SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE
BY REQUEST OF THE STATE FUND

IN THE SENATE

FEBRUARY 9, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
	FIRST READING.
FEBRUARY 11, 1993	ADDITIONAL SPONSORS ADDED.
FEBRUARY 13, 1993	ADDITIONAL SPONSOR ADDED.
FEBRUARY 22, 1993	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 23, 1993	PRINTING REPORT.
	SECOND READING, DO PASS.
	ENGROSSING REPORT.
FEBRUARY 24, 1993	THIRD READING, PASSED. AYES, 48; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 1, 1993	INTRODUCED AND REFERRED TO SELECT COMMITTEE ON WORKERS' COMPENSATION.
	FIRST READING.
MARCH 11, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
	ON MOTION, REREFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
MARCH 20, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT

	ADOPTED.
MARCH 24, 1993	SECOND READING, CONCURRED IN.
MARCH 25, 1993	THIRD READING, CONCURRED IN. AYES, 59; NOES, 40.
	RETURNED TO SENATE WITH AMENDMENTS.
	IN THE SENATE
MARCH 27, 1993	ON MOTION, CONSIDERATION PASSED UNTIL THE 76TH LEGISLATIVE DAY.
APRIL 5, 1993	SECOND READING, AMENDMENTS NOT CONCURRED IN.
	PREVIOUS ACTION RECONSIDERED.
	SECOND READING, AMENDMENTS CONCURRED IN.
APRIL 6, 1993	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.
APRIL 12, 1993	SIGNED BY PRESIDENT.
	IN THE HOUSE
APRIL 12, 1993	SIGNED BY SPEAKER.
	IN THE SENATE
APRIL 13, 1993	DELIVERED TO GOVERNOR.
APRIL 16, 1993	RETURNED FROM GOVERNOR WITH RECOMMENDED AMENDMENTS.
APRIL 19, 1993	SECOND READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.
APRIL 20, 1993	THIRD READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.
	IN THE HOUSE
APRIL 22, 1993	SECOND READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

THIRD READING, GOVERNOR'S RECOMMENDED AMENDMENTS CONCURRED IN.

RETURNED TO SENATE.

IN THE SENATE

APRIL 22, 1993

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

Senate BILL NO. 347

INTRODUCED BY HARP, Wilson, Kennedy, AKLESTAD, Blaylock, SWYSGOOD, NATHE, GRINDE, Hillard, MERCER, Wagner, TOM NELSON

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; REVISING PROVISIONS REGARDING IMPAIRMENT EVALUATIONS; REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, 39-71-711, AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

Section 1. 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 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~~ the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section 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."

Section 2. Section 39-71-116, MCA, is amended to read:

"**39-71-116. Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the

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Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for

support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(7) "Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is

located or a board-certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.

~~(7)~~(8) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9) "Department" means the department of labor and industry.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work-related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when

further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer ~~shall~~ has not ~~have~~ operated a sufficient or any length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~(18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~ (19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(17) The--term--"physician"--includes--"surgeon"--and--in either-case-means-one-authorized--by--law--to--practice--his profession-in-this-state.~~

~~(18)~~ (20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment, for conditions resulting from the injury, necessary for achieving medical stability. The term includes medical,

surgical, hospital, nursing, and ambulance services and drugs or medicine.

~~(19)~~ (22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~ (23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~ (24) "Reasonably safe tools and appliances" are ~~such~~ tools and appliances as are adapted to and are reasonably safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration, physical conditioning, or exercise programs or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~ (26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a

part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under

Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. 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 ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection (1)(d)~~ this chapter, the insurer shall furnish~~, without limitation as to length of time or dollar amount,~~ reasonable primary medical services ~~by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the department for the injuries sustained, subject to the requirements of 39-71-727~~ 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.

~~(b)~~(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.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to--rules adopted--by-the-department~~ only if the travel is incurred at the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

~~(d)~~(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; or

(ii) when necessary to monitor the status of a

prosthetic device.

