Enrolled
Senate Bill 670

Sponsored by Senator WALKER

CHAPTER .....

AN ACT

Relating to certification for managed care organization; amending ORS 656.260.

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

SECTION 1. ORS 656.260 is amended to read:

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

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

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

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

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

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

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

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

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

(b) Subject to any other provision of law, does not discriminate against or exclude from participation in the plan any category of medical service providers and includes an adequate number of each category of medical service providers to give workers adequate flexibility to choose medical service providers from among those individuals who provide services under the plan. However,

nothing in the requirements of this paragraph shall affect the provisions of ORS 441.055 relating to the granting of medical staff privileges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) Notwithstanding ORS 656.005 (12) or subsection (4)(b) of this section, a managed care organization contract may designate any medical service provider or category of providers as attending physicians.

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

(15) Upon a request for administrative review, the director shall create a documentary record sufficient for judicial review. The director shall complete administrative review and issue a proposed order within a reasonable time. The proposed administrative order of the director pursuant

to this section shall become final and not subject to further review unless a written request for a hearing is filed with the director within 30 days of the mailing of the order to all parties.

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

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

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

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

Passed by Senate May 3, 2005

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Secretary of Senate

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President of Senate

Passed by House June 14, 2005

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Speaker of House

Received by Governor:

.....M.,....., 2005

Approved:

.....M.,....., 2005

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Governor

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.....M.,....., 2005

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Secretary of State