

HOUSE BILL 628

Introduced by Toole, et al.

| | |
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| 2/13 | Introduced |
| 2/13 | Referred to Workers' Compensation Select Committee |
| 2/13 | First Reading |
| 2/13 | Fiscal Note Requested |
| 2/17 | Hearing |
| 2/19 | Fiscal Note Received |
| 2/20 | Fiscal Note Printed |
| 2/23 | Corrected Fiscal Note Printed |
| 3/11 | Committee Report--Bill Passed as Amended and Rereferred to Labor and Employment Relations |
| 3/16 | Hearing |
| 3/20 | Committee Report--Bill Passed as Amended |
| 3/25 | 2nd Reading Do Pass Motion Failed |

1 House BILL NO. 628
 2 INTRODUCED BY Donnell McEllen Ward Harold
 3
 4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING
 5 WORKERS' COMPENSATION LAWS; MANDATING MANAGED CARE IN
 6 CERTAIN INSTANCES; CREATING A MEDICAL PROCEDURES
 7 AUTHORIZATION COMMITTEE; PROVIDING FOR MEDICAL CARE PLANS;
 8 LIMITING FREEDOM OF CHOICE OF PRACTITIONERS; REQUIRING STATE
 9 FUND PREMIUM RATES TO BE IN ACCORDANCE WITH RATES
 10 ESTABLISHED BY THE NATIONAL COUNCIL ON COMPENSATION
 11 INSURANCE; AUTHORIZING THE STATE FUND TO DECLARE DIVIDENDS
 12 FOR CERTAIN INDUSTRY CATEGORIES; AMENDING SECTIONS
 13 33-22-111, 39-71-608, AND 39-71-2316, MCA; AND PROVIDING AN
 14 IMMEDIATE EFFECTIVE DATE."

15
 16 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

17 NEW SECTION. Section 1. Managed care. (1) Managed care
 18 is medical care that is subject to the planning and
 19 budgeting procedures provided for in [sections 1 through 4].
 20 (2) Insurers operating under plans No. 1, 2, and 3 are
 21 required to use the procedures set forth in the authorized
 22 medical procedures manual provided for in [section 3] in
 23 order to control the costs of medical care while providing
 24 full medical benefits in all cases in which medical benefits
 25 are authorized.

1 (3) In all cases involving head injuries or multiple
 2 injuries or in cases in which a licensed physician
 3 determines within 30 days after the date of the injury that
 4 it is likely that the claimant's maximum healing condition
 5 will result in a whole-body impairment rating greater than
 6 10%, the managed care procedures provided in [sections 1
 7 through 4] must be followed by health care providers,
 8 claimants, and attorneys representing claimants.

9 NEW SECTION. Section 2. Managed care treatment
 10 planning and budgeting. (1) In all cases in which managed
 11 care is required, medical care plans must be established to
 12 govern the course of medical treatment for the injury.
 13 Medical care plans must establish projected treatment
 14 protocols for every case in which managed care is required
 15 to be used and must include:

16 (a) allowable diagnostic procedures for initial and
 17 subsequent care;
 18 (b) allowable therapeutic modalities;
 19 (c) allowable maintenance therapies;
 20 (d) allowable medications; and
 21 (e) any other anticipated therapies reasonably
 22 necessary for the case.

23 (2) Every medical care plan must set forth the
 24 estimated quantity, duration, and timeframe for each
 25 approved diagnostic technique, therapeutic modality,

1 maintenance therapy, medication, or other therapy.

2 (3) All medical care plans and projected treatment
3 protocols must be based on the most recent authorized
4 medical procedures manual developed and maintained by the
5 medical procedures authorization committee in accordance
6 with [section 3] and must be prepared on forms developed by
7 the department.

8 (4) A budget must be established as part of each
9 medical care plan. Each budget must provide a complete
10 estimate of the cost of each authorized diagnostic procedure
11 and therapeutic modality and must be adopted by the insurer
12 after consultation with the treating physician, the
13 claimant, and the claimant's counsel, if any.

14 (5) Treatment plans must provide that care is to
15 terminate when the claimant reaches maximum healing. If in
16 the opinion of the claimant's health care provider long-term
17 medical care will most likely be required, the insurer is
18 permitted to develop a modified plan for the anticipated
19 care.

