

1 _____ BILL NO. _____

2 INTRODUCED BY _____
 3 (Primary Sponsor)

4 A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING A JUDGMENT LIEN FOR ATTORNEY
 5 COMPENSATION ON WORKERS' COMPENSATION INSURER PAYMENTS FOR MEDICAL SERVICES;
 6 AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

9

10 **Section 1.** Section 39-71-704, MCA, is amended to read:

11 **"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates**
 12 **-- fee limitation -- no lien attachment to medical services benefits.** (1) In addition to the compensation
 13 provided under this chapter and as an additional benefit separate and apart from compensation benefits
 14 actually provided, the following must be furnished:

15 (a) After the happening of a compensable injury and subject to other provisions of this chapter,
 16 the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for
 17 those periods as the nature of the injury or the process of recovery requires.

18 (b) The insurer shall furnish secondary medical services only upon a clear demonstration of
 19 cost-effectiveness of the services in returning the injured worker to actual employment.

20 (c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses,
 21 prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in
 22 39-71-119, arising out of and in the course of employment.

23 (d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a
 24 medical provider for treatment of an injury only if the travel is incurred at the request of the insurer.
 25 Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

26 (e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury,
 27 the benefits provided for in this section terminate when they are not used for a period of 60 consecutive
 28 months.

29 (f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker
 30 has achieved medical stability, palliative or maintenance care except:

1 (i) when provided to a worker who has been determined to be permanently totally disabled and
 2 for whom it is medically necessary to monitor administration of prescription medication to maintain the
 3 worker in a medically stationary condition;

4 (ii) when necessary to monitor the status of a prosthetic device; or

5 (iii) when the worker's treating physician believes that the care that would otherwise not be
 6 compensable under this subsection (1)(f) is appropriate to enable the worker to continue current
 7 employment or that there is a clear probability of returning the worker to employment. A dispute regarding
 8 the compensability of palliative or maintenance care is considered a dispute over which, after mediation
 9 pursuant to department rule, the workers' compensation court has jurisdiction.

10 (g) Notwithstanding any other provisions of this chapter, the department, by rule and upon the
 11 advice of the professional licensing boards of practitioners affected by the rule, may exclude from
 12 compensability any medical treatment that the department finds to be unscientific, unproved, outmoded,
 13 or experimental.

14 (2) The department shall annually establish a schedule of fees for medical services not provided
 15 at a hospital that are necessary for the treatment of injured workers. Charges submitted by providers must
 16 be the usual and customary charges for nonworkers' compensation patients. The department may require
 17 insurers to submit information to be used in establishing the schedule.

18 (3) (a) The department shall establish rates for hospital services necessary for the treatment of
 19 injured workers.

20 ~~(b) Except as provided in subsection (3)(g), rates for services provided at a hospital must be the~~
 21 ~~greater of:~~

22 ~~—— (i) 69% of the hospital's January 1, 1997, usual and customary charges; or~~

23 ~~—— (ii) the discount factor established by the department that was in effect on June 30, 1997, for the~~
 24 ~~hospital. The discount factor for a hospital formed by the merger of two or more existing hospitals is~~
 25 ~~computed by using the weighted average of the discount factors in effect at the time of the merger.~~

26 ~~(e)(b)~~ Except as provided in subsection ~~(3)(g)~~, beginning July 1, 1998 ~~(3)(f)~~, the department shall
 27 adjust hospital discount factors so that the rate of payment does not exceed the annual percentage
 28 increase in the state's average weekly wage, as defined in 39-71-116.

29 ~~(d)(c)~~ The department may establish a fee schedule for hospital outpatient services ~~rendered on~~
 30 ~~or after July 1, 1998~~. The fee schedule must, in the aggregate, provide for fees that are equal to the

1 statewide average discount factors paid to hospitals to provide the same or equivalent procedure to
2 workers' compensation hospital outpatients.

3 ~~(e)~~(d) The discount factors established by the department pursuant to this subsection (3) may not
4 be less than medicaid reimbursement rates.

5 ~~(f)~~(e) For services available in Montana, insurers are not required to pay facilities located outside
6 Montana rates that are greater than those allowed for services delivered in Montana.

7 ~~(g)~~(f) For a hospital licensed as a medical assistance facility pursuant to Title 50, chapter 5, the
8 rate for services is the hospital's usual and customary charge. Fees paid to a hospital licensed as a medical
9 assistance facility are not subject to the limitation provided in subsection (4).

10 (4) The percentage increase in medical costs payable under this chapter may not exceed the
11 annual percentage increase in the state's average weekly wage, as defined in 39-71-116.

12 (5) Payment pursuant to reimbursement agreements between managed care organizations or
13 preferred provider organizations and insurers is not bound by the provisions of this section.

14 (6) Disputes between an insurer and a medical service provider regarding the amount of a fee for
15 medical services must be resolved by a hearing before the department upon written application of a party
16 to the dispute.

17 (7) (a) After the initial visit, the worker is responsible for 20%, but not to exceed \$10, of the cost
18 of each subsequent visit to a medical service provider for treatment relating to a compensable injury or
19 occupational disease, unless the visit is to a medical service provider in a managed care organization as
20 requested by the insurer or is a visit to a preferred provider as requested by the insurer.

21 (b) After the initial visit, the worker is responsible for \$25 of the cost of each subsequent visit to
22 a hospital emergency department for treatment relating to a compensable injury or occupational disease.

23 (c) "Visit", as used in subsections (7)(a) and (7)(b), means each time that the worker obtains
24 services relating to a compensable injury or occupational disease from:

25 (i) a treating physician;

26 (ii) a physical therapist;

27 (iii) a psychologist; or

28 (iv) hospital outpatient services available in a nonhospital setting.

29 (d) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if
30 the visit is an examination requested by an insurer pursuant to 39-71-605.

1 (8) A judgment lien for attorney compensation does not attach to payments for medical services
2 made by an insurer directly to a hospital or other provider pursuant to this section."

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4 NEW SECTION. **Section 2. Effective date.** [This act] is effective on passage and approval.

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