Enrolled
House Bill 2197

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CHAPTER .....

AN ACT

Relating to workers' compensation; amending ORS 656.245, 656.248 and 656.622; and repealing ORS 656.270.

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

SECTION 1. 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) 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, non-experimental 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. 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*] **the first visit on the initial claim** 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. However, an emergency room physician who is not authorized to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of the first visit on the initial claim.

(C) Except as otherwise provided in this chapter, only a physician qualified to serve as an attending physician under ORS 656.005 (12)(b)(A) who is serving as 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.

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

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

(ii) May 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 or nurse practitioner authorized to provide compensable medical services under this section under an expired or terminated managed care organization contract if the 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 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) 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.

(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.

SECTION 2. ORS 656.248 is amended to read:

656.248. (1) The Director of the Department of Consumer and Business Services, in compliance with ORS 656.794 and ORS chapter 183, shall promulgate rules for developing and publishing fee schedules for medical services provided under this chapter. These schedules shall represent the reimbursement generally received for the services provided. Where applicable, and to the extent the director determines practicable, these fee schedules shall be based upon any one or all of the following:

(a) The current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein;

(b) The average rates of fee schedules of the Oregon health insurance industry;

(c) A reasonable rate of markup for the sale of medical devices or other medical services;

(d) A commonly used and accepted medical service fee schedule; or

(e) The actual cost of providing medical services.

(2) Medical fees equal to or less than the fee schedules published under this section shall be paid when the vendor submits a billing for medical services. In no event shall that portion of a medical fee be paid that exceeds the schedules.

(3) In no event shall a provider charge more than the provider charges to the general public.

(4) If no fee has been established for a given service or procedure the director may, in compliance with ORS 656.794 and ORS chapter 183, promulgate a reasonable rate, which shall be the same within any given area for all primary health care providers to be paid for that service or procedure.

(5) At the request of the director and in the method and manner prescribed by rule, all providers of health insurance, as defined by ORS 731.162, shall cooperate and consult with the director in providing information reasonably necessary and available to develop the fee schedules prescribed under subsection (1) of this section. A provider shall not be required to provide information or data that the provider deems proprietary or confidential. However, the information provided shall be considered proprietary and shall not be released by the director. The director shall not require such

information from a health insurance provider more than once per year and shall reimburse the provider's costs for providing the required information.

(6) Notwithstanding subsection (1) or (2) of this section, such rates or fees provided in subsections (1) and (2) of this section shall be adequate to insure at all times to the injured workers the standard of services and care intended by this chapter.

(7) The director shall update the schedule required by subsection (1) of this section annually. As appropriate and applicable, the update shall be based upon:

(a) A statistically valid survey by the director of medical service fees or markups;

(b) That information provided to the director by any person or state agency having access to medical service fee information;

(c) That information provided to the director pursuant to subsection (5) of this section; or

(d) The annual percentage increase or decrease in the physician's services component of the national Consumer Price Index published by the Bureau of Labor Statistics of the United States Department of Labor.

(8) The director is prohibited from adopting or administering rules which treat manipulation, when performed by an osteopathic physician, as anything other than a separate therapeutic procedure which is paid in addition to other services or office visits.

(9) The director may, by rule, establish a fee schedule for reimbursement for specific hospital services based upon the actual cost of providing the services.

(10) A medical service provider is not authorized to charge a fee for preparing or submitting a medical report form required by the director under this chapter.

(11) Notwithstanding any other provision of this section, fee schedules for medical services and hospital services shall apply to those services performed by a managed care organization certified pursuant to ORS 656.260, unless otherwise provided in the managed care contract.

(12) When a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, notwithstanding any other provision of this chapter, the injured worker, insurer, self-insured employer or medical service provider [*shall*] **may** request administrative review by the director. The decision of the director is subject to review under ORS 656.704.

(13) The director may exclude hospitals defined in ORS 442.470 from imposition of a fee schedule authorized by this section upon a determination of economic necessity.

