HOUSE BILL NO. 110

INTRODUCED BY M. LANGE

A BILL FOR AN ACT ENTITLED: "AN ACT LIMITING TO A MAXIMUM OF $200 THE TOTAL AMOUNT FOR WHICH AN INJURED WORKER IS LIABLE TO ALL MEDICAL SERVICE PROVIDERS OR TO A HOSPITAL EMERGENCY DEPARTMENT FOR TREATMENT RELATED TO A COMPENSABLE INJURY OR OCCUPATIONAL DISEASE AFTER THE INITIAL VISIT; AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY 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 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 was required.

(e) 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.

(f) 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)(f) 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.

(g) 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) 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.

(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) 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) For a hospital licensed as a medical assistance facility or a critical access hospital pursuant to Title 50, chapter 5, the rate for services is the hospital's usual and customary charge. Fees paid to a hospital licensed as a medical assistance facility 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) 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) 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) (a) After the initial visit, the worker is responsible for 20%, but not to exceed $10, of the cost of each subsequent visit to a medical service provider <u>or not to exceed a total of $200 for all medical service providers</u> for treatment relating to a compensable injury or occupational disease, unless the visit is to a medical service provider in a managed care organization as requested by the insurer or is a visit to a preferred provider as requested by the insurer.

(b) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit <u>not to</u>

exceed a total of $200 to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsections (7)(a) and (7)(b), 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.

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

NEW SECTION. **Section 2. Effective date -- applicability.** [This act] is effective on passage and approval and applies to claims for treatment filed on or after [the effective date of this act].

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