

House Bill 2424

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of House Interim Committee on Business and Labor for Oregon Chiropractic Association)

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**.

Permits attending physician or authorized nurse practitioner to refer worker for treatment by chiropractic physician that is not member of managed care organization under specified circumstances.

A BILL FOR AN ACT

1
2 Relating to managed care organizations that provide managed care to injured workers; amending
3 ORS 656.245 and 656.260.

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

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

6 656.260. (1) [*Any*] **A** health care provider or group of medical service providers may [*make*
7 *written application*] **apply in writing** to the Director of the Department of Consumer and Business
8 Services to become certified to provide managed care to injured workers for injuries and diseases
9 compensable under this chapter, [*However, nothing in this section authorizes*] **but this section does**
10 **not authorize** an organization that is formed, owned or operated by an insurer or employer other
11 than a health care provider to become certified to provide managed care.

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

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

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

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

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

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

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

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

30 (A) Meets quality, continuity and other treatment standards adopted by the health care provider

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 or group of medical service providers in accordance with processes approved by the director; and

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

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

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

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

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

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

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

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

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

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

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

40 (g)(A) Authorizes workers to receive compensable medical treatment from a primary care phy-
41 sician or chiropractic physician who is not a member of the managed care organization, but who
42 maintains the worker's medical records and is a physician with whom the worker has a documented
43 history of treatment, if:

44 (i) **Except as provided in paragraph (h) of this subsection**, the primary care physician or
45 chiropractic physician agrees to refer the worker to the managed care organization for any spe-

1 cialized treatment, including physical therapy, to be furnished by another provider that the worker
2 may require;

3 (ii) The primary care physician or chiropractic physician agrees to comply with all the rules,
4 terms and conditions regarding services performed by the managed care organization; and

5 (iii) The treatment is determined to be medically appropriate according to the service utilization
6 review process of the managed care organization.

7 (B) *[Nothing in]* This paragraph *[is intended to]* **does not** limit the worker's right to change
8 primary care physicians or chiropractic physicians *[prior to the]* **before** filing *[of]* a workers' com-
9 pensation claim.

10 (C) A chiropractic physician authorized to provide compensable medical treatment under this
11 paragraph may provide services and authorize temporary disability compensation as provided in ORS
12 656.005 (12)(b)(B) and 656.245 (2)(b). However, the managed care organization may authorize
13 chiropractic physicians to provide medical services and authorize temporary disability payments
14 beyond the periods established in ORS 656.005 (12)(b)(B) and 656.245 (2)(b).

15 (D) As used in this paragraph, "primary care physician" means a physician who is qualified to
16 be an attending physician, *[referred to]* **as defined** in ORS 656.005 (12)(b)(A), and who is a family
17 practitioner, a general practitioner or an internal medicine practitioner.

18 **(h) Authorizes an attending physician or authorized nurse practitioner to refer a worker
19 for compensable medical treatment by a chiropractic physician who is not a member of the
20 managed care organization if:**

21 **(A) The worker has a documented history of treatment with the chiropractic physician;**

22 **(B) The chiropractic physician agrees to comply with the rules, terms and conditions for
23 providing services that the managed care organization provides; and**

24 **(C) The managed care organization's service utilization review process determines that
25 the treatment is medically appropriate.**

26 *[(h)]* (i) Provides a written explanation for denial of participation in the managed care organ-
27 ization plan to any licensed health care provider that has been denied participation in the managed
28 care organization plan.

29 *[(i)]* (j) Does not prohibit the injured worker's attending physician from advocating for medical
30 services and temporary disability benefits for the injured worker that are supported by the medical
31 record.

32 *[(j)]* (k) Complies with any other requirement the director determines is necessary to provide
33 quality medical services and health care to injured workers.

34 (5)(a) Notwithstanding ORS 656.245 (5) and subsection (4)(g) **and (h)** of this section, a managed
35 care organization may deny or terminate the authorization of a primary care physician or
36 chiropractic physician to serve as an attending physician under subsection (4)(g) of this section, **of**
37 **a chiropractic physician to serve as a provider under subsection (4)(h) of this section** or of
38 a nurse practitioner to provide medical services as provided in ORS 656.245 (5) if the physician or
39 nurse practitioner, within two years prior to the worker's enrollment in the plan:

40 (A) Has been terminated from serving as an attending physician or nurse practitioner for a
41 worker enrolled in the plan for failure to meet the requirements of subsection (4)(g) **and (h)** of this
42 section or of ORS 656.245 (5); or

43 (B) Has failed to satisfy the credentialing standards for participating in the managed care or-
44 ganization.