(g) If the worker's treating physician believes that palliative or maintenance 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, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of physicians, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(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) The department shall annually establish a schedule of fees for medical nonhospital services and hospital outpatient services that are available in a nonhospital setting and 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. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section 14].

(3) ~~Beginning January 1, 1988, the~~ The department shall establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates must be based on per diem or diagnostic-related groups. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities.

(4) ~~Notwithstanding subsection (2), beginning January 1, 1988, through December 31, 1991, the maximum fees payable by insurers must be limited to the fee schedule established in January 1987. Notwithstanding subsection (3), beginning January 1, 1988, through December 31, 1991, the hospital rates payable by insurers must be limited to those set in January 1988. After December 31, 1991, the~~ 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 $10 of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease.

(b) 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.

(c) "Visit", as used in subsection (7)(a) and (7)(b), means each time 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."

Section 4. Section 39-71-711, MCA, is amended to read:

"39-71-711. **Impairment evaluation -- ratings.** (1) An

impairment rating:

(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;

(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and

(c) must be expressed as a percentage of the whole person.

(2) A claimant or insurer, or both, may obtain an impairment rating from ~~an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice~~ a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.~~

~~(4)~~(3) Disputes over impairment ratings are not subject to 39-71-605."

Section 5. Section 39-71-727, MCA, is amended to read:

"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the physician specifies no substitutions or~~ the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the ~~physician specified no substitutions or that the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per

product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502."

NEW SECTION. **Section 6. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 7. Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with physicians or physician groups or clinics, hospitals, pharmacies, physical therapists, suppliers of

soft and durable medical goods, and other medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers.

NEW SECTION. **Section 8. Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6], through appropriate health care professionals.

(2) The department shall develop criteria pursuant to [section 10] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers.

NEW SECTION. **Section 9. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification

requirements provided in [section 10]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 10. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required

information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards

prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees

to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 11. Compliance with medical treatment required -- termination of compensation benefits for noncompliance.** An insurer that provides 14 days' notice to the worker and the department may terminate any

compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 12. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a

means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing minimum hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 13. Physician self-referral prohibition.** A treating physician may not refer a claimant to a health care facility outside the physician's office practice at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated

need in the community for the facility and alternative financing is not available. The insurer is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 14. Medical advisory committees -- composition -- function.** (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

NEW SECTION. **Section 15. Codification instruction.** [Sections 6 through 14] 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 6 through 14].

NEW SECTION. **Section 16. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are

severable from the invalid applications.

NEW SECTION. **Section 17.** **Retroactive applicability.** Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before [the effective date of this act].

NEW SECTION. **Section 18.** **Effective date.** [This act] is effective July 1, 1993.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0347, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:
An act generally revising workers' compensation law to attain better medical cost containment; revising an injured workers' freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding impairment evaluations; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees.

ASSUMPTIONS:
Department of Labor and Industry:
1. The proposed legislation increases the need for the department to do additional rulemaking. 1.00 FTE (grade 17) attorney would be required to draft and defend court challenges to the rules.
2. The proposed legislation would increase rulemaking hearings and administrative contested cases that would be heard by Department's hearings officers. 1.00 FTE (grade 16) hearings officer III would be required to conduct the additional rulemaking hearings and to conduct the additional contested cases.
3. 1.00 FTE legal secretary (grade 9) would be needed to support the additional staff requirements.
4. 1.00 FTE program officer (grade 15) to establish and work with the six medical advisory committees who develop and implement palliative care review, domiciliary care, and utilization/ treatment standards, and the exclusion of unproven and unscientific procedures, as described in 39-71-704, section 1(g), and new sections 2, 7, and 9.
5. 1.00 FTE program officer (grade 15) to work on the development of Managed Care Organization (MCO) and Preferred Provider Organization (PPO) certification, maintain the MCO and PPO processes and provide oversight to ensure compliance to administrative rules.
6. 1.00 FTE program officer (grade 15) to develop a Diagnostically Related Groups (DRG) system for the uses intended in this legislation, and update DRG standards once initially established.
7. 1.00 FTE administrative assistant (grade 10) to schedule the advisory committees, file and manage the documents processing workload.
8. 1.00 FTE workers' compensation mediator (grade 16) to conduct the increased mediation workload created by additional disputes.
9. One-time start-up costs include office equipment and PCs.
10. Per diem reimbursements would be paid to advisory committee members.

