

SENATE BILL NO. 78

INTRODUCED BY M. MCNALLY

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING AN INJURED WORKER WITH A 90-DAY NOTICE OF A WORKERS' COMPENSATION CLAIM CLOSURE AND NOTICE OF REMEDIES; AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

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 or occupational disease and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services, including prescription drugs for conditions that are a direct result of the compensable injury or occupational disease, for those periods specified in this section.

(b) Subject to the limitations in this chapter, 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 health care 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

1 for the worker's medical condition. The rules must exclude from reimbursement:

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

4 (B) travel to a health care provider within the community in which the worker resides;

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

7 (D) travel for unauthorized treatment or disallowed procedures.

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

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

18 (f) (i) The benefits provided for in this section terminate 60 months from the date of injury or diagnosis
19 of an occupational disease. A worker may request reopening of medical benefits that were terminated under this
20 subsection (1)(f) as provided in 39-71-717.

21 (ii) Subsection (1)(f)(i) does not apply to a worker who is permanently totally disabled as a result of a
22 compensable injury or occupational disease or for the repair or replacement of a prosthesis furnished as a direct
23 result of a compensable injury or occupational disease.

24 ~~(iii) If an injured worker has received medical benefits within 12 months of when the injured worker's~~
25 ~~medical benefits are due to terminate under subsection (1)(f)(i), the insurer shall notify the injured worker between~~
26 ~~90 and 120 days prior to the date of benefit termination that the injured worker's benefits are due to expire. The~~
27 ~~notification under this subsection (1)(f)(iii) must also describe available remedies for addressing the termination~~
28 ~~of benefits. IF AN INSURER IS CURRENTLY PAYING MEDICAL BENEFITS 90 DAYS PRIOR TO WHEN THE INJURED WORKER'S~~
29 ~~MEDICAL BENEFITS ARE DUE TO TERMINATE, THE INSURER SHALL PROVIDE NOTIFICATION TO THE INJURED WORKER AND~~
30 ~~THE INJURED WORKER'S ATTORNEY, IF APPLICABLE, THAT THE INJURED WORKER'S BENEFITS WILL CEASE, OF THE DATE~~

1 THE BENEFITS WILL TERMINATE, AND OF AVAILABLE REMEDIES. NOTICE MUST BE SENT TO THE INJURED WORKER'S
2 LAST-KNOWN MAILING ADDRESS AND THE INJURED WORKER'S ATTORNEY, IF APPLICABLE. THE FACT OF PAYMENT OF
3 MEDICAL BENEFITS AFTER THE INSURER GIVES NOTICE DOES NOT CONSTITUTE A REASON, IN AND OF ITSELF, SUFFICIENT
4 TO JUSTIFY REOPENING MEDICAL BENEFITS. HOWEVER, AN INSURER THAT FAILS TO NOTIFY THE INJURED WORKER AND,
5 IF APPLICABLE, THE INJURED WORKER'S ATTORNEY SHALL CONTINUE TO PAY THE INJURED WORKER'S BENEFITS UNTIL
6 NOTIFICATION IS MADE.

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

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

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

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

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

21 (2) (a) The department shall annually establish a schedule of fees for medical services that are
22 necessary for the treatment of injured workers. Regardless of the date of injury, payment for medical services
23 is based on the fee schedule rates in this section in effect on the date on which the medical service is provided.
24 Charges submitted by providers must be the usual and customary charges for nonworkers' compensation
25 patients. The department may require insurers to submit information to be used in establishing the schedule.

26 (b) (i) The department may not set the rate for medical services at a rate greater than 10% above the
27 average of the conversion factors used by up to the top five insurers or third-party administrators providing group
28 health insurance coverage within this state who use the resource-based relative value scale to determine fees
29 for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy
30 at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

1 (ii) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their
2 standard conversion rates to the department.