45 (b) The director shall adopt by rule reporting standards for managed care organizations to re-

1 port denials and terminations of the authorization of primary care physicians, chiropractic physi-
 2 cians and nurse practitioners who are not members of the managed care organization to provide
 3 compensable medical treatment under ORS 656.245 (5) and subsection (4)(g) **and (h)** of this section.
 4 The director shall annually report to the Workers' Compensation Management-Labor Advisory
 5 Committee the information reported to the director by managed care organizations under this par-
 6 agraph.

7 (6) The director shall refuse to certify or may revoke or suspend the certification of any health
 8 care provider or group of medical service providers to provide managed care if the director finds
 9 that:

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

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

13 (7) Any issue concerning the provision of medical services to injured workers subject to a
 14 managed care contract and service utilization review, quality assurance, dispute resolution, contract
 15 review and peer review activities as well as authorization of medical services to be provided by
 16 other than an attending physician pursuant to ORS 656.245 (2)(b) *[shall be]* **is** subject to review by
 17 the director or the director's designated representatives. The decision of the director is subject to
 18 review under ORS 656.704. Data generated by or received in connection with these activities, in-
 19 cluding written reports, notes or records of any such activities, or of any review thereof, *[shall be]*
 20 **are** confidential, and *[shall]* **may** not be disclosed except as considered necessary by the director in
 21 the administration of this chapter. The director may report professional misconduct to an appropri-
 22 ate licensing board.

23 (8) *[No]* Data generated by service utilization review, quality assurance, dispute resolution or
 24 peer review activities and *[no]* physician profiles or data used to create physician profiles pursuant
 25 to this section or a review *[thereof shall be]* **of data or profiles may not be** used in any action, suit
 26 or proceeding except to the extent considered necessary by the director in the administration of this
 27 chapter. The confidentiality provisions of this section *[shall]* **do** not apply in any action, suit or
 28 proceeding arising out of or related to a contract between a managed care organization and a health
 29 care provider whose confidentiality is protected by this section.

30 (9) A person participating in service utilization review, quality assurance, dispute resolution or
 31 peer review activities pursuant to this section *[shall]* **may** not be examined as to any communication
 32 made in the course of such activities or the findings thereof, *[nor shall any person be]* **a person**
 33 **may not be** subject to an action for civil damages for affirmative actions taken or statements made
 34 in good faith.

35 (10) *[No]* **A** person who participates in forming consortiums, collectively negotiating fees or
 36 otherwise solicits or enters into contracts in a good faith effort to provide medical or health care
 37 services according to the provisions of this section *[shall]* **may not** be examined or subject to ad-
 38 ministrative or civil liability regarding any such participation except pursuant to the director's ac-
 39 tive supervision of such activities and the managed care organization. Before engaging in such
 40 activities, the person shall provide notice of intent to the director in a form prescribed by the di-
 41 rector.

42 (11) The provisions of this section *[shall]* **do** not affect the confidentiality or admission in evi-
 43 dence of a claimant's medical treatment records.

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

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

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

7 (15) If a worker, insurer, self-insured employer, the attending physician or an authorized health
8 care provider is dissatisfied with an action of the managed care organization regarding the provision
9 of medical services pursuant to this chapter, peer review, service utilization review or quality as-
10 surance activities, that person or entity must first apply to the director for administrative review
11 of the matter before requesting a hearing. Such application must be made not later than the 60th
12 day after the date the managed care organization has completed and issued *[its]* **the managed care**
13 **organization’s** final decision.

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

19 (17) At the contested case hearing, the order may be modified only if *[it]* **the order** is not sup-
20 ported by substantial evidence in the record or reflects an error of law. *[No]* New medical evidence
21 or issues *[shall]* **may not** be admitted. The dispute may also be remanded to the managed care or-
22 ganization for further evidence taking, correction or other necessary action if the Administrative
23 Law Judge or director determines the record has been improperly, incompletely or otherwise insuf-
24 ficiently developed. Decisions by the director regarding medical disputes are subject to review under
25 ORS 656.704.

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

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

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

35 (21)(a) Except as otherwise provided in this chapter, only a managed care organization certified
36 by the director may:

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

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

39 (C) Restrict the ability of a medical service provider to refer a worker to another provider;

40 (D) Require preauthorization or precertification to determine the necessity of medical services
41 or treatment; or

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

44 (b) The provisions of paragraph (a) of this subsection do not apply to:

45 (A) A medical service provider who refers a worker to another medical service provider;

1 (B) Use of an on-site medical service facility by the employer to assess the nature or extent of
 2 a worker's injury; or

3 (C) Treatment provided by a medical service provider or transportation of a worker in an
 4 emergency or trauma situation.