20 NEW SECTION. Section 3. Medical procedures
21 authorization committee -- creation -- membership --
22 responsibilities. (1) A medical procedures authorization
23 committee is established and shall operate under and with
24 technical assistance from the department. The committee
25 consists of one practitioner licensed in this state from

1 each of the following categories:

- 2 (a) orthopedic surgeon;
- 3 (b) chiropractor;
- 4 (c) physical therapist;
- 5 (d) neuropsychologist;
- 6 (e) occupational therapist; and
- 7 (f) dentist.

8 (2) The committee members must be selected by the
9 governor. Each member shall serve a 3-year term.

10 (3) The committee shall develop and maintain an
11 authorized medical procedures manual for use in developing
12 medical care plans and budgets under [section 2]. The manual
13 must contain a current list of diagnostic and therapeutic
14 protocols setting forth medical conditions and authorized
15 charges for each listed procedure.

16 NEW SECTION. Section 4. Medical care plan
17 implementation -- exceptions. (1) In all claims in which
18 medical care plans are used, the plan governs all care
19 except when it clearly appears that one or more of the
20 following circumstances exist and a modification is
21 required:

- 22 (a) a substantial and continuing change in the medical
23 condition or circumstances of the claimant renders one or
24 more parts of the treatment plan inappropriate;
- 25 (b) a medical emergency necessitates a change;

(c) a health care provider change or designation is made pursuant to 33-22-111; or

(d) medical circumstances require a change in the plan currently in effect.

(2) If a plan requires modification under subsection (1), the insurer shall, unless the claim no longer meets the criteria for case management under [section 1], put in place a new medical care plan and budget following the procedures set forth in [section 2].

Section 5. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, and, except as provided in subsection (3), all policies insuring the payment of compensation under the Workers' Compensation Act shall must provide that the insured ~~shall--have~~ has full freedom of choice in the selection of any duly licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of ~~his~~ the person's practice. Whenever such policies insure against the expense of drugs, the

insured ~~shall~~ must have full freedom of choice in the selection of any duly licensed and registered pharmacist.

(2) ~~Nothing--in--this~~ This section ~~shall~~ may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1); ~~nor--shall--this~~ This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

(3) If a workers' compensation claimant is subject to the managed care requirements of [section 2], the freedom of choice provided in subsection (1) does not apply in the following instances:

(a) the claimant obtains services from more than one health care provider without a referral from the claimant's initial treating physician;

(b) the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide satisfactory therapy for the claimant's injuries;

(c) the claimant seeks to change or add health care providers without the insurer's authorization; or

(d) the insurer determines, during the course of treatment, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the

claimant's recovery or therapy.

(4) In any of the situations listed in subsection (3), the insurer, after giving notice to the claimant and allowing the claimant 10 days in which to contact and discuss the matter with the insurer, the treating physician, or the claimant's attorney, is authorized to designate all health care providers, including the treating physician."

Section 6. Section 39-71-608, MCA, is amended to read:

"39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice. An insurer may, after written notice to the claimant and the department, make payment of compensation benefits, including managed medical care benefits, within 30 days of receipt of a claim for compensation without such the payments being construed as an admission of liability or a waiver of any right of defense. Managed care provisions under [section 2] must apply at the election of the insurer, without obligating the insurer or claimant to continue managed care in the event that liability or coverage is otherwise denied."

Section 7. Section 39-71-2316, MCA, is amended to read:

"39-71-2316. Powers of the state fund -- rulemaking. For the purposes of carrying out its functions, the state fund may:

(1) insure any employer for workers' compensation and

occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance. The state fund may charge a minimum yearly premium to cover its administrative costs for coverage of a small employer.

(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 21, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

(6) adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may only be adopted and changed using a process, a procedure, formulas, and factors set forth in rules adopted under Title 2, chapter 4, parts 2 through 4. After such rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate. The state fund must belong to the national council on

1 compensation insurance and shall use the classifications of
2 employment adopted by the national council and corresponding
3 rates as a basis for setting its own rates.