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

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

6 (c) The fee schedule rates established in subsection (2)(b), when adopted, must be based on the
7 following standards as adopted by the centers for medicare and medicaid services, regardless of where services
8 are provided:

9 (i) the American medical association current procedural terminology codes, as those codes exist on
10 January 1 of each year;

11 (ii) the healthcare common procedure coding system, as those codes and their relative weights exist on
12 January 1 of each year;

13 (iii) the medicare severity diagnosis-related groups, as those codes and their relative weights exist on
14 January 1 of each year;

15 (iv) the ambulatory payment classifications, as those codes and their relative weights exist on January
16 1 of each year;

17 (v) the ratio of costs to charges for each hospital, as those codes exist on January 1 of each year;

18 (vi) the national correct coding initiative edits, as those codes exist on January 1 of each year; and

19 (vii) the relative value units in the published resource-based relative value scale, as those codes exist
20 on January 1 of each year.

21 (d) The department may establish additional codes and coding standards for use by providers when
22 billing for medical services under this section.

23 (3) (a) The department shall establish by rule evidence-based utilization and treatment guidelines for
24 primary and secondary medical services. There is a rebuttable presumption that the adopted utilization and
25 treatment guidelines establish compensable medical treatment for an injured worker.

26 (b) (i) The department may adopt a drug formulary as part of its utilization and treatment guidelines. To
27 implement this section, the department may annually adopt by rule an evidence-based commercial or other
28 evidence-based drug formulary as part of its utilization and treatment guidelines.

29 (ii) If the department adopts a commercial drug formulary, the formulary automatically includes all of the
30 changes and updates furnished by the commercial vendor that are made during the year. This process is

1 independent of the provisions of 2-4-307.

2 (iii) If the department adopts a drug formulary, the department shall, by rule, provide for:

3 (A) an appropriate transition of treatment, if the treatment began prior to the adoption of a drug formulary,
4 to treatment that is consistent with the application of the formulary; and

5 (B) a timely and responsive dispute resolution process for disputes related to use of the formulary.

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

10 (d) The department, in consultation with health care providers with relevant experience and education,
11 shall provide for an annual review of the evidence-based utilization and treatment guidelines to consider
12 amendments or changes to the guidelines.

13 (4) The department shall hire a medical director. The department may establish by rule an independent
14 medical review process for treatment or services denied by an insurer pursuant to subsection (3) prior to
15 mediation under 39-71-2401.

16 (5) For services available in Montana, insurers may pay facilities located outside Montana according to
17 the workers' compensation fee schedule of the state where the medical service is performed.

18 (6) (a) An insurer shall make payments at the fee schedule rate within 30 days of receipt of medical bills
19 for which a claim has been accepted and for which no other disputes exist. Disputes must be defined by the
20 department by rule.

21 (b) Any unpaid balance under this subsection (6) accrues interest at 12% a year or 1% a month or a
22 fraction of a month. If the charge is not paid within 30 days, interest on the unpaid balance accrues from the date
23 of receipt of the original billing.

24 (7) Once a determination has been made regarding the correct reimbursement amount, any
25 overpayment made to a health care provider must be reimbursed to the insurer within 30 days of the
26 determination. Any reimbursement amount remaining unpaid after 30 days accrues interest at 12% a year or 1%
27 a month or a fraction of a month. Interest on the reimbursement amount remaining unpaid accrues from the date
28 of receipt of the determination of the correct reimbursement amount.

29 (8) For a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual
30 and customary charge.

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

3 (10) After mediation pursuant to department rules, an unresolved dispute between an insurer and a health
4 care provider regarding the amount of a fee for medical services may be brought before the workers'
5 compensation court.

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

8 (b) "Visit", as used in this subsection (11), means each time that the worker obtains services relating to
9 a compensable injury or occupational disease from:

10 (i) a treating physician;

11 (ii) a physical therapist;

12 (iii) a psychologist; or

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

14 (c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (11)(a) if the visit
15 is for treatment requested by an insurer."

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17 **NEW SECTION. Section 2. Effective date.** [This act] is effective July 1, 2019.

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