5 (c) Except as provided in paragraph (b) of this subsection, if the director finds that a person has
 6 violated a provision of paragraph (a) of this subsection, the director may impose a sanction that may
 7 include a civil penalty not to exceed \$2,000 for each violation.

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

12 (e)(A) Penalties imposed under this subsection are subject to ORS 656.735 (4) to (6) and 656.740.

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

14 **SECTION 2.** ORS 656.245 is amended to read:

15 656.245. (1)(a) For every compensable injury, *[the]* **an** insurer or *[the]* **a** self-insured employer
 16 shall cause to be provided medical services for conditions caused in material part by the injury for
 17 such period as the nature of the injury or the process of the recovery requires, subject to the limi-
 18 tations in ORS 656.225, including such medical services as may be required after a determination
 19 of permanent disability. In addition, for consequential and combined conditions described in ORS
 20 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical
 21 services directed to medical conditions caused in major part by the injury.

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

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

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

31 (B) Prescription medications.

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

34 (D) Prosthetic devices, braces and supports.

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

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

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

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

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

41 (J) With the approval of the insurer or self-insured employer, palliative care that the worker's
 42 attending physician referred to in ORS 656.005 (12)(b)(A) prescribes and that is necessary to enable
 43 the worker to continue current employment or a vocational training program. If the insurer or
 44 self-insured employer does not approve, the attending physician or the worker may request approval
 45 from the Director of the Department of Consumer and Business Services for such treatment. The

1 director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327
2 (3) to aid in the review of such treatment. The decision of the director is subject to review under
3 ORS 656.704.

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

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

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

15 (e) Except for services provided under a managed care contract, out-of-pocket expense re-
16 imbursement to receive care from the attending physician or nurse practitioner authorized to pro-
17 vide compensable medical services under this section [*shall*] **may** not exceed the amount required
18 to seek care from an appropriate nurse practitioner or attending physician of the same specialty
19 who is in a medical community geographically closer to the worker's home. For the purposes of this
20 paragraph, all physicians and nurse practitioners within a metropolitan area are [*considered to be*]
21 part of the same medical community.

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

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

32 (A) A medical service provider who is not qualified to be an attending physician may provide
33 compensable medical [*service*] **services** to an injured worker for a period of 30 days from the date
34 of the first visit on the initial claim or for 12 visits, whichever first occurs, without the authori-
35 zation of an attending physician. Thereafter, medical service provided to an injured worker without
36 the written authorization of an attending physician is not compensable.

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

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

1 of evaluating the worker's disability.

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

4 (i) May provide compensable medical services for 180 days from the date of the first visit on the
5 initial claim;

6 (ii) May authorize the payment of temporary disability benefits for a period not to exceed 180
7 days from the date of the first visit on the initial claim; and

8 (iii) When an injured worker treating with a nurse practitioner authorized to provide
9 compensable services under this section becomes medically stationary within the 180-day period in
10 which the nurse practitioner is authorized to treat the injured worker, shall refer the injured worker
11 to a physician qualified to be an attending physician as defined in ORS 656.005 for the purpose of
12 making findings regarding the worker's impairment for the purpose of evaluating the worker's disa-
13 bility. If a worker returns to the nurse practitioner after initial claim closure for evaluation of a
14 possible worsening of the worker's condition, the nurse practitioner shall refer the worker to an
15 attending physician and the insurer shall compensate the nurse practitioner for the examination
16 performed.

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

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

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

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

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

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

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

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

28 (5)(a) A nurse practitioner licensed under ORS 678.375 to 678.390 who is not a member of the
29 managed care organization is authorized to provide the same level of services as a primary care
30 physician as established by ORS 656.260 (4) if the nurse practitioner maintains the worker's medical
31 records and [*with whom*] **if** the worker has a documented history of treatment **with the nurse**
32 **practitioner**, if [*that*] **the** nurse practitioner agrees to refer the worker to the managed care or-
33 ganization for any specialized treatment, including physical therapy, **subject to the provisions of**
34 **ORS 656.260 (4)(h)**, [*to be*] **that will be** furnished by another provider that the worker may require
35 and if [*that*] **the** nurse practitioner agrees to comply with all the rules, terms and conditions re-
36 garding services performed by the managed care organization.

37 (b) A nurse practitioner authorized to provide medical services to a worker enrolled in the
38 managed care organization may provide medical treatment to the worker if the treatment is deter-
39 mined to be medically appropriate according to the service utilization review process of the man-
40 aged care organization and may authorize temporary disability payments as provided in subsection
41 (2)(b)(D) of this section. However, the managed care organization may authorize the nurse practi-
42 tioner to provide medical services and authorize temporary disability payments beyond the periods
43 established in subsection (2)(b)(D) of this section.

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

1 pursuant to ORS 656.260 or 656.327.

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