

HB 3022-2  
(LC 696)  
4/10/19 (TSB/ps)

Requested by HOUSE COMMITTEE ON BUSINESS AND LABOR (at the request of the  
Management-Labor Advisory Committee)

**PROPOSED AMENDMENTS TO  
HOUSE BILL 3022**

1 On page 1 of the printed bill, line 2, after “ORS” delete the rest of the  
2 line and lines 3 and 4 and insert “656.245, 656.266 and 656.704; and declaring  
3 an emergency.”.

4 Delete lines 6 through 30 and delete pages 2 through 50 and insert:

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

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

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

21 **“(c) In addition to other benefits allowed under this chapter, after**

1 **an industrial accident or occupational disease has been determined to**  
2 **be compensable, diagnostic services are compensable if the diagnostic**  
3 **services are reasonable and necessary to identify the nature or extent**  
4 **of a medical condition that might be related to the industrial accident**  
5 **or occupational disease. Surgery and surgical procedures are**  
6 **compensable diagnostic services only if other diagnostic services are**  
7 **inadequate for identifying the nature and extent of the effects of an**  
8 **industrial accident or occupational disease and for establishing a**  
9 **treatment plan. For purposes of this paragraph, a diagnostic injection**  
10 **is not surgery or a surgical procedure.**

11 “[c)] (d) Notwithstanding any other provision of this chapter, medical  
12 services after the worker’s condition is medically stationary are not  
13 compensable except for the following:

14 “(A) Services provided to a worker who has been determined to be per-  
15 manently and totally disabled.

16 “(B) Prescription medications.

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

19 “(D) Prosthetic devices, braces and supports.

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

22 “(F) Services provided pursuant to an accepted claim for aggravation un-  
23 der ORS 656.273.

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

25 “(H) Services that are necessary to diagnose the worker’s condition.

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

28 “(J) With the approval of the insurer or self-insured employer, palliative  
29 care that the worker’s attending physician referred to in ORS 656.005  
30 (12)(b)(A) prescribes and that is necessary to enable the worker to continue

1 current employment or a vocational training program. If the insurer or self-  
2 insured employer does not approve, the attending physician or the worker  
3 may request approval from the Director of the Department of Consumer and  
4 Business Services for such treatment. The director may order a medical re-  
5 view by a physician or panel of physicians pursuant to ORS 656.327 (3) to  
6 aid in the review of such treatment. The decision of the director is subject  
7 to review under ORS 656.704.

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

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

15 “[*d*] (e) When the medically stationary date in a disabling claim is es-  
16 tablished by the insurer or self-insured employer and is not based on the  
17 findings of the attending physician, the insurer or self-insured employer is  
18 responsible for reimbursement to affected medical service providers for oth-  
19 erwise compensable services rendered until the insurer or self-insured em-  
20 ployer provides written notice to the attending physician of the worker’s  
21 medically stationary status.

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

1       “(2)(a) The worker may choose an attending doctor, physician or nurse  
2 practitioner within the State of Oregon. The worker may choose the initial  
3 attending physician or nurse practitioner and may subsequently change at-  
4 tending physician or nurse practitioner two times without approval from the  
5 director. If the worker thereafter selects another attending physician or  
6 nurse practitioner, the insurer or self-insured employer may require the  
7 director’s approval of the selection. The decision of the director is subject  
8 to review under ORS 656.704. The worker also may choose an attending  
9 doctor or physician in another country or in any state or territory or pos-  
10 session of the United States with the prior approval of the insurer or self-  
11 insured employer.

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

14       “(A) A medical service provider who is not qualified to be an attending  
15 physician may provide compensable medical service to an injured worker for  
16 a period of 30 days from the date of the first visit on the initial claim or for  
17 12 visits, whichever first occurs, without the authorization of an attending  
18 physician. Thereafter, medical service provided to an injured worker without  
19 the written authorization of an attending physician is not compensable.

20       “(B) A medical service provider who is not an attending physician cannot  
21 authorize the payment of temporary disability compensation. However, an  
22 emergency room physician who is not authorized to serve as an attending  
23 physician under ORS 656.005 (12)(c) may authorize temporary disability ben-  
24 efits for a maximum of 14 days. A medical service provider qualified to serve  
25 as an attending physician under ORS 656.005 (12)(b)(B) may authorize the  
26 payment of temporary disability compensation for a period not to exceed 30  
27 days from the date of the first visit on the initial claim.

28       “(C) Except as otherwise provided in this chapter, only a physician qual-  
29 ified to serve as an attending physician under ORS 656.005 (12)(b)(A) or (B)(i)  
30 who is serving as the attending physician at the time of claim closure may

1 make findings regarding the worker’s impairment for the purpose of evalu-  
2 ating the worker’s disability.

