and Business Services Fund" means the fund created by ORS 705.145.
21 (16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.
22 (17) "Medically stationary" means that no further material improvement would reasonably be
23 expected from medical treatment, or the passage of time.
24 (18) "Noncomplying employer" means a subject employer who has failed to comply with ORS
25 656.017.
26 (19) "Objective findings" in support of medical evidence are verifiable indications of injury or
27 disease that may include, but are not limited to, range of motion, atrophy, muscle strength and
28 palpable muscle spasm. "Objective findings" does not include physical findings or subjective re-
29 sponses to physical examinations that are not reproducible, measurable or observable.
30 (20) "Palliative care" means medical service rendered to reduce or moderate temporarily the
31 intensity of an otherwise stable medical condition, but does not include those medical services ren-
32 dered to diagnose, heal or permanently alleviate or eliminate a medical condition.
33 (21) "Party" means a claimant for compensation, the employer of the injured worker at the time
34 of injury and the insurer, if any, of such employer.
35 (22) "Payroll" means a record of wages payable to workers for their services and includes
36 commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or
37 similar advantage received from the employer. However, "payroll" does not include overtime pay,
38 vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments
39 to reward workers for safe working practices. Bonus pay is limited to payments which are not an-
40 ticipated under the contract of employment and which are paid at the sole discretion of the em-
41 ployer. The exclusion from payroll of bonus payments to reward workers for safe working practices
42 is only for the purpose of calculations based on payroll to determine premium for workers' com-
43 pensation insurance, and does not affect any other calculation or determination based on payroll for
44 the purposes of this chapter.
45 (23) "Person" includes partnership, joint venture, association, limited liability company and

corporation.

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

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

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

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

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

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

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

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

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

(27) "Subject employer" means an employer who is subject to this chapter as provided by ORS 656.023.

(28) "Subject worker" means a worker who is subject to this chapter as provided by ORS 656.027.

(29) "Wages" means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer.

(30) "Worker" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant. For the purpose of determining entitlement to temporary disability benefits or permanent total disability benefits under this chapter, "worker" does not include a person who has withdrawn from the workforce during the period for which such benefits are sought.

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

SECTION 2. ORS 656.005, as amended by section 2, chapter 811, Oregon Laws 2003, is amended to read:

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

(2) "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter. "Beneficiary" does not include:

(a) A spouse of an injured worker living in a state of abandonment for more than one year at the time of the injury or subsequently. A spouse who has lived separate and apart from the worker for a period of two years and who has not during that time received or attempted by process of law to collect funds for support or maintenance is considered living in a state of abandonment.

(b) A person who intentionally causes the compensable injury to or death of an injured worker.

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

(4) "Carrier-insured employer" means an employer who provides workers' compensation coverage with a guaranty contract insurer.

(5) "Child" includes a posthumous child, a child legally adopted prior to the injury, a child toward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such stepchild was, at the time of the injury, a member of the worker's family and substantially dependent upon the worker for support. An invalid dependent child is a child, for purposes of benefits, regardless of age, so long as the child was an invalid at the time of the accident and thereafter remains an invalid substantially dependent on the worker for support. For purposes of this chapter, an invalid dependent child is considered to be a child under 18 years of age.

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

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

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

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

(b) "Compensable injury" does not include:

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

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

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

such consumption.

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

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

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

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

(10) "Dependent" means any of the following-named relatives of a worker whose death results from any injury: Father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half sister, half brother, niece or nephew, who at the time of the accident, are dependent in whole or in part for their support upon the earnings of the worker. Unless otherwise provided by treaty, aliens not residing within the United States at the time of the accident other than father, mother, husband, wife or children are not included within the term "dependent."

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

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

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

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a period of [*30*] **60** days from the date of first visit on the initial claim or for [*12*] **24** visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

(c) "Consulting physician" means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury.

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

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

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

(14) "Guaranty contract insurer" and "insurer" mean the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers' compensation insur-

ance in this state or an assigned claims agent selected by the director under ORS 656.054.

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

(16) "Invalid" means one who is physically or mentally incapacitated from earning a livelihood.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) For the purposes of industrial injury claims, a condition does not contribute to disability or

