

**A-Engrossed**  
**Senate Bill 670**

Ordered by the Senate April 27  
Including Senate Amendments dated April 27

Sponsored by Senator WALKER

**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.

Requires Director of Department of Consumer and Business Services to [*adopt rules establishing*] **review and approve** certain treatment standards for care provided to injured workers by managed care organization. Requires managed care organization plan to allow attending physician to advocate for medical services and temporary disability benefits for certain injured workers as prerequisite for certification.

**A BILL FOR AN ACT**

1  
2 Relating to certification for managed care organization; 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:

**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 (a) Proposes to provide services that meet quality, continuity and other treatment standards  
2 [prescribed by the director] **reviewed and approved by the director** and will provide all medical  
3 and health care services that may be required by this chapter in a manner that is timely, effective  
4 and convenient for the worker.

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

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

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

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

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

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

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

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

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

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

42 (g) Authorizes workers to receive compensable medical treatment from a primary care physician  
43 who is not a member of the managed care organization, but who maintains the worker's medical  
44 records and with whom the worker has a documented history of treatment, if that primary care  
45 physician agrees to refer the worker to the managed care organization for any specialized treatment,

1 including physical therapy, to be furnished by another provider that the worker may require and if  
2 that primary care physician agrees to comply with all the rules, terms and conditions regarding  
3 services performed by the managed care organization. Nothing in this paragraph is intended to limit  
4 the worker's right to change primary care physicians prior to the filing of a workers' compensation  
5 claim. As used in this paragraph, "primary care physician" means a physician who is qualified to  
6 be an attending physician referred to in ORS 656.005 (12)(b)(A) and who is a family practitioner, a  
7 general practitioner or an internal medicine practitioner.

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

11 **(i) Does not prohibit the injured worker's attending physician from advocating for med-**  
12 **ical services and temporary disability benefits for the injured worker that are supported by**  
13 **the medical record.**

14 [(i)] (j) Complies with any other requirement the director determines is necessary to provide  
15 quality medical services and health care to injured workers.

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

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

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

22 (6) Any issue concerning the provision of medical services to injured workers subject to a  
23 managed care contract and service utilization review, quality assurance, dispute resolution, contract  
24 review and peer review activities as well as authorization of medical services to be provided by  
25 other than an attending physician pursuant to ORS 656.245 (2)(b) shall be subject solely to review  
26 by the director or the director's designated representatives, or as otherwise provided in this section.  
27 Data generated by or received in connection with these activities, including written reports, notes  
28 or records of any such activities, or of the director's review thereof, shall be confidential, and shall  
29 not be disclosed except as considered necessary by the director in the administration of this chapter.  
30 The director may report professional misconduct to an appropriate licensing board.

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

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

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

1 such activities and the managed care organization. Before engaging in such activities, the person  
2 shall provide notice of intent to the director in a form prescribed by the director.

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

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

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

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

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

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

24 (16) At the contested case hearing, the administrative order may be modified only if it is not  
25 supported by substantial evidence in the record or reflects an error of law. No new medical evidence  
26 or issues shall be admitted. The dispute may also be remanded to the managed care organization for  
27 further evidence taking, correction or other necessary action if the director determines the record  
28 has been improperly, incompletely or otherwise insufficiently developed. Decisions by the director  
29 regarding medical disputes are subject to review under ORS chapter 183.

30 (17) Any person who is dissatisfied with an action of a managed care organization other than  
31 regarding the provision of medical services pursuant to this chapter, peer review, service utilization  
32 review or quality assurance activities may request a contested case hearing before the director  
33 pursuant to ORS chapter 183. The decision of the director is final if an appeal is not made to the  
34 Court of Appeals within 60 days of the mailing of the order.

35 (18) Notwithstanding any other provision of law, original jurisdiction over contract review dis-  
36 putes is with the director. The director may resolve the matter by issuing an order subject to re-  
37 view under ORS chapter 183, or the director may determine that the matter in dispute would be best  
38 addressed in another forum and so inform the parties.

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

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