4 (7) pay the amounts determined due under a policy of
5 insurance issued by the state fund;

6 (8) hire personnel;

7 (9) declare dividends ~~if there is an excess of assets~~
8 ~~over liabilities. However, dividends may not be paid until~~
9 ~~adequate actuarially determined reserves are set aside. If~~
10 ~~those reserves have been set aside, money that can be~~
11 ~~declared as a dividend must be transferred to the account~~
12 ~~created by 39-71-2321 for claims for injuries resulting from~~
13 ~~accidents that occurred before July 17, 1998 and used for~~
14 ~~the purposes of that account. After all claims funded by~~
15 ~~that account have been paid, dividends may be declared and~~
16 paid to insureds as provided in this subsection. After
17 establishing rates for all covered employments in accordance
18 with the rates of the national council on compensation
19 insurance, if it is actuarially determined that in-state
20 experience ratings within certain industry categories
21 justify a reduction of rates for those categories and that
22 rate-reduction dividends may be declared based upon the
23 experience ratings for those industries without impairing
24 the ability of the state fund to meet its obligations or to
25 ensure that assets will exceed liabilities, then the state

1 fund is authorized to declare appropriate dividends for
2 those industries.

3 (10) perform all functions and exercise all powers of a
4 domestic mutual insurer that are necessary, appropriate, or
5 convenient for the administration of the state fund."

6 NEW SECTION. Section 8. Codification instruction.
7 [Sections 1 through 4] are intended to be codified as an
8 integral part of Title 39, chapter 71, and the provisions of
9 Title 39, chapter 71, apply to [sections 1 through 4].

10 NEW SECTION. Section 9. Effective date. [This act] is
11 effective on passage and approval.

-End-

STATE OF MONTANA - FISCAL NOTE

Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for HB0628, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

An act generally revising workers' compensation laws; mandating managed care in certain instances; creating a medical procedures authorization committee; providing for medical care plans; limiting freedom of choice of practitioners; requiring State Fund premium rates to be in accordance with rates established by the National Council on Compensation Insurance; authorizing the State Fund to declare dividends for certain industry categories.

ASSUMPTIONS:

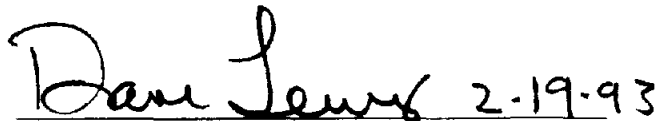
Department of Labor and Industry:

1. 1.00 FTE mediator (grade 16) would be required to meet the additional mediation workload created by the proposed legislation's section (Bill Section 5) 32-22-111.
2. 1.00 FTE program officer (grade 14) for ERD's Policy Compliance Unit to meet the increased workload created by the proposed legislation's new Section 3 and to work with the Medical Procedures Authorization Committee to establish the procedures manual and to maintain the manual after it is developed.
3. Costs would be funded from assessments to workers' compensation carriers.

State Compensation Mutual Insurance Fund:

1. In order to determine the fiscal impact to the State Fund as a result of this bill an actuarial study would be necessary; however, due to the time constraints a study cannot be accomplished for the fiscal note.
2. A portion of the costs incurred by the Department of Labor and Industry would be assessed to the State Fund. Approximately 50% of costs would be assessed under the mediation category (State Fund share = 70%); 50% of costs would be assessed under the medical regulation category (State Fund share = 65%).

(continued)

 2-19-93

DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

HOWARD TOOLE, PRIMARY SPONSOR DATE

Fiscal Note for HB0628, as introduced

HB 628

FISCAL IMPACT:

Expenditures:

DLI Employment Relations Div. (Pg 04):

| | FY '94 | | | FY '95 | | |
|-----------------------|------------------|------------------|------------|------------------|------------------|------------|
| | Current Law | Proposed Law | Difference | Current Law | Proposed Law | Difference |
| FTE | 60.55 | 62.55 | 2.00 | 60.55 | 62.55 | 2.00 |
| Personal Services | 1,813,414 | 1,888,530 | 70,116 | 1,817,143 | 1,888,219 | 71,076 |
| Operating Expenses | 943,410 | 981,689 | 38,279 | 926,413 | 961,592 | 35,179 |
| Equipment | 87,020 | 96,020 | 9,000 | 87,020 | 87,020 | 0 |
| Benefits | <u>1,628,827</u> | <u>1,628,827</u> | <u>0</u> | <u>1,769,827</u> | <u>1,769,827</u> | <u>0</u> |
| Total | 4,472,671 | 4,590,066 | 117,395 | 4,600,403 | 4,706,658 | 106,255 |
| Funding: | | | | | | |
| General Fund | 348,118 | 348,118 | 0 | 319,589 | 319,589 | 0 |
| State Special Revenue | 1,723,306 | 1,840,701 | 117,395 | 1,722,779 | 1,829,034 | 106,255 |
| Federal Revenue | 635,365 | 635,365 | 0 | 632,662 | 632,662 | 0 |
| Proprietary Revenue | <u>1,765,882</u> | <u>1,765,882</u> | <u>0</u> | <u>1,925,373</u> | <u>1,925,373</u> | <u>0</u> |
| Total | 4,472,671 | 4,590,066 | 117,395 | 4,600,403 | 4,706,658 | 106,255 |
| <u>Revenues:</u> | | | | | | |
| WC Assessments (02) | 3,197,368 | 3,314,763 | 117,395 | 3,199,373 | 3,305,628 | 106,255 |

