

House Bill 2346

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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**.

Prohibits employer or insurer from requiring injured worker to obtain nonemergency medical services from specific provider. Exempts employer or insurer that has managed care organization contract. Requires employer to provide injured worker with written notice of medical treatment rights in workers' compensation claim.

A BILL FOR AN ACT

1
2 Relating to medical services provided to injured workers; amending ORS 656.245, 656.260 and
3 656.265.

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

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

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

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

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

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

22 (B) Prescription medications.

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

25 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

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

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

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

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

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

28 (2)(a) The worker may choose an attending doctor, physician or nurse practitioner within the
 29 State of Oregon. The worker may choose the initial attending physician or nurse practitioner and
 30 may subsequently change attending physician or nurse practitioner two times without approval from
 31 the director. If the worker thereafter selects another attending physician or nurse practitioner, the
 32 insurer or self-insured employer may require the director's approval of the selection. The decision
 33 of the director is subject to review under ORS 656.704. The worker also may choose an attending
 34 doctor or physician in another country or in any state or territory or possession of the United
 35 States with the prior approval of the insurer or self-insured employer.

36 **(b) Except as authorized by subsection (4) of this section, an insurer or a self-insured**
 37 **employer may not require the worker to obtain nonemergency medical services from a spe-**
 38 **specific doctor, physician, nurse practitioner, occupational medical center, emergency care**
 39 **clinic or other medical group.**

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

42 (A) A medical service provider who is not qualified to be an attending physician may provide
 43 compensable medical service to an injured worker for a period of 30 days from the date of the first
 44 visit on the initial claim or for 12 visits, whichever first occurs, without the authorization of an
 45 attending physician. Thereafter, medical service provided to an injured worker without the written

1 authorization of an attending physician is not compensable.

2 (B) A medical service provider who is not an attending physician cannot authorize the payment
 3 of temporary disability compensation. However, an emergency room physician who is not authorized
 4 to serve as an attending physician under ORS 656.005 (12)(c) may authorize temporary disability
 5 benefits for a maximum of 14 days. A medical service provider qualified to serve as an attending
 6 physician under ORS 656.005 (12)(b)(B) may authorize the payment of temporary disability compen-
 7 sation for a period not to exceed 30 days from the date of the first visit on the initial claim.

8 (C) Except as otherwise provided in this chapter, only a physician qualified to serve as an at-
 9 tending physician under ORS 656.005 (12)(b)(A) or (B)(i) who is serving as the attending physician
 10 at the time of claim closure may make findings regarding the worker's impairment for the purpose
 11 of evaluating the worker's disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **SECTION 2.** 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

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

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

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

40 (d) Provides adequate methods of peer review, service utilization review, quality assurance,
 41 contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate
 42 or excessive treatment, to exclude from participation in the plan those individuals who violate these
 43 treatment standards and to provide for the resolution of such medical disputes as the director con-
 44 siders appropriate. A majority of the members of each peer review, quality assurance, service utili-
 45 zation and contract review committee shall be physicians licensed to practice medicine by the

1 Oregon Medical Board. As used in this paragraph:

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

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

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

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

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

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

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

24 (g) Authorizes workers to receive compensable medical treatment from a primary care physician
25 who is not a member of the managed care organization, but who maintains the worker's medical
26 records and with whom the worker has a documented history of treatment, if that primary care
27 physician agrees to refer the worker to the managed care organization for any specialized treatment,
28 including physical therapy, to be furnished by another provider that the worker may require and if
29 that primary care physician agrees to comply with all the rules, terms and conditions regarding
30 services performed by the managed care organization. Nothing in this paragraph is intended to limit
31 the worker's right to change primary care physicians prior to the filing of a workers' compensation
32 claim. As used in this paragraph, "primary care physician" means a physician who is qualified to
33 be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a
34 general practitioner or an internal medicine practitioner.

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

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

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

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

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

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

4 (6) Any issue concerning the provision of medical services to injured workers subject to a
5 managed care contract and service utilization review, quality assurance, dispute resolution, contract
6 review and peer review activities as well as authorization of medical services to be provided by
7 other than an attending physician pursuant to ORS 656.245 [(2)(b)] **(2)(c)** shall be subject to review
8 by the director or the director's designated representatives. The decision of the director is subject
9 to review under ORS 656.704. Data generated by or received in connection with these activities,
10 including written reports, notes or records of any such activities, or of any review thereof, shall be
11 confidential, and shall not be disclosed except as considered necessary by the director in the ad-
12 ministration of this chapter. The director may report professional misconduct to an appropriate li-
13 censing board.

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

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

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

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

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

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

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

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

1 ization has completed and issued its final decision.

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

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

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

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

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

22 **SECTION 3.** ORS 656.265 is amended to read:

23 656.265. (1) Notice of an accident resulting in an injury or death shall be given immediately by
 24 the worker or a dependent of the worker to the employer, but not later than 90 days after the ac-
 25 cident. The employer shall acknowledge forthwith receipt of such notice.

26 (2) The notice need not be in any particular form. However, it shall be in writing and shall ap-
 27 prise the employer when and where and how an injury has occurred to a worker. A report or
 28 statement secured from a worker, or from the doctor of the worker and signed by the worker, con-
 29 cerning an accident which may involve a compensable injury shall be considered notice from the
 30 worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

31 (3) Notice shall be given to the employer by mail, addressed to the employer at the last-known
 32 place of business of the employer, or by personal delivery to the employer or to a foreman or other
 33 supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may
 34 be given to the Director of the Department of Consumer and Business Services and referred to the
 35 insurer or self-insured employer.

36 (4) Failure to give notice as required by this section bars a claim under this chapter unless the
 37 notice is given within one year after the date of the accident and:

- 38 (a) The employer had knowledge of the injury or death;
- 39 (b) The worker died within 180 days after the date of the accident; or
- 40 (c) The worker or beneficiaries of the worker establish that the worker had good cause for
 41 failure to give notice within 90 days after the accident.

42 (5) The issue of failure to give notice must be raised at the first hearing on a claim for com-
 43 pensation in respect to the injury or death.

44 (6) The director shall promulgate and prescribe uniform forms to be used by workers in report-
 45 ing their injuries to their employers. These forms shall be supplied by all employers to injured

1 workers upon [*request of the injured worker or some other person on behalf of the worker*] **receipt**
2 **of the notice required under subsection (1) of this section.** The failure of the worker to use a
3 specified form shall not, in itself, defeat the claim of the worker if the worker has complied with the
4 requirement that the claim be presented in writing.

5 **(7)(a) Upon receipt of the notice required under subsection (1) of this section, the em-**
6 **ployer shall provide written notice to the worker explaining the medical treatment rights the**
7 **worker has for a compensable injury. The notice required under this subsection must in-**
8 **clude, but is not limited to, an explanation that:**

9 **(A) Subject to the provisions of this chapter, the worker may seek treatment with a**
10 **medical service provider of the worker's choice;**

11 **(B) Neither the worker's employer or any other person may require the worker to seek**
12 **medical treatment from a medical service provider other than the provider selected by the**
13 **worker; and**

14 **(C) If the worker's employer requires post-injury drug testing by a facility of the**
15 **employer's choice, the worker may continue treatment after the testing with the medical**
16 **service provider of the worker's choice.**

17 **(b) The notice of medical treatment rights required by this subsection must be signed**
18 **by the employer and the injured worker. A copy of the signed notice must be provided to**
19 **the injured worker.**

20 **(c) The director shall adopt by rule a form to be used by employers to provide workers**
21 **notice of their medical treatment rights under this chapter.**

22