1 need for treatment if the condition merely renders the worker more susceptible to the injury.
2 (25) "Self-insured employer" means an employer or group of employers certified under ORS
3 656.430 as meeting the qualifications set out by ORS 656.407.
4 (26) "State Accident Insurance Fund Corporation" and "corporation" mean the State Accident
5 Insurance Fund Corporation created under ORS 656.752.
6 (27) "Subject employer" means an employer who is subject to this chapter as provided by ORS
7 656.023.
8 (28) "Subject worker" means a worker who is subject to this chapter as provided by ORS
9 656.027.
10 (29) "Wages" means the money rate at which the service rendered is recompensed under the
11 contract of hiring in force at the time of the accident, including reasonable value of board, rent,
12 housing, lodging or similar advantage received from the employer, and includes the amount of tips
13 required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of
14 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips
15 reported, whichever amount is greater. The State Accident Insurance Fund Corporation may estab-
16 lish assumed minimum and maximum wages, in conformity with recognized insurance principles, at
17 which any worker shall be carried upon the payroll of the employer for the purpose of determining
18 the premium of the employer.
19 (30) "Worker" means any person, including a minor whether lawfully or unlawfully employed,
20 who engages to furnish services for a remuneration, subject to the direction and control of an em-
21 ployer and includes salaried, elected and appointed officials of the state, state agencies, counties,
22 cities, school districts and other public corporations, but does not include any person whose services
23 are performed as an inmate or ward of a state institution or as part of the eligibility requirements
24 for a general or public assistance grant. For the purpose of determining entitlement to temporary
25 disability benefits or permanent total disability benefits under this chapter, "worker" does not in-
26 clude a person who has withdrawn from the workforce during the period for which such benefits are
27 sought.
28 (31) "Independent contractor" has the meaning for that term provided in ORS 670.600.
29 **SECTION 3.** ORS 656.260 is amended to read:
30 656.260. (1) Any health care provider or group of medical service providers may make written
31 application to the Director of the Department of Consumer and Business Services to become certi-
32 fied to provide managed care to injured workers for injuries and diseases compensable under this
33 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
34 erated by an insurer or employer other than a health care provider to become certified to provide
35 managed care.
36 (2) Each application for certification shall be accompanied by a reasonable fee prescribed by the
37 director. A certificate is valid for such period as the director may prescribe unless sooner revoked
38 or suspended.
39 (3) Application for certification shall be made in such form and manner and shall set forth such
40 information regarding the proposed plan for providing services as the director may prescribe. The
41 information shall include, but not be limited to:
42 (a) A list of the names of all individuals who will provide services under the managed care plan,
43 together with appropriate evidence of compliance with any licensing or certification requirements
44 for that individual to practice in this state.
45 (b) A description of the times, places and manner of providing services under the plan.

1 (c) A description of the times, places and manner of providing other related optional services
2 the applicants wish to provide.
3 (d) Satisfactory evidence of ability to comply with any financial requirements to insure delivery
4 of service in accordance with the plan which the director may prescribe.
5 (4) The director shall certify a health care provider or group of medical service providers to
6 provide managed care under a plan if the director finds that the plan:
7 (a) Proposes to provide services that meet quality, continuity and other treatment standards
8 reviewed and approved by the director and will provide all medical and health care services that
9 may be required by this chapter in a manner that is timely, effective and convenient for the worker.
10 (b) Subject to any other provision of law, does not discriminate against or exclude from partic-
11 ipation in the plan any category of medical service providers and includes an adequate number of
12 each category of medical service providers to give workers adequate flexibility to choose medical
13 service providers from among those individuals who provide services under the plan. However,
14 nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to
15 the granting of medical staff privileges.
16 (c) Provides appropriate financial incentives to reduce service costs and utilization without
17 sacrificing the quality of service.
18 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
19 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
20 or excessive treatment, to exclude from participation in the plan those individuals who violate these
21 treatment standards and to provide for the resolution of such medical disputes as the director con-
22 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
23 zation and contract review committee shall be physicians licensed to practice medicine by the Board
24 of Medical Examiners. As used in this paragraph:
25 (A) "Peer review" means evaluation or review of the performance of colleagues by a panel with
26 similar types and degrees of expertise. Peer review requires participation of at least three physicians
27 prior to final determination.
28 (B) "Service utilization review" means evaluation and determination of the reasonableness, ne-
29 cessity and appropriateness of a worker's use of medical care resources and the provision of any
30 needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service
31 utilization review" includes prior authorization, concurrent review, retrospective review, discharge
32 planning and case management activities.
33 (C) "Quality assurance" means activities to safeguard or improve the quality of medical care
34 by assessing the quality of care or service and taking action to improve it.
35 (D) "Dispute resolution" includes the resolution of disputes arising under peer review, service
36 utilization review and quality assurance activities between insurers, self-insured employers, workers
37 and medical and health care service providers, as required under the certified plan.
38 (E) "Contract review" means the methods and processes whereby the managed care organization
39 monitors and enforces its contracts with participating providers for matters other than matters
40 enumerated in subparagraphs (A), (B) and (C) of this paragraph.
41 (e) Provides a program involving cooperative efforts by the workers, the employer and the
42 managed care organizations to promote workplace health and safety consultative and other services
43 and early return to work for injured workers.
44 (f) Provides a timely and accurate method of reporting to the director necessary information
45 regarding medical and health care service cost and utilization to enable the director to determine