State Compensation Mutual Insurance Fund:

Expenditures:

The proposed legislation may result in some level of savings in workers' compensation medical benefits for the State Fund. Workers' compensation assessments would increase by approximately \$79,200 in FY94 and \$71,700 in FY95.

Revenues:

The proposed legislation would result in a major increase in premium revenue. The increase would be unlikely to be refunded to policyholders for several years until the financial performance for a policy period was determined.

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:

Local governments which self-insure for workers' compensation coverage would incur additional workers' compensation assessments from the Department of Labor.

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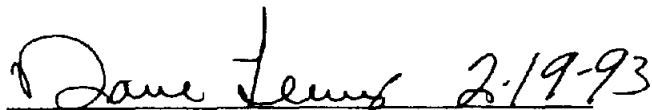
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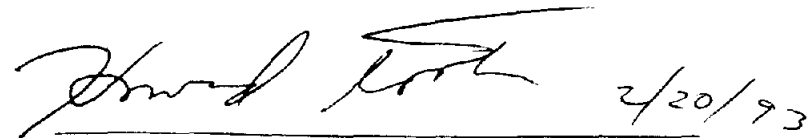
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(continued)

 2-19-93

DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

 2/20/93

HOWARD TOOLE, PRIMARY SPONSOR DATE

Fiscal Note for HB0628, as introduced

HB 628

FISCAL IMPACT:

Expenditures:

DLI Employment Relations Div. (Pg 04):

| | <u>FY '94</u> | | | <u>FY '95</u> | | |
|--------------------|--------------------|---------------------|-------------------|--------------------|---------------------|-------------------|
| | <u>Current Law</u> | <u>Proposed Law</u> | <u>Difference</u> | <u>Current Law</u> | <u>Proposed Law</u> | <u>Difference</u> |
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| Personal Services | 1,813,414 | 1,888,530 | 70,116 | 1,817,143 | 1,888,219 | 71,076 |
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| | | | | | | |
|-----------------------|------------------|------------------|----------|------------------|------------------|----------|
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Expenditures:

The proposed legislation is likely to result in a significant savings in workers' compensation medical benefits for the State Fund. Workers' compensation assessments would increase by approximately \$79,200 in FY94 and \$71,700 in FY95.

Revenues:

The proposed legislation would result in a major increase in premium revenue. The increase would be unlikely to be refunded to policyholders for several years until the financial performance for a policy period was determined.

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Local governments which self-insure for workers' compensation coverage would incur additional workers' compensation assessments from the Department of Labor.

HB 628

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(continued)

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DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

 2/23/93

HOWARD TOOLE, PRIMARY SPONSOR DATE

Fiscal Note for HB0628, as introduced HB0628-H2
corrected copy

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HB628-4

*Approved by the
Select committee
on workers compensation.*

53rd Legislature

HB 0628/02

HB 0628/02

RE-REFERRED AND
APPROVED BY COMMITTEE
ON LABOR & EMPLOYMENT
RELATIONS

HOUSE BILL NO. 628

INTRODUCED BY TOOLE, DRISCOLL, MCCULLOCH,
WANZENRIED, HIBBARD

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING
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18 medical care will most likely be required, the insurer is
19 permitted to develop a modified plan for the anticipated
20 care.

21 NEW SECTION. Section 3. Medical procedures
22 authorization committee -- creation -- membership --
23 responsibilities. (1) A medical procedures authorization
24 committee is established and shall operate under and with
25 technical assistance from the department. The committee

1 consists of one practitioner licensed in this state from
2 each of the following categories:

- 3 (a) orthopedic surgeon;
- 4 (b) chiropractor;
- 5 (c) physical therapist;
- 6 (d) neuropsychologist;
- 7 (e) occupational therapist; and
- 8 (f) dentist.

