HOUSE BILL NO. 738

INTRODUCED BY MENDENHALL, COCCHIARELLA

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING WORKERS' COMPENSATION ~~LAW TO PROVIDE A CLOSURE DATE FOR INJURY AND OCCUPATIONAL DISEASE CLAIMS~~ LAWS; PROVIDING THAT THE DEPARTMENT OF LABOR AND INDUSTRY MAY NOT SET THE RATE FOR MEDICAL SERVICES AT A RATE GREATER THAN 10 PERCENT ABOVE THE ~~WEIGHTED AVERAGE OF THE REIMBURSEMENT RATE USED BY DOMESTIC INSURERS~~ AVERAGE OF THE CONVERSION FACTORS USED BY THE TOP FIVE INSURERS OR THIRD-PARTY ADMINISTRATORS PROVIDING DISABILITY INSURANCE WITHIN THIS STATE WHO USE THE RESOURCE-BASED RELATIVE VALUE SCALE TO DETERMINE FEES FOR COVERED SERVICES; MODIFYING DEPARTMENT PROCEDURES FOR ESTABLISHING FEE SCHEDULES FOR MEDICAL SERVICES AND PRESCRIPTION DRUGS; PROVIDING FOR UTILIZATION AND TREATMENT GUIDELINES TO BE ESTABLISHED BY RULE; AMENDING SECTIONS ~~39-71-601,~~ 39-71-704~~,~~ AND 39-71-743, MCA; AND PROVIDING AN EFFECTIVE DATE AND ~~AN~~ APPLICABILITY ~~DATE~~ DATES."

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

~~**Section 1.** Section 39-71-601, MCA, is amended to read:~~

~~**"39-71-601. Statute of limitation on presentment of claim -- closure of claims -- waiver.** (1) Except for a claim for benefits for occupational diseases pursuant to subsections (3) (4) and (4) (5), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department, as the case may be, within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.~~

~~(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:~~

~~(a) lack of knowledge of disability;~~

~~(b) latent injury; or~~

~~(c) equitable estoppel.~~

~~(3) (a) When a claim for an injury has been made and liability has been accepted by the insurer or~~

payments have been made by the insurer pursuant to 39-71-615, all benefits provided for in this chapter terminate within 2 years of the date of the injury or within 2 5 years from the last payment of benefits, whichever is later.

(b) When a claim for an occupational disease has been made and liability has been accepted by the insurer or payments have been made by the insurer pursuant to 39-71-615, all benefits provided for in this chapter terminate within 2 5 years of the date the occupational disease claim was received by the insurer or within 2 years from the last payment of benefits, whichever is later.

(c) THE TIME PERIOD FOR CLOSURE OF A CLAIM PROVIDED FOR IN SUBSECTION (3)(A) OR (3)(B) IS TOLLED WHILE THERE IS A DISPUTE REGARDING WHETHER BENEFITS ARE DUE UNDER THE CLAIM IF A PARTY TO THE DISPUTE HAS REQUESTED MEDIATION PURSUANT TO DEPARTMENT RULES. THE TOLLING OF THE TIME PERIOD CONTINUES UNTIL THE 2-YEAR LIMITATION PERIOD OF 39-71-2905 EXPIRES OR THERE IS A FINAL JUDICIAL DECISION REGARDING THE DISPUTE, WHICHEVER IS LATER. HOWEVER, THE TOLLING OF THE TIME PERIOD CEASES IF THE PARTIES OTHERWISE RESOLVE THE DISPUTE.

(3)(4) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

(4)(5) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court. A CLAIMANT MUST BE GIVEN 60 DAYS' NOTICE PRIOR TO THE TERMINATION OF A CLAIM OR BENEFITS UNDER THIS CHAPTER."

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

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

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

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of

cost-effectiveness of the services in returning the injured worker to actual employment.

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

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

(A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605;

(B) travel to a medical provider within the community in which the worker resides;

(C) travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the travel and treatment were required.

