

House Bill 2093

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Pre-session filed (at the request of Governor John A. Kitzhaber for Department of Consumer and Business Services)

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**.

Limits provision of managed care services for injured workers to certified managed care organizations. Authorizes imposition of sanction that includes civil penalty for violation. Allows issuance of cease and desist order for repeated or willful violation.

A BILL FOR AN ACT

1
2 Relating to managed care in workers' compensation system; amending ORS 656.260.

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

4 **SECTION 1.** ORS 656.260 is amended to read:

5 656.260. (1) Any health care provider or group of medical service providers may make written
6 application to the Director of the Department of Consumer and Business Services to become certi-
7 fied to provide managed care to injured workers for injuries and diseases compensable under this
8 chapter. However, nothing in this section authorizes an organization that is formed, owned or op-
9 erated by an insurer or employer other than a health care provider to become certified to provide
10 managed care.

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

14 (3) Application for certification shall be made in such form and manner and shall set forth such
15 information regarding the proposed plan for providing services as the director may prescribe. The
16 information shall include, but not be limited to:

17 (a) A list of the names of all individuals who will provide services under the managed care plan,
18 together with appropriate evidence of compliance with any licensing or certification requirements
19 for that individual to practice in this state.

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

21 (c) A description of the times, places and manner of providing other related optional services
22 the applicants wish to provide.

23 (d) Satisfactory evidence of ability to comply with any financial requirements to insure delivery
24 of service in accordance with the plan which the director may prescribe.

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

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

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

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

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

2 (b) Subject to any other provision of law, does not discriminate against or exclude from partic-
3 ipation in the plan any category of medical service providers and includes an adequate number of
4 each category of medical service providers to give workers adequate flexibility to choose medical
5 service providers from among those individuals who provide services under the plan. However,
6 nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to
7 the granting of medical staff privileges.

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

10 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
11 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
12 or excessive treatment, to exclude from participation in the plan those individuals who violate these
13 treatment standards and to provide for the resolution of such medical disputes as the director con-
14 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
15 zation and contract review committee shall be physicians licensed to practice medicine by the
16 Oregon Medical Board. As used in this paragraph:

17 (A) "Peer review" means evaluation or review of the performance of colleagues by a panel with
18 similar types and degrees of expertise. Peer review requires participation of at least three physicians
19 prior to final determination.

20 (B) "Service utilization review" means evaluation and determination of the reasonableness, ne-
21 cessity and appropriateness of a worker's use of medical care resources and the provision of any
22 needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service
23 utilization review" includes prior authorization, concurrent review, retrospective review, discharge
24 planning and case management activities.

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

27 (D) "Dispute resolution" includes the resolution of disputes arising under peer review, service
28 utilization review and quality assurance activities between insurers, self-insured employers, workers
29 and medical and health care service providers, as required under the certified plan.

30 (E) "Contract review" means the methods and processes whereby the managed care organization
31 monitors and enforces its contracts with participating providers for matters other than matters
32 enumerated in subparagraphs (A), (B) and (C) of this paragraph.

33 (e) Provides a program involving cooperative efforts by the workers, the employer and the
34 managed care organizations to promote workplace health and safety consultative and other services
35 and early return to work for injured workers.

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

39 (g) Authorizes workers to receive compensable medical treatment from a primary care physician
40 who is not a member of the managed care organization, but who maintains the worker's medical
41 records and with whom the worker has a documented history of treatment, if that primary care
42 physician agrees to refer the worker to the managed care organization for any specialized treatment,
43 including physical therapy, to be furnished by another provider that the worker may require and if
44 that primary care physician agrees to comply with all the rules, terms and conditions regarding
45 services performed by the managed care organization. Nothing in this paragraph is intended to limit

1 the worker's right to change primary care physicians prior to the filing of a workers' compensation
2 claim. As used in this paragraph, "primary care physician" means a physician who is qualified to
3 be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a
4 general practitioner or an internal medicine practitioner.

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

8 (i) Does not prohibit the injured worker's attending physician from advocating for medical ser-
9 vices and temporary disability benefits for the injured worker that are supported by the medical
10 record.

11 (j) Complies with any other requirement the director determines is necessary to provide quality
12 medical services and health care to injured workers.

13 (5) The director shall refuse to certify or may revoke or suspend the certification of any health
14 care provider or group of medical service providers to provide managed care if the director finds
15 that:

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

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

19 (6) Any issue concerning the provision of medical services to injured workers subject to a
20 managed care contract and service utilization review, quality assurance, dispute resolution, contract
21 review and peer review activities as well as authorization of medical services to be provided by
22 other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject to review by the
23 director or the director's designated representatives. The decision of the director is subject to re-
24 view under ORS 656.704. Data generated by or received in connection with these activities, includ-
25 ing written reports, notes or records of any such activities, or of any review thereof, shall be
26 confidential, and shall not be disclosed except as considered necessary by the director in the ad-
27 ministration of this chapter. The director may report professional misconduct to an appropriate li-
28 censing board.

29 (7) No data generated by service utilization review, quality assurance, dispute resolution or peer
30 review activities and no physician profiles or data used to create physician profiles pursuant to this
31 section or a review thereof shall be used in any action, suit or proceeding except to the extent
32 considered necessary by the director in the administration of this chapter. The confidentiality pro-
33 visions of this section shall not apply in any action, suit or proceeding arising out of or related to
34 a contract between a managed care organization and a health care provider whose confidentiality
35 is protected by this section.

36 (8) A person participating in service utilization review, quality assurance, dispute resolution or
37 peer review activities pursuant to this section shall not be examined as to any communication made
38 in the course of such activities or the findings thereof, nor shall any person be subject to an action
39 for civil damages for affirmative actions taken or statements made in good faith.

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

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

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

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

8 (13) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care or-
9 ganization contract may designate any medical service provider or category of providers as attend-
10 ing physicians.

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

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

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

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

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

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

37 **(20)(a) Except as otherwise provided in this chapter, only a managed care organization**
38 **certified by the director may:**

39 **(A) Restrict the choice of a health care provider or medical service provider by a worker;**

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

41 **(C) Restrict the ability of a medical service provider to refer a worker to another pro-**
42 **vider;**

43 **(D) Require preauthorization or precertification of medical services or treatment; or**

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

1 **(b) If the director finds that a person has engaged in managed care in violation of para-**
2 **graph (a) of this subsection, the director may impose a sanction that may include a civil**
3 **penalty not to exceed \$2,000 for each violation. Each day a violation continues shall be con-**
4 **sidered a separate violation.**

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

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

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