9 (2) The committee members must be selected by the
10 governor. Each member shall serve a 3-year term.

11 (3) The committee shall develop and maintain an
12 authorized medical procedures manual for use in developing
13 medical care plans and budgets under [section 2]. The manual
14 must contain a current list of diagnostic and therapeutic
15 protocols setting forth medical conditions and authorized
16 charges for each listed procedure.

17 NEW SECTION. Section 4. Medical care plan
18 implementation -- exceptions. (1) In all claims in which
19 medical care plans are used, the plan governs all care
20 except when it clearly appears that one or more of the
21 following circumstances exist and a modification is
22 required:

- 23 (a) a substantial and continuing change in the medical
- 24 condition or circumstances of the claimant renders one or
- 25 more parts of the treatment plan inappropriate;

(b) a medical emergency necessitates a change;

(c) a health care provider change or designation is made pursuant to 33-22-111; or

(d) medical circumstances require a change in the plan currently in effect.

(2) If a plan requires modification under subsection (1), the insurer shall, unless the claim no longer meets the criteria for case management under [section 1], put in place a new medical care plan and budget following the procedures set forth in [section 2].

Section 5. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, and, except as provided in subsection (3), all policies insuring the payment of compensation under the Workers' Compensation Act ~~shall~~ must provide that the insured ~~shall--have~~ has full freedom of choice in the selection of any duly licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of ~~his~~ the person's practice. Whenever

such policies insure against the expense of drugs, the insured ~~shall~~ must have full freedom of choice in the selection of any duly licensed and registered pharmacist.

(2) ~~Nothing--in--this~~ This section ~~shall~~ may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). ~~nor--shall--this~~ This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

(3) If a workers' compensation claimant is subject to the managed care requirements of [section 2], the freedom of choice provided in subsection (1) does not apply in the following instances:

(a) the claimant obtains services from more than one health care provider without a referral from the claimant's initial treating physician;

(b) the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide satisfactory therapy for the claimant's injuries;

(c) the claimant seeks to change or add health care providers without the insurer's authorization; or

(d) the--insurer--determines,--during--the--course--of treatment THE DEPARTMENT DETERMINES, UPON APPLICATION BY THE INSURER OR THE CLAIMANT AND FOLLOWING CONSULTATION WITH THE

INSURER, THE CLAIMANT, OR THE CLAIMANT'S ATTORNEY, AND THE TREATING PHYSICIAN, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the claimant's recovery or therapy.

(4) In any of the situations listed in subsection (3), the insurer DEPARTMENT, after giving notice to the claimant and allowing the claimant 10 days in which to contact and discuss the matter with the insurer, the treating physician, or the claimant's attorney, is authorized to designate all health care providers, including the treating physician."

Section 6. Section 39-71-608, MCA, is amended to read:

"39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice. An insurer may, after written notice to the claimant and the department, make payment of compensation benefits, including managed medical care benefits, within 30 days of receipt of a claim for compensation without such the payments being construed as an admission of liability or a waiver of any right of defense. Managed care provisions under [section 2] must apply at the election of the insurer, without obligating the insurer or claimant to continue managed care in the event that liability or coverage is otherwise denied."

Section 7. Section 39-71-2316, MCA, is amended to read:

"39-71-2316. Powers of the state fund -- rulemaking.

For the purposes of carrying out its functions, the state fund may:

(1) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance. The state fund may charge a minimum yearly premium to cover its administrative costs for coverage of a small employer.

(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 21, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

(6) adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may only be adopted and changed using a process, a procedure, formulas, and factors set forth in rules adopted under Title 2, chapter 4, parts 2 through 4. After such rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when

changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate. The state fund must belong to the national council on compensation insurance and shall use the classifications of employment adopted by the national council and corresponding rates as a basis for setting its own rates.