(continued)

Dave Lewis 2-13-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN HARP PRIMARY SPONSOR 2/16/93 DATE

ASSUMPTIONS:

State Compensation Mutual Insurance Fund:

1. 1.00 FTE medical benefits coordinator and 1.00 FTE medical claims technician would assume responsibility for cost containment measures within the State Fund.
2. FY94 start-up costs include $357,000 for computer programming. Ongoing operational expenses would be incurred for computer processing charges, postage, and other incidental costs.
3. The cost containment program would not be fully implemented until approximately January 1, 1994.
4. The State Fund would notify providers and claimants of claimants responsibility to pay deductible.
5. All computer system development would be provided by contracted services.
6. Costs incurred by the Department of Labor and Industry would be assessed to workers' compensation carriers. The State Fund's share would be assessed on the same basis as current medical regulation assessments which would allocate an estimated 65% of costs to the State Fund.

FISCAL IMPACT:

Department of Labor and Industry:

Expenditures:

Employment Relations Div. (Pg 04)	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	60.55	68.55	8.00	60.55	68.55	8.00
Personal Services	1,813,414	2,078,162	264,748	1,817,143	2,085,732	268,589
Operating Expenses	943,410	1,085,418	142,008	926,413	1,030,157	103,744
Equipment	87,020	123,020	36,000	87,020	87,020	0
Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
Total	4,472,671	4,915,427	442,756	4,600,403	4,972,736	372,333
Funding:						
General Fund	348,118	348,118	0	319,589	319,589	0
State Special Revenue	1,723,306	1,772,347	442,756	1,722,779	1,762,886	372,333
Federal Revenue	635,365	635,365	0	632,662	632,662	0
Proprietary Revenue	1,765,882	1,765,882	0	1,925,373	1,925,373	0
Total	4,472,671	4,915,427	442,756	4,600,403	4,972,736	372,333
Revenues:						
WC Assessment (02)	1,723,306	1,772,347	442,756	1,722,779	1,762,886	372,333

(continued)

FISCAL IMPACT:

State Compensation Mutual Insurance Fund:

Expenditures:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	224.50	226.50	2.00	227.50	229.50	2.00
Personal Services	6,498,681	6,557,798	59,117	6,584,924	6,644,041	59,117
Operating Expenses	3,615,187	4,059,927	444,740	3,922,172	4,118,962	196,790
Equipment	310,066	325,578	15,512	236,597	236,597	0
Benefits	166,027,953	166,027,953	0	182,948,465	182,948,465	0
Transfers	2,839,300	3,127,091	287,791	2,716,695	2,958,711	242,016
Debt Service	134,256	134,256	0	221,580	221,580	0
Total (Proprietary)	$179,425,443	$180,232,603	$807,160	$196,630,433	$197,128,356	$497,923

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
Local governments which self-insure would be assessed for the additional costs incurred by the Department of Labor but would also experience long term savings on medical benefit costs as described below.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Major savings on medical benefit costs are considered likely. Based on data supplied by the National Council on Compensation Insurance, the proposed legislation could potentially reduce medical benefit costs by 6.6% to 7.0%.

SB 347

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0347, third reading.

DESCRIPTION OF PROPOSED LEGISLATION:
An act generally revising workers' compensation law to attain better medical cost containment; revising an injured workers' freedom of choice of physicians; amending medical definitions; distinguishing between primary and secondary medical services; revising provisions regarding payment for prescription drugs; providing for managed care and a preferred providers organization; requiring the injured worker to comply with recommended medical treatment; regulating domiciliary care; limiting physician self-referral; creating medical advisory committees.