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

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

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

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

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

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

1       “(a) Those workers who are subject to the contract shall receive medical  
2 services in the manner prescribed in the contract. Workers subject to the  
3 contract include those who are receiving medical treatment for an accepted  
4 compensable injury or occupational disease, regardless of the date of injury  
5 or medically stationary status, on or after the effective date of the contract.  
6 If the managed care organization determines that the change in provider  
7 would be medically detrimental to the worker, the worker shall not become  
8 subject to the contract until the worker is found to be medically stationary,  
9 the worker changes physicians or nurse practitioners, or the managed care  
10 organization determines that the change in provider is no longer medically  
11 detrimental, whichever event first occurs. A worker becomes subject to the  
12 contract upon the worker’s receipt of actual notice of the worker’s enroll-  
13 ment in the managed care organization, or upon the third day after the no-  
14 tice was sent by regular mail by the insurer or self-insured employer,  
15 whichever event first occurs. A worker shall not be subject to a contract  
16 after it expires or terminates without renewal. A worker may continue to  
17 treat with the attending physician or nurse practitioner authorized to pro-  
18 vide compensable medical services under this section under an expired or  
19 terminated managed care organization contract if the physician or nurse  
20 practitioner agrees to comply with the rules, terms and conditions regarding  
21 services performed under any subsequent managed care organization contract  
22 to which the worker is subject. A worker shall not be subject to a contract  
23 if the worker’s primary residence is more than 100 miles outside the managed  
24 care organization’s certified geographical area. Each such contract must  
25 comply with the certification standards provided in ORS 656.260. However,  
26 a worker may receive immediate emergency medical treatment that is  
27 compensable from a medical service provider who is not a member of the  
28 managed care organization. Insurers or self-insured employers who contract  
29 with a managed care organization for medical services shall give notice to  
30 the workers of eligible medical service providers and such other information

1 regarding the contract and manner of receiving medical services as the di-  
2 rector may prescribe. Notwithstanding any provision of law or rule to the  
3 contrary, a worker of a noncomplying employer is considered to be subject  
4 to a contract between the State Accident Insurance Fund Corporation as a  
5 processing agent or the assigned claims agent and a managed care organ-  
6 ization.

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

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

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

26 “(D) If the claim is denied, the worker may receive medical services after  
27 the date of denial from sources other than the managed care organization  
28 until the denial is reversed. Reasonable and necessary medical services re-  
29 ceived from sources other than the managed care organization after the date  
30 of claim denial must be paid as provided in ORS 656.248 by the insurer or

1 self-insured employer if the claim is finally determined to be compensable.

2 “(5)(a) A nurse practitioner licensed under ORS 678.375 to 678.390 who is  
3 not a member of the managed care organization is authorized to provide the  
4 same level of services as a primary care physician as established by ORS  
5 656.260 (4) if the nurse practitioner maintains the worker’s medical records  
6 and with whom the worker has a documented history of treatment, if that  
7 nurse practitioner agrees to refer the worker to the managed care organiza-  
8 tion for any specialized treatment, including physical therapy, to be fur-  
9 nished by another provider that the worker may require and if that nurse  
10 practitioner agrees to comply with all the rules, terms and conditions re-  
11 garding services performed by the managed care organization.

12 “(b) A nurse practitioner authorized to provide medical services to a  
13 worker enrolled in the managed care organization may provide medical  
14 treatment to the worker if the treatment is determined to be medically ap-  
15 propriate according to the service utilization review process of the managed  
16 care organization and may authorize temporary disability payments as pro-  
17 vided in subsection (2)(b)(D) of this section. However, the managed care or-  
18 ganization may authorize the nurse practitioner to provide medical services  
19 and authorize temporary disability payments beyond the periods established  
20 in subsection (2)(b)(D) of this section.

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

25 **“SECTION 2.** ORS 656.266 is amended to read:

26 “656.266. (1) The burden of proving that an injury or occupational disease  
27 is compensable and of proving the nature and extent of any disability re-  
28 sulting therefrom is upon the worker. The worker cannot carry the burden  
29 of proving that an injury or occupational disease is compensable merely by  
30 disproving other possible explanations of how the injury or disease occurred.



1 “(2) Notwithstanding subsection (1) of this section, for the purpose of  
2 combined condition injury claims under ORS 656.005 (7)(a)(B) only:

3 “(a) Once the worker establishes an otherwise compensable injury, the  
4 employer shall bear the burden of proof to establish the otherwise  
5 compensable injury is not, or is no longer, the major contributing cause of  
6 the disability of the combined condition or the major contributing cause of  
7 the need for treatment of the combined condition.

8 “(b) Notwithstanding ORS 656.804, paragraph (a) of this subsection does  
9 not apply to any occupational disease claim.