(e) Pursuant to rules adopted by the department, an insurer shall reimburse a catastrophically injured worker's family or, if a family member is unavailable, a person designated by the injured worker or approved by the insurer for travel assistance expenditures in an amount not to exceed $2,500 to be used as a match to those funds raised by community service organizations to help defray the costs of travel and lodging expenses incurred by the family member or designated person when traveling to be with the injured worker. These funds must be paid in addition to any travel expenses paid by an insurer for a travel companion when it is medically necessary for a travel companion to accompany the catastrophically injured worker.

(f) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury or occupational disease, the benefits provided for in this section terminate ~~when they are not used for a period of 60 consecutive months~~ as provided in 39-71-601(3).

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

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

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

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

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

(2) (a) The department shall annually establish a schedule of fees for medical services ~~not provided at a hospital~~ that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule. Until the department adopts a fee schedule applicable to medical services provided by a hospital, insurers shall pay at the rate payable on June 30, 2007, for those services provided by the hospital. The rate must be adjusted by the annual percentage increase in the state's average weekly wage, as defined in 39-71-116, factoring in changes in the hospital's medical service charges.

(b) The department may not set the rate for medical services at a rate greater than 10% above the ~~weighted average of the reimbursement rate used by domestic insurers~~ AVERAGE OF THE CONVERSION FACTORS USED BY THE TOP FIVE INSURERS OR THIRD-PARTY ADMINISTRATORS providing disability insurance within this state who use the resource-based relative value scale to determine fees for covered services. THE TOP FIVE INSURERS OR THIRD-PARTY ADMINISTRATORS SHALL PROVIDE THEIR STANDARD CONVERSION RATES TO THE DEPARTMENT. THE DEPARTMENT MAY USE THE CONVERSION RATES ONLY FOR THE PURPOSE OF DETERMINING AVERAGE CONVERSION RATES UNDER THIS SUBSECTION (2), AND THE DEPARTMENT SHALL MAINTAIN THE CONFIDENTIALITY OF THE CONVERSION RATES.

(c) The fee schedule rates established in subsection (2)(b) apply to medical services covered by the American medical association current procedural terminology codes in effect at the time the services are provided

regardless of where the services are provided.

(d) The department may establish coding standards to be utilized by providers when billing for medical services under this section.

(3) (a) The department may establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the utilization and treatment guidelines established by the department are correct medical treatment for the injured worker.

(b) An insurer ~~is~~ AND AN INJURED WORKER ARE not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer.

(c) The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

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

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

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

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

~~(c) Except as provided in subsection (3)(g), the department shall adjust hospital discount factors so that the rate of payment does not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.~~

~~(d) The department may establish a fee schedule for hospital outpatient services rendered. The fee schedule must, in the aggregate, provide for fees that are equal to the statewide average discount factors paid to hospitals to provide the same or equivalent procedure to workers' compensation hospital outpatients.~~

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

~~(f)~~(4) For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

~~(g)~~(5) For a medical assistance facility or a critical access hospital licensed pursuant to Title 50, chapter

5, the rate for services is the usual and customary charge. ~~Fees paid to a licensed medical assistance facility or critical access hospital are not subject to the limitation provided in subsection (4).~~

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

~~(5)~~(6) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

~~(6)~~(7) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

~~(7)~~(8) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(b) "Visit", as used in this subsection ~~(7)~~ (8), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

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

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection ~~(7)(a)~~ (8)(a) if the visit is for treatment requested by an insurer."

Section 2. Section 39-71-743, MCA, is amended to read:

"39-71-743. Assignment or attachment of payments. (1) Payments under this chapter may not be assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law;

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to this chapter; or

(d) for workers' compensation benefits payable to an injured worker to pay restitution to an insurer

whenever the injured worker is subject to court-ordered restitution for theft of workers' compensation benefits. The insurer shall notify the injured worker in writing of the withholding of any court-ordered restitution from the injured worker's benefits.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is necessary to pay current child support and a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in ~~39-71-704(7)~~ 39-71-704(8), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

COORDINATION SECTION. **SECTION 3. COORDINATION INSTRUCTION.** IF SENATE BILL NO. 108 AND [THIS ACT] ARE BOTH PASSED AND APPROVED AND IF THEY CONTAIN A SECTION THAT AMENDS 39-71-704, THEN THE SECTIONS AMENDING 39-71-704 ARE VOID AND 39-71-704 MUST BE AMENDED AS FOLLOWS:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

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

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

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

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the

department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

(A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605;

(B) travel to a medical provider within the community in which the worker resides;

(C) travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the travel and treatment were required.