ASSUMPTIONS:
Department of Labor and Industry:
1. The proposed legislation increases the need for the department to do additional rulemaking. 1.00 FTE (grade 17) attorney would be required to draft and defend court challenges to the rules.
2. 1.00 FTE program officer (grade 15) to establish and work with the six medical advisory committees who develop and implement palliative care review, domiciliary care, and utilization/ treatment standards, and the exclusion of unproven and unscientific procedures, as described in 39-71-704, section 1(g), and new sections 2, 7, and 9.
3. 1.00 FTE program officer (grade 15) to work on the development of Managed Care Organization (MCO) and Preferred Provider Organization (PPO) certification, maintain the MCO and PPO processes and provide oversight to ensure compliance to administrative rules.
4. 1.00 FTE program officer (grade 15) to develop a Diagnostically Related Groups (DRG) system for the uses intended in this legislation, and update DRG standards once initially established.
5. 1.00 FTE administrative assistant (grade 10) to schedule the advisory committees, file and manage the documents processing workload.
6. 1.00 FTE workers' compensation mediator (grade 16) to conduct the increased mediation workload created by additional disputes.
7. One-time start-up costs include office equipment, PCs, and systems development. Estimated systems development costs assume that the department can utilize the existing SRS Medicaid DRG system with a minimum of system modifications.
8. Per diem reimbursements would be paid to advisory committee members.

(continued)

Dave Lewis 3-12-93
DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN HARP, PRIMARY SPONSOR 3/15/93 DATE

ASSUMPTIONS:

State Compensation Mutual Insurance Fund:

1. 1.00 FTE medical benefits coordinator and 1.00 FTE medical claims technician would assume responsibility for cost containment measures within the State Fund.
2. FY94 start-up costs include $357,000 for computer programming. Ongoing operational expenses would be incurred for computer processing charges, postage, and other incidental costs.
3. The cost containment program would not be fully implemented until approximately January 1, 1994.
4. The State Fund would notify providers and claimants of claimants responsibility to pay deductible.
5. All computer system development would be provided by contracted services.
6. Costs incurred by the Department of Labor and Industry would be assessed to workers' compensation carriers. The State Fund's share would be assessed on the same basis as current medical regulation assessments which would allocate an estimated 65% of costs to the State Fund.

FISCAL IMPACT:

Department of Labor and Industry:

Expenditures:

Employment Relations Div. (Pg 04)	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	60.55	66.55	6.00	60.55	66.55	6.00
Personal Services	1,813,414	2,021,161	207,747	1,817,143	2,027,771	210,628
Operating Expenses	943,410	1,062,966	119,556	926,413	1,011,381	84,968
Equipment	87,020	114,020	27,000	87,020	87,020	0
Benefits	1,628,827	1,628,827	0	1,769,827	1,769,827	0
Total	4,472,671	4,826,974	354,303	4,600,403	4,895,999	295,596
Funding:						
General Fund	348,118	348,118	0	319,589	319,589	0
State Special Revenue	1,723,306	2,077,609	354,303	1,722,779	2,018,375	295,596
Federal Revenue	635,365	635,365	0	632,662	632,662	0
Proprietary Revenue	1,765,882	1,765,882	0	1,925,373	1,925,373	0
Total	4,472,671	4,826,974	354,303	4,600,403	4,895,999	295,596

Revenues:

WC Assessment (02)	1,723,306	2,077,609	354,303	1,722,779	2,018,375	295,596

(continued)

FISCAL IMPACT:

State Compensation Mutual Insurance Fund:

Expenditures:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	224.50	226.50	2.00	227.50	229.50	2.00
Personal Services	6,498,681	6,557,798	59,117	6,584,924	6,644,041	59,117
Operating Expenses	3,615,187	4,059,927	444,740	3,922,172	4,118,962	196,790
Equipment	310,066	325,578	15,512	236,597	236,597	0
Benefits	166,027,953	166,027,953	0	182,948,465	182,948,465	0
Transfers	2,839,300	3,069,597	230,297	2,716,695	2,908,832	192,137
Debt Service	134,256	134,256	0	221,580	221,580	0
Total (Proprietary)	$179,425,443	$180,175,109	$749,666	$196,630,433	$197,078,477	$448,044