(7) pay the amounts determined due under a policy of insurance issued by the state fund;

(8) hire personnel;

(9) declare dividends ~~if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside. If those reserves have been set aside, money that can be declared as a dividend must be transferred to the account created by 39-71-2321 for claims for injuries resulting from accidents that occurred before July 1, 1990, and used for the purposes of that account. After all claims funded by that account have been paid, dividends may be declared and paid to insureds as provided in this subsection.~~ After establishing rates for all covered employments in accordance with the rates of the national council on compensation insurance, if it is actuarially determined that in-state experience ratings within certain industry categories justify a reduction of rates for those categories and that

rate-reduction dividends may be declared based upon the experience ratings for those industries without impairing the ability of the state fund to meet its obligations or to ensure that assets will exceed liabilities, then the state fund is authorized to declare appropriate dividends for those industries.

(10) perform all functions and exercise all powers of a domestic mutual insurer that are necessary, appropriate, or convenient for the administration of the state fund."

NEW SECTION. Section 8. Codification instruction.

[Sections 1 through 4] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 1 through 4].

NEW SECTION. Section 9. Effective date. [This act] is effective on passage and approval.

-End-

RE-REFERRED AND HB 0628/03
 APPROVED BY COMMITTEE
 ON LABOR & EMPLOYMENT
 RELATIONS
 AS AMENDED

HOUSE BILL NO. 628

INTRODUCED BY TOOLE, DRISCOLL, MCCULLOCH,
 WANZENRIED, HIBBARD

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING
 WORKERS' COMPENSATION LAWS; MANDATING MANAGED CARE
 MANAGEMENT AND BUDGETING IN CERTAIN INSTANCES; CREATING A
 MEDICAL PROCEDURES AUTHORIZATION COMMITTEE; PROVIDING FOR
 MEDICAL CARE PLANS; LIMITING---FREEDOM-OF-CHOICE-OF
 PRACTITIONERS;--REQUIRING-STATE-FUND-PREMIUM-RATES-TO--BE--IN
 ACCORDANCE-WITH-RATES-ESTABLISHED-BY-THE-NATIONAL-COUNCIL-ON
 COMPENSATION---INSURANCE;--AUTHORIZING--THE--STATE--FUND--TO
 DECLARE-DIVIDENDS-FOR-CERTAIN-INDUSTRY-CATEGORIES; AMENDING
 SECTIONS SECTION 33-22-111, 39-71-608, AND 39-71-2316, MCA;
 AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

NEW SECTION. Section 1. Managed care. (1) Managed care
 is--medical--care--that--is--subject--to--the--planning--and
 budgeting-procedures-provided-for-in-{sections-1-through-4}--

(2) insurers CARE MANAGEMENT AND BUDGETING. (1) THE
STATE FUND operating under plans No. 17-27 and PLAN NO. 3
 are IS required to use the procedures set forth in the
 authorized medical procedures manual provided for in
 [section 3] in order to control the costs of medical care

while providing full medical benefits in all cases in which
 medical benefits are authorized.

(3) (2) In all cases involving head injuries or multiple
 injuries--or--in cases in which a licensed physician
 determines within 30 days after the date of the injury that
 it is MORE likely THAN NOT that the claimant's maximum
 healing condition will result in a whole-body impairment
 rating greater than 10%, the managed care MANAGEMENT AND
BUDGETING procedures provided in [sections 1 through 4] must
 be followed by health care providers, claimants, and
 attorneys representing claimants.

NEW SECTION. Section 2. Managed care treatment CARE
MANAGEMENT planning and budgeting. (1) In all cases in which
 managed care MANAGEMENT AND BUDGETING is required, medical
 care plans must be established to govern the course of
 medical treatment for the injury. Medical--care CARE plans
 must establish projected treatment protocols for every case
 in which managed-care-is THEY ARE required to--be--used and
 must include:

- (a) allowable diagnostic procedures for initial and
 subsequent care;
- (b) allowable therapeutic modalities;
- (c) allowable maintenance therapies;
- (d) allowable medications; and
- (e) any other anticipated therapies reasonably

1 necessary for the case.

2 (2) Every medical care plan must set forth the
3 estimated quantity, duration, and timeframe for each
4 approved diagnostic technique, therapeutic modality,
5 maintenance therapy, medication, or other therapy.

6 (3) All medical care plans and projected treatment
7 protocols must be based on the most recent authorized
8 medical procedures manual developed and maintained by the
9 medical procedures authorization committee in accordance
10 with [section 3] and must be prepared on forms developed by
11 the department.