SECTION 3. ORS 656.622 is amended to read:

656.622. (1) There is established a Reemployment Assistance Program for the benefit of employers and workers and for the purpose of:

(a) Giving employers and workers the benefits provided in this section.

(b) Providing reimbursement of reasonable program administration costs of self-insured employers and of insurers of employers who participate in any program funded through the Reemployment Assistance Program.

(2) In order to preclude or reduce nondisabling claims from becoming disabling claims, preclude on-the-job injuries from recurring, reduce disability by returning injured workers to work sooner and to help injured workers remain employed, the Director of the Department of Consumer and Business Services may provide assistance to employers from the Reemployment Assistance Program in such manner and amount as the director considers appropriate. Assistance may include, but need not be limited to, modification of work sites. For purposes of this subsection, work site modification may include engineering design work and occupational health consulting services. Factors to be considered by the director in determining the extent of assistance must include but need not be limited to [*the financial stability and solvency of employers,*] the employer's record of returning injured workers to the workplace and the cost-effectiveness of modifications. Assistance may be provided in the form of grants and matching contributions from employers for funds.

(3) In order to encourage the employment of individuals who have incurred compensable injuries that result in disability which may be a substantial obstacle to employment, the director may pro-

vide, to eligible injured workers and to employers who employ them, assistance from the Workers' Benefit Fund in such manner and amount as the director considers appropriate.

(4)(a) In addition to such assistance as the director may provide under this section, the director shall provide reimbursement to self-insured employers or to the insurers of employers who hire preferred workers for the claim costs incurred for injuries to those workers during the first three years from the date of hire, as follows:

(A) The claim costs of injuries incurred by those workers.

(B) Reasonable claims administration costs.

(b) A worker may not waive eligibility for preferred worker status in the claim by agreement pursuant to ORS 656.236.

(5)(a) In addition to such assistance as the Director of the Department of Consumer and Business Services may provide under subsection (3) of this section, the director shall provide to participating self-insured employers and the insurers of participating employers reimbursement of reasonable program administration costs.

(b) As used in this subsection, "participating employer" or "participating self-insured employer" means an employer participating in any program funded through the Reemployment Assistance Program.

(6) Notwithstanding any other provision of law, determinations by the director regarding assistance pursuant to this section are not subject to review by any court or other administrative body.

(7) The Reemployment Assistance Program shall be funded with moneys collected as provided in ORS 656.506.

(8) Any assistance from the Reemployment Assistance Program shall be to the extent of the moneys available in the Workers' Benefit Fund, for the purpose of the program as determined by the director.

(9) The director may make such rules as may be required to establish, regulate, manage and disburse moneys in the Workers' Benefit Fund in accordance with the intent of this section. Such rules shall include, but are not limited to, the eligibility criteria to receive assistance under this section and the issuance of identity cards to preferred workers to assist employers in the administration of the program.

(10) **If claim cost reimbursement is requested under subsection (4) of this section,** claims costs incurred as a result of an injury sustained by a preferred worker during the three years after that worker is hired shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by a guaranty contract insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Business Services. Neither insurance premiums nor premium assessments under this chapter are payable for preferred workers **during the first three years from the date of hire**.

(11) Any moneys from the Workers' Benefit Fund reimbursed to an agency for costs incurred in reemploying injured state workers in the manner described in ORS 659A.052 or in providing wage subsidies for the reemployment of injured state workers shall be outside the biennial expenditure limitation imposed on the agency by the Legislative Assembly and shall be available for expenditure by the agency as a continuous appropriation.

(12) As used in this section, "preferred worker" means a worker who, because of a permanent disability resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment, whether or not an order has been issued awarding permanent disability.

SECTION 4. ORS 656.622, as amended by section 16, chapter 241, Oregon Laws 2007, is amended to read:

656.622. (1) There is established a Reemployment Assistance Program for the benefit of employers and workers and for the purpose of:

(a) Giving employers and workers the benefits provided in this section.