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
Local governments which self-insure would be assessed for the additional costs incurred by the Department of Labor but would also experience long term savings on medical benefit costs as described below.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Major savings on medical benefit costs are considered likely. Based on data supplied by the National Council on Compensation Insurance, the proposed legislation could potentially reduce medical benefit costs by 6.6% to 7.0%.

SB 347-#2

APPROVED BY COMMITTEE
ON LABOR & EMPLOYMENT
RELATIONS

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS---REGARDING---IMPAIRMENT---EVALUATIONS;~~ REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711;~~ AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

Section 1. 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 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~~ the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section 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."

Section 2. Section 39-71-116, MCA, is amended to read:

SECOND READING

"39-71-116. **Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is a full-time student in an accredited school or is enrolled

in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related employment that is not directly involved on a regular basis

in the provision of physical labor at a construction or renovation site.

~~(7) "Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is located or a board certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.~~

~~(7)~~(8) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9) "Department" means the department of labor and industry.

(9) "DISABILITY" MEANS A CONDITION IN WHICH A WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT IS DIMINISHED AS A RESULT OF PHYSICAL RESTRICTIONS RESULTING FROM AN INJURY. THE RESTRICTIONS MAY BE COMBINED WITH FACTORS, SUCH AS THE WORKER'S AGE, EDUCATION, WORK HISTORY, AND OTHER FACTORS THAT AFFECT THE WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT. DISABILITY DOES NOT MEAN A PURELY MEDICAL CONDITION.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting

business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer ~~shall~~ has not ~~have~~ operated a sufficient or any

length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~ (18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~ (19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be

considered in determining if a worker is permanently totally disabled.

~~(17) "The--term--"physician"--includes--"surgeon"--and--in either-case-means-one-authorized--by--law--to--practice--his profession-in-this-state.~~

~~(18)~~ (20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment PRESCRIBED BY A TREATING PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability. ~~The--term-includes-medical,-surgical,-hospital,-nursing,-and ambulance-services-and-drugs-or-medicine.~~

~~(19)~~ (22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~ (23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~ (24) "Reasonably safe tools and appliances" are ~~such~~ tools and appliances as are adapted to and are reasonably

safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, ~~physical--restoration,--physical--conditioning,--or-exercise programs~~ PHYSICAL RESTORATION PROGRAMS AND OTHER RESTORATION PROGRAMS DESIGNED TO ADDRESS DISABILITY AND NOT IMPAIRMENT, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is

primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. 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 ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection--(1)(d)~~ this chapter, the insurer shall furnish~~,--without--limitation--as--to length--of--time--or--dollar--amount,~~ reasonable primary medical services ~~by--a--physician--or--surgeon,--reasonable--hospital services--and--medicines--when--needed,--and--such--other--treatment as--may--be--approved--by--the--department--for--the--injuries sustained,--subject--to--the--requirements--of--39-71-727~~ 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.

~~(b)~~(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.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to--rules adopted--by--the--department~~ only if the travel is incurred at the request of the insurer. Reimbursement must be at the

rates allowed for reimbursement of travel by state employees.

~~(d)~~(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; or

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

(g) If the worker's treating physician believes that palliative or maintenance 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, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of

physicians, INCLUDING AT LEAST ONE TREATING PHYSICIAN FROM THE AREA OF SPECIALTY IN WHICH THE INJURED WORKER IS BEING TREATED, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(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) The department shall annually establish a schedule of fees for medical nonhospital services ~~and--hospital outpatient-services-that--are--available--in--a--nonhospital setting--and-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. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section ~~14~~ 13].