12 (4) A budget must be established as part of each
13 medical care plan. Each budget must provide a complete
14 estimate of the cost of each authorized diagnostic procedure
15 and therapeutic modality and must be adopted by the insurer
16 after consultation with the treating physician, the
17 claimant, and the claimant's counsel, if any.

18 (5) Treatment CARE plans must provide that care is to
19 terminate when the claimant reaches maximum healing. If in
20 the opinion of the claimant's health care provider long-term
21 medical care will most likely be required, the insurer is
22 permitted to develop a modified plan for the anticipated
23 care.

24 NEW SECTION. Section 3. Medical procedures
25 authorization committee -- creation -- membership --

1 responsibilities. (1) A medical procedures authorization
2 committee is established and shall operate under and with
3 technical assistance from the department. The committee
4 consists of one practitioner licensed in this state from
5 each of the following categories:

- 6 (a) orthopedic surgeon;
- 7 (b) chiropractor;
- 8 (c) physical therapist;
- 9 (d) neuropsychologist;
- 10 (e) occupational therapist; and
- 11 (f) dentist.

12 (2) The committee members must be selected by the
13 governor. Each member shall serve a 3-year term.

14 (3) The committee shall develop and maintain an
15 authorized medical procedures manual for use in developing
16 medical care plans and budgets under [section 2]. The manual
17 must contain a current list of diagnostic and therapeutic
18 protocols setting forth medical conditions and authorized
19 charges AS SET FORTH IN DIAGNOSTIC RESEARCH GROUPS for each
20 listed procedure. THESE CHARGES MAY NOT EXCEED THOSE
21 CURRENTLY CONTAINED IN THE MEDICAL FEE SCHEDULE AUTHORIZED
22 IN 39-71-704.

23 NEW SECTION. Section 4. Medical CARE plan
24 implementation -- exceptions. (1) In all claims in which
25 medical care plans are used, the plan governs all care

except when it clearly appears that one or more of the following circumstances exist and a modification is required:

(a) a substantial and continuing change in the medical condition or circumstances of the claimant renders one or more parts of the treatment plan inappropriate;

(b) a medical emergency necessitates a change;

(c) a health care provider change or designation is made pursuant to 33-22-111; or

(d) medical circumstances require a change in the plan currently in effect.

(2) If a plan requires modification under subsection (1), the insurer shall, unless the claim no longer meets the criteria for case management under [section 1], put in place a new medical care plan and budget following the procedures set forth in [section 2].

Section 5.--Section 33-22-111, MCA, is amended to read:--

"33-22-111.--Policies to provide for freedom of choice of practitioners--professional practice not enlarged--(1) All policies of disability insurance, including individual, group, and blanket policies, and except as provided in subsection (3), all policies insuring the payment of compensation under the Workers' Compensation Act shall must provide that the insured shall have has full freedom of choice in the selection of any duly licensed physician,

physician--assistant-certified,--dentist,--osteopathy, chiropractor,--optometrist,--podiatrist,--psychologist, licensed-social-worker,--licensed-professional-counselor, acupuncturist, or nurse-specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his the person's practice. Whenever such policies insure against the expense of drugs, the insured shall must have full freedom of choice in the selection of any duly licensed and registered pharmacist.

(2)--Nothing in this This section shall may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1); nor shall this This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

(3)--If a worker's compensation claimant is subject to the managed care requirements of [section 2], the freedom of choice provided in subsection (1) does not apply in the following instances:

(a)--the claimant obtains services from more than one health care provider without a referral from the claimant's initial treating physician;

(b)--the claimant is referred by the claimant's treating physician to another health care provider due to an inability of the treating physician to diagnose or provide

~~satisfactory therapy for the claimant's injuries;~~

~~(c) the claimant seeks to change or add health care providers without the insurer's authorization; or~~

~~(d) the insurer determines, during the course of treatment, the department determines, upon application by the insurer or the claimant and following consultation with the insurer, the claimant, or the claimant's attorney, and the treating physician, that it would be in the best interests of all concerned parties to designate a different or additional health care provider to hasten or otherwise benefit the claimant's recovery or therapy.~~

~~(4) in any of the situations listed in subsection (3), the insurer, department, after giving notice to the claimant and allowing the claimant 10 days in which to contact and discuss the matter with the insurer, the treating physician, or the claimant's attorney, is authorized to designate all health care providers, including the treating physician."~~