1 the effectiveness of the plan.
2 (g) Authorizes workers to receive compensable medical treatment from a primary care physician
3 who is not a member of the managed care organization, but who maintains the worker's medical
4 records and with whom the worker has a documented history of treatment, if that primary care
5 physician agrees to refer the worker to the managed care organization for any specialized treatment,
6 including physical therapy, to be furnished by another provider that the worker may require and if
7 that primary care physician agrees to comply with all the rules, terms and conditions regarding
8 services performed by the managed care organization. Nothing in this paragraph is intended to limit
9 the worker's right to change primary care physicians prior to the filing of a workers' compensation
10 claim. As used in this paragraph, "primary care physician" means a physician who is qualified to
11 be an attending physician referred to in ORS 656.005 (12)(b)(A) **or (B)** and who is a family practi-
12 tioner, a general practitioner**,** [*or*] an internal medicine practitioner **or a doctor or physician li-**
13 **censed by the State Board of Chiropractic Examiners**.
14 (h) Provides a written explanation for denial of participation in the managed care organization
15 plan to any licensed health care provider that has been denied participation in the managed care
16 organization plan.
17 (i) Does not prohibit the injured worker's attending physician from advocating for medical ser-
18 vices and temporary disability benefits for the injured worker that are supported by the medical
19 record.
20 (j) Complies with any other requirement the director determines is necessary to provide quality
21 medical services and health care to injured workers.
22 (5) The director shall refuse to certify or may revoke or suspend the certification of any health
23 care provider or group of medical service providers to provide managed care if the director finds
24 that:
25 (a) The plan for providing medical or health care services fails to meet the requirements of this
26 section.
27 (b) Service under the plan is not being provided in accordance with the terms of a certified plan.
28 (6) Any issue concerning the provision of medical services to injured workers subject to a
29 managed care contract and service utilization review, quality assurance, dispute resolution, contract
30 review and peer review activities as well as authorization of medical services to be provided by
31 other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the
32 director or the director's designated representatives. The decision of the director is subject to re-
33 view under ORS 656.704. Data generated by or received in connection with these activities, includ-
34 ing written reports, notes or records of any such activities, or of any review thereof, shall be
35 confidential, and shall not be disclosed except as considered necessary by the director in the ad-
36 ministration of this chapter. The director may report professional misconduct to an appropriate li-
37 censing board.
38 (7) No data generated by service utilization review, quality assurance, dispute resolution or peer
39 review activities and no physician profiles or data used to create physician profiles pursuant to this
40 section or a review thereof shall be used in any action, suit or proceeding except to the extent
41 considered necessary by the director in the administration of this chapter. The confidentiality pro-
42 visions of this section shall not apply in any action, suit or proceeding arising out of or related to
43 a contract between a managed care organization and a health care provider whose confidentiality
44 is protected by this section.
45 (8) A person participating in service utilization review, quality assurance, dispute resolution or

peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. ORS 656.245 is amended to read:

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

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

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

(A) Services provided to a worker who has been determined to be permanently and totally disabled.

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

notice to the attending physician of the worker's medically stationary status.

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

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

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

(A) A medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of injury or occupational disease or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable.

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

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

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

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

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

(3) Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards

of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental. The decision of the director is subject to review under ORS 656.704.

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or nurse practitioners, or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician**, doctor or physician licensed by the State Board of Chiropractic Examiners** or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the **doctor,** physician or nurse practitioner agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a managed care organization.

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

(B) If the insurer or self-insured employer gives notice that the worker is required to receive treatment from the managed care organization, the insurer or self-insured employer must guarantee that any reasonable and necessary services so received, that are not otherwise covered by health insurance, will be paid as provided in ORS 656.248, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever event first occurs. The worker may elect to receive care from a primary care physician**,** [*or*] nurse practitioner **or a doctor or physician licensed by the State Board of Chiropractic Examiners** authorized to provide compensable medical services under this section who agrees to the conditions

of ORS 656.260 (4)(g). However, guarantee of payment is not required by the insurer or self-insured employer if this election is made.

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

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

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

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

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

SECTION 5. ORS 656.245, as amended by section 4, chapter 811, Oregon Laws 2003, and section 4, chapter 26, Oregon Laws 2005, is amended to read:

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

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

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

(A) Services provided to a worker who has been determined to be permanently and totally disabled.

(B) Prescription medications.

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

(D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

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

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

(A) A medical service provider who is not qualified to be an attending physician may provide compensable medical service to an injured worker for a period of 30 days from the date of injury or occupational disease or for 12 visits, whichever first occurs, without the authorization of an attending physician. Thereafter, medical service provided to an injured worker without the written authorization of an attending physician is not compensable.

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

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

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

(a) Those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract. Workers subject to the contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease, regardless of the date of injury or medically stationary status, on or after the effective date of the contract. If the managed care organization determines that the change in provider would be medically detrimental to the worker, the worker shall not become subject to the contract until the worker is found to be medically stationary, the worker changes physicians or the managed care organization determines that the change in provider is no longer medically detrimental, whichever event first occurs. A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs. A worker shall not be subject to a contract after it expires or terminates without renewal. A worker may continue to treat with the attending physician **or doctor or physician licensed by the State Board of Chiropractic Examiners** under an expired or terminated managed care organization contract if the physician agrees to comply with the rules, terms and conditions regarding services performed under any subsequent managed care organization contract to which the worker is subject. A worker shall not be subject to a contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical area. Each such contract must comply with the certification standards provided in ORS 656.260. However, a worker may receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe. Notwithstanding any provision of law or rule to the contrary, a worker of a noncomplying employer is considered to be subject to a contract between the State Accident Insurance Fund Corporation as a processing agent or the assigned claims agent and a

managed care organization.

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

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

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

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

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

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