(3) ~~Beginning-January-1,-1988,-the~~ The department shall establish rates for hospital services necessary for the

treatment of injured workers. Beginning January 1, 1995, the rates ~~must~~ MAY be based on per diem or diagnostic-related groups. THE RATES ESTABLISHED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION MAY NOT BE LESS THAN MEDICAID REIMBURSEMENT RATES. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities. 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.

(4) ~~Notwithstanding--subsection--(2),-beginning-January 1,-1988,-through-December-31,-1991,-the-maximum-fees-payable by-insurers-must-be-limited-to-the-fee-schedule--established in--January--1987.--Notwithstanding-subsection-(3),-beginning January-1,-1988,-through-December--31,--1991,--the--hospital rates--payable--by--insurers-must-be-limited-to-those-set-in January-1988.-After-December-31,-1991,--the~~ 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 $10 of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease.

(b) 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.

(c) "Visit", as used in subsection (7)(a) and (7)(b), means each time 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."

~~Section 4. Section 39-71-711, MCA, is amended to read:~~

~~"39-71-711. Impairment evaluation ratings. (1) An impairment rating:~~

~~(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;~~

~~(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and~~

~~(c) must be expressed as a percentage of the whole person.~~

~~(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.~~

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.~~

~~(4)~~(3) Disputes over impairment ratings are not subject

~~to 39-71-605.~~"

Section 4. Section 39-71-727, MCA, is amended to read:

"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the physician specifies no substitutions~~ or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the ~~physician specified no substitutions or that the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7 6] are limited to the average wholesale price of the product at the time of

dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed

care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9 8]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 6. Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in

39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with ~~physicians-or-physician-groups-or~~ clinics, hospitals, pharmacies, ~~physical--therapists,~~ suppliers of soft and durable medical goods, and other medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. THIS SECTION DOES NOT PROHIBIT THE WORKER FROM CHOOSING THE INITIAL TREATING PHYSICIAN UNDER [SECTION 5(1)].

NEW SECTION. **Section 7. Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6 5], through appropriate health care professionals.

(2) The department shall develop criteria pursuant to [section ~~10~~ 9] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A WORKER WHO IS SUBJECT TO MANAGED CARE MAY CHOOSE FROM MANAGED CARE ORGANIZATIONS IN THE WORKER'S COMMUNITY THAT HAVE A CONTRACT WITH THE INSURER RESPONSIBLE FOR THE WORKER'S MEDICAL SERVICES.

NEW SECTION. **Section 8. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in [section ~~10~~ 9]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 9. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a

workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the

applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the

injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner, OR A CHIROPRACTOR.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care

provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 10. Compliance with medical treatment required -- termination of compensation benefits for noncompliance.** An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization OR TREATING PHYSICIAN;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 11. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an

industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal

year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing minimum hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 12.** **Physician self-referral prohibition.** A treating physician may not refer a claimant to a health care facility outside the physician's office practice at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer OR THE CLAIMANT is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 13.** **Medical advisory committees -- composition -- function.** (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

(3) THE DEPARTMENT MAY SEEK RECOMMENDATIONS FOR REPRESENTATIVES FROM THE STATE LICENSING BOARDS GOVERNING THE PROVIDERS.

NEW SECTION. **Section 14.** **Codification instruction.** [Sections 6 through ~~14~~ 13] 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 6 through ~~14~~ 13].

NEW SECTION. **Section 15.** **Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16.** **Retroactive applicability.** Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the

conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before [the effective date of this act].

NEW SECTION. **Section 17.** Effective date. [This act] is effective July 1, 1993.

-End-

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS---REGARDING---IMPAIRMENT---EVALUATIONS;~~ REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711,~~ AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

Section 1. 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 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 the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section 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."

Section 2. Section 39-71-116, MCA, is amended to read:

THIRD READING

"39-71-116. **Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is a full-time student in an accredited school or is enrolled

in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related employment that is not directly involved on a regular basis

in the provision of physical labor at a construction or renovation site.