(b) Providing reimbursement of reasonable program administration costs of self-insured employers and of insurers of employers who participate in any program funded through the Reemployment Assistance Program.

(2) In order to preclude or reduce nondisabling claims from becoming disabling claims, preclude on-the-job injuries from recurring, reduce disability by returning injured workers to work sooner and to help injured workers remain employed, the Director of the Department of Consumer and Business Services may provide assistance to employers from the Reemployment Assistance Program in such manner and amount as the director considers appropriate. Assistance may include, but need not be limited to, modification of work sites. For purposes of this subsection, work site modification may include engineering design work and occupational health consulting services. Factors to be considered by the director in determining the extent of assistance must include but need not be limited to [*the financial stability and solvency of employers,*] the employer's record of returning injured workers to the workplace and the cost-effectiveness of modifications. Assistance may be provided in the form of grants and matching contributions from employers for funds.

(3) In order to encourage the employment of individuals who have incurred compensable injuries that result in disability which may be a substantial obstacle to employment, the director may provide, to eligible injured workers and to employers who employ them, assistance from the Workers' Benefit Fund in such manner and amount as the director considers appropriate.

(4)(a) In addition to such assistance as the director may provide under this section, the director shall provide reimbursement to self-insured employers or to the insurers of employers who hire preferred workers for the claim costs incurred for injuries to those workers during the first three years from the date of hire, as follows:

(A) The claim costs of injuries incurred by those workers.

(B) Reasonable claims administration costs.

(b) A worker may not waive eligibility for preferred worker status in the claim by agreement pursuant to ORS 656.236.

(5)(a) In addition to such assistance as the Director of the Department of Consumer and Business Services may provide under subsection (3) of this section, the director shall provide to participating self-insured employers and the insurers of participating employers reimbursement of reasonable program administration costs.

(b) As used in this subsection, "participating employer" or "participating self-insured employer" means an employer participating in any program funded through the Reemployment Assistance Program.

(6) Notwithstanding any other provision of law, determinations by the director regarding assistance pursuant to this section are not subject to review by any court or other administrative body.

(7) The Reemployment Assistance Program shall be funded with moneys collected as provided in ORS 656.506.

(8) Any assistance from the Reemployment Assistance Program shall be to the extent of the moneys available in the Workers' Benefit Fund, for the purpose of the program as determined by the director.

(9) The director may make such rules as may be required to establish, regulate, manage and disburse moneys in the Workers' Benefit Fund in accordance with the intent of this section. Such rules shall include, but are not limited to, the eligibility criteria to receive assistance under this section and the issuance of identity cards to preferred workers to assist employers in the administration of the program.

(10) **If claim cost reimbursement is requested under subsection (4) of this section,** claims costs incurred as a result of an injury sustained by a preferred worker during the three years after that worker is hired shall not be included in any data used for ratemaking or individual employer rating or dividend calculations by an insurer, a rating organization licensed pursuant to ORS chapter 737, the State Accident Insurance Fund Corporation or the Department of Consumer and Busi-

ness Services. Neither insurance premiums nor premium assessments under this chapter are payable for preferred workers **during the first three years from the date of hire**.

(11) Any moneys from the Workers' Benefit Fund reimbursed to an agency for costs incurred in reemploying injured state workers in the manner described in ORS 659A.052 or in providing wage subsidies for the reemployment of injured state workers shall be outside the biennial expenditure limitation imposed on the agency by the Legislative Assembly and shall be available for expenditure by the agency as a continuous appropriation.

(12) As used in this section, "preferred worker" means a worker who, because of a permanent disability resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment, whether or not an order has been issued awarding permanent disability.

SECTION 5. ORS 656.270 is repealed.

Passed by House February 25, 2009

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Chief Clerk of House

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Speaker of House

Passed by Senate March 20, 2009

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President of Senate

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.....M.,....., 2009

Approved:

.....M.,....., 2009

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Governor

Filed in Office of Secretary of State:

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Secretary of State