10 “(3) **For denials issued under ORS 656.262 (6)(c) or (7)(b), the em-**  
11 **ployer bears the burden of proof to establish that an otherwise**  
12 **compensable condition and any other objective medical findings that**  
13 **the industrial accident caused are no longer the major contributing**  
14 **cause of the need for treatment and disability of the combined condi-**  
15 **tion.**

16 “**SECTION 3.** ORS 656.704 is amended to read:

17 “656.704. (1) Actions and orders of the Director of the Department of  
18 Consumer and Business Services regarding matters concerning a claim under  
19 this chapter, and administrative and judicial review of those matters, are  
20 subject to the procedural provisions of this chapter and such procedural  
21 rules as the Workers’ Compensation Board may prescribe.

22 “(2)(a) A party dissatisfied with an action or order regarding a matter  
23 other than a matter concerning a claim under this chapter may request a  
24 hearing on the matter in writing to the director. The director shall refer the  
25 request for hearing to the Workers’ Compensation Board for a hearing before  
26 an Administrative Law Judge. Review of an order issued by the Administra-  
27 tive Law Judge shall be by the director and the director shall issue a final  
28 order that is subject to judicial review as provided by ORS 183.480 to 183.497.

29 “(b) The director shall prescribe the classes of orders issued under this  
30 subsection by Administrative Law Judges and other personnel that are final,

1 appealable orders and those orders that are preliminary orders subject to  
2 revision by the director.

3 “(3)(a) For the purpose of determining the respective authority of the di-  
4 rector and the board to conduct hearings, investigations and other pro-  
5 ceedings under this chapter, and for determining the procedure for the  
6 conduct and review thereof, matters concerning a claim under this chapter  
7 are those matters in which a worker’s right to receive compensation, or the  
8 amount thereof, are directly in issue. However, subject to paragraph (b) of  
9 this subsection, such matters do not include any disputes arising under ORS  
10 656.245, 656.247, 656.248, 656.260 or 656.327, any other provisions directly re-  
11 lating to the provision of medical services to workers or any disputes arising  
12 under ORS 656.340 except as those provisions may otherwise provide.

13 “(b) The respective authority of the board and the director to resolve  
14 medical service disputes shall be determined according to the following  
15 principles:

16 “(A) Any dispute that requires a determination of the compensability of  
17 the medical condition for which medical services are proposed is a matter  
18 concerning a claim.

19 “(B) Any dispute that requires a determination of whether medical ser-  
20 vices are excessive, inappropriate, ineffectual or in violation of the rules  
21 regarding the performance of medical services, or a determination of whether  
22 medical services for an accepted condition qualify as compensable medical  
23 services among those listed in ORS 656.245 [(1)(c)] **(1)(d)**, is not a matter  
24 concerning a claim.

25 “(C) Any dispute that requires a determination of whether a sufficient  
26 causal relationship exists between medical services and an accepted claim to  
27 establish compensability is a matter concerning a claim.

28 “(c) Notwithstanding ORS 656.283 (3), if parties to a hearing scheduled  
29 before an Administrative Law Judge are involved in a dispute regarding both  
30 matters concerning a claim and matters not concerning a claim, the Admin-

1 istrative Law Judge may defer any action on the matter concerning a claim  
2 until the director has completed an administrative review of the matters  
3 other than those concerning a claim. The director shall mail a copy of the  
4 administrative order to the parties and to the Administrative Law Judge. A  
5 party may request a hearing on the order of the director. At the request of  
6 a party or by the own motion of the Administrative Law Judge, the hearings  
7 on the separate matters may be consolidated. The Administrative Law Judge  
8 shall issue an order for those matters concerning a claim and a separate  
9 order for matters other than those concerning a claim.

10 “(4) Hearings under ORS 656.740 shall be conducted by an Administrative  
11 Law Judge from the board’s Hearings Division.

12 “(5) If a request for hearing or administrative review is filed with either  
13 the director or the board and it is determined that the request should have  
14 been filed with the other, the dispute shall be transferred. Filing a request  
15 will be timely filed if the original filing was completed within the prescribed  
16 time.

17 **“SECTION 4. (1) Except as provided in subsection (2) of this section,**  
18 **the amendments to ORS 656.245, 656.266 and 656.704 by sections 1 to 3**  
19 **of this 2019 Act apply to all claims or causes of action that exist or**  
20 **that arise on or after the effective date of this 2019 Act, regardless of**  
21 **the date of injury or the date the claim is presented.**

22 **“(2) The amendments to ORS 656.266 by section 2 of this 2019 Act**  
23 **apply to denials that are issued after the effective date of this 2019 Act.**

24 **“(3) This 2019 Act is retroactive unless a specific provision of this**  
25 **2019 Act indicates otherwise.**

26 **“SECTION 5. This 2019 Act being necessary for the immediate**  
27 **preservation of the public peace, health and safety, an emergency is**  
28 **declared to exist, and this 2019 Act takes effect on its passage.”.**

29