Section 5. Section 39-71-608, MCA, is amended to read:

"39-71-608. Payments within thirty days by insurer without admission of liability or waiver of defense authorized -- notice. An insurer may, after written notice to the claimant and the department, make payment of compensation benefits, including managed medical care benefits UNDER CARE MANAGEMENT AND BUDGETING, within 30 days of receipt of a claim for compensation without such the

payments being construed as an admission of liability or a waiver of any right of defense. Managed care CARE MANAGEMENT AND BUDGETING provisions under [section 2] must apply at the election of the insurer, without obligating the insurer or claimant to continue managed care MANAGEMENT AND BUDGETING in the event that liability or coverage is otherwise denied."

Section 7. Section 39-71-2316, MCA, is amended to read:

"39-71-2316. Powers of the state fund ----- rulemaking. For the purposes of carrying out its functions, the state fund may:

(1) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance. The state fund may charge a minimum yearly premium to cover its administrative costs for coverage of a small employer;

(2) sue and be sued;

(3) adopt, amend, and repeal rules relating to the conduct of its business;

(4) except as provided in section 217, Chapter 4, Special Laws of May 1990, enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(5) collect and disburse money received;

1 {6}--adopt-classifications-and-charge-premiums--for--the
 2 classifications--so-that-the-state-fund-will-be-neither-more
 3 nor--less--than--self-supporting.---Premium---rates---for
 4 classifications-may-only-be--adopted--and--changed--using--a
 5 process,--a--procedure,--formulas,--and-factors-set-forth-in
 6 rules-adopted-under-Title-2, chapter-4, parts-2--through--4.
 7 After--such-rules-have-been-adopted, the-state-fund-need-not
 8 follow-the-rulemaking-provisions-of-Title-2, chapter-4, when
 9 changing-classifications-and-premium--rates.---The--contested
 10 case--rights--and--provisions--of-Title-2, chapter-4, do-not
 11 apply-to-an-employer's-classification-or-premium--rate.---The
 12 state---fund---must---belong--to--the--national--council--on
 13 compensation-insurance-and-shall-use-the-classifications--of
 14 employment-adopted-by-the-national-council-and-corresponding
 15 rates-as-a-basis-for-setting-its-own-rates.

16 {7}--pay--the--amounts--determined-due-under-a-policy-of
 17 insurance-issued-by-the-state-fund;

18 {8}--hire-personnel;

19 {9}--declare-dividends-if-there-is-an-excess--of--assets
 20 over--liabilities.---However, dividends-may-not-be-paid-until
 21 adequate-actuarially-determined-reserves-are-set--aside.---If
 22 those--reserves--have--been--set--aside,--money--that-can-be
 23 declared-as-a-dividend-must-be-transferred--to--the--account
 24 created-by-39-71-2321-for-claims-for-injuries-resulting-from
 25 accidents--that--occurred--before-July-1, 1990, and-used-for

1 the-purposes-of-that-account.---After--all--claims--funded--by
 2 that--account--have-been-paid, dividends-may-be-declared-and
 3 paid-to-insureds as--provided--in--this--subsection. After
 4 establishing-rates-for-all-covered-employments-in-accordance
 5 with--the--rates--of--the--national--council-on-compensation
 6 insurance, if-it-is--actuarially--determined--that--in-state
 7 experience---ratings---within--certain--industry--categories
 8 justify-a-reduction-of-rates-for-those-categories--and--that
 9 rate-reduction--dividends--may-be-declared--based-upon-the
 10 experience-ratings-for-those--industries--without--impairing
 11 the--ability-of-the-state-fund-to-meet-its-obligations-or-to
 12 ensure-that-assets-will-exceed-liabilities, then--the--state
 13 fund--is--authorized--to--declare--appropriate-dividends-for
 14 those-industries.

15 {10}--perform-all-functions-and-exercise-all-powers-of--a
 16 domestic--mutual-insurer-that-are-necessary, appropriate, or
 17 convenient-for-the-administration-of-the-state-fund."

18 NEW SECTION. Section 6. Codification instruction.
 19 [Sections 1 through 4] are intended to be codified as an
 20 integral part of Title 39, chapter 71, and the provisions of
 21 Title 39, chapter 71, apply to [sections 1 through 4].

22 NEW SECTION. Section 7. Effective date. [This act] is
 23 effective on passage and approval.

-End-