(e) Pursuant to rules adopted by the department, an insurer shall reimburse a catastrophically injured worker's family or, if a family member is unavailable, a person designated by the injured worker or approved by the insurer for travel assistance expenditures in an amount not to exceed $2,500 to be used as a match to those funds raised by community service organizations to help defray the costs of travel and lodging expenses incurred by the family member or designated person when traveling to be with the injured worker. These funds must be paid in addition to any travel expenses paid by an insurer for a travel companion when it is medically necessary for a travel companion to accompany the catastrophically injured worker.

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

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

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

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

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable

under subsection (1)(g) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

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

(2) (a) The department shall annually establish a schedule of fees for medical services ~~not provided at a hospital~~ that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule. Until the department adopts a fee schedule applicable to medical services provided by a hospital, insurers shall pay at the rate payable on June 30, 2007, for those services provided by a hospital. The rate must be adjusted by the annual percentage increase in the state's average weekly wage, as defined in 39-71-116, factoring in changes in the hospital's medical service charges.

(b) (i) The department may not set the rate for medical services at a rate greater than 10% above the average of the conversion factors used by the top five insurers or third-party administrators providing disability insurance within this state who use the resource-based relative value scale to determine fees for covered services.

(ii) The top five insurers or third-party administrators shall provide their standard conversion rates to the department.

(iii) The department may use the conversion rates only for the purpose of determining average conversion rates under this subsection (2).

(iv) The department shall maintain the confidentiality of the conversion rates.

(c) The fee schedule rates established in subsection (2)(b) apply to medical services covered by the American medical association current procedural terminology codes in effect at the time the services are provided regardless of where the services are provided.

(d) The department may establish coding standards to be utilized by providers when billing for medical services under this section.

(3) (a) The department may establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the utilization and treatment

guidelines established by the department are correct medical treatment for the injured worker.

(b) An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

(c) The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

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

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

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

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

~~(c) Except as provided in subsection (3)(g), the department shall adjust hospital discount factors so that the rate of payment does not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.~~

~~(d) The department may establish a fee schedule for hospital outpatient services rendered. The fee schedule must, in the aggregate, provide for fees that are equal to the statewide average discount factors paid to hospitals to provide the same or equivalent procedure to workers' compensation hospital outpatients.~~

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

~~(f)~~(4) For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

~~(g)~~(5) For a medical assistance facility or a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual and customary charge. ~~Fees paid to a licensed medical assistance facility or critical access hospital are not subject to the limitation provided in subsection (4).~~

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

~~(5)~~(6) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

~~(6)~~(7) ~~Disputes~~ After mediation pursuant to department rules, disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

~~(7)~~(8) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

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

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

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

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is for treatment requested by an insurer."

NEW SECTION. **Section 4. Effective date.** [This act] is effective July 1, 2007.

NEW SECTION. **Section 5. Applicability DATES.** (1) ~~Sections 39-71-601(3) and 39-71-704(1)(f) AND (3) apply~~ [SECTION 3(3)(A) THROUGH (3)(C)] APPLIES to injuries or occupational diseases occurring on or after July 1, 2007.

~~(2) SECTION 39-71-704(2) APPLIES TO MEDICAL SERVICES FURNISHED ON OR AFTER JULY 1, 2007.~~

(2) [SECTION 3(2)(B) THROUGH (2)(D)] APPLIES TO MEDICAL TREATMENT OR SERVICES FURNISHED ON OR AFTER JANUARY 1, 2008.

- END -