~~(7)--"Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is located or a board certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.~~

~~(7)~~(8)(7) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9)(8) "Department" means the department of labor and industry.

(9) "DISABILITY" MEANS A CONDITION IN WHICH A WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT IS DIMINISHED AS A RESULT OF PHYSICAL RESTRICTIONS RESULTING FROM AN INJURY. THE RESTRICTIONS MAY BE COMBINED WITH FACTORS, SUCH AS THE WORKER'S AGE, EDUCATION, WORK HISTORY, AND OTHER FACTORS THAT AFFECT THE WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT. DISABILITY DOES NOT MEAN A PURELY MEDICAL CONDITION.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting

business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer ~~shall~~ has not have operated a sufficient or any

length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~ (18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~ (19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be

considered in determining if a worker is permanently totally disabled.

~~(17) The term "physician" includes "surgeon" and in either case means one authorized by law to practice his profession in this state.~~

~~(18)~~ (20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment PRESCRIBED BY A TREATING PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability. ~~The term includes medical, surgical, hospital, nursing, and ambulance services and drugs or medicine.~~

~~(19)~~ (22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~ (23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~ (24) "Reasonably safe tools and appliances" are such tools and appliances as are adapted to and are reasonably

safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, ~~physical--restoration,--physical--conditioning,--or-exercise programs~~ PHYSICAL RESTORATION PROGRAMS AND OTHER RESTORATION PROGRAMS DESIGNED TO ADDRESS DISABILITY AND NOT IMPAIRMENT, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is

primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. 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 the a compensable injury and subject to the other provisions of ~~subsection--(1)~~(d) this chapter, the insurer shall furnish~~,--without--limitation--as--to length--of--time--or--dollar--amount,~~ reasonable primary medical services ~~by--a--physician--or--surgeon,--reasonable--hospital services--and--medicines--when--needed,--and--such--other--treatment as--may--be--approved--by--the--department--for--the--injuries sustained,--subject--to--the--requirements--of--39-71-727~~ 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.

~~(b)~~(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.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to--rules adopted--by--the--department~~ only if the travel is incurred at the request of the insurer. Reimbursement must be at the

rates allowed for reimbursement of travel by state employees.

~~(d)~~(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; or

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

(g) If the worker's treating physician believes that palliative or maintenance 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, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of

physicians, INCLUDING AT LEAST ONE TREATING PHYSICIAN FROM THE AREA OF SPECIALTY IN WHICH THE INJURED WORKER IS BEING TREATED, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(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) The department shall annually establish a schedule of fees for medical nonhospital services ~~and--hospital outpatient-services-that--are--available--in--a--nonhospital setting--and-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. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section ~~14~~ 13].

(3) ~~Beginning-January-1,-1988,-the~~ The department shall establish rates for hospital services necessary for the

treatment of injured workers. Beginning January 1, 1995, the rates ~~must~~ MAY be based on per diem or diagnostic-related groups. THE RATES ESTABLISHED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION MAY NOT BE LESS THAN MEDICAID REIMBURSEMENT RATES. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities. 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.

(4) ~~Notwithstanding--subsection--(2),-beginning-January 1,-1988,-through-December-31,-1991,-the-maximum-fees-payable by-insurers-must-be-limited-to-the-fee-schedule--established in--January--1987,-Notwithstanding-subsection-(3),-beginning January-1,-1988,-through-December--31,--1991,--the--hospital rates--payable--by--insurers-must-be-limited-to-those-set-in January-1988.-After-December-31,-1991,--the~~ 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 $10 of the cost of each subsequent visit to a medical service provider for treatment relating to a compensable injury or occupational disease.

(b) 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.

(c) "Visit", as used in subsection (7)(a) and (7)(b), means each time 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."

~~Section 4. Section 39-71-711, MCA, is amended to read:~~

~~"39-71-711. Impairment -- evaluation ------ ratings. (1) An impairment rating:~~

~~(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;~~

~~(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and~~

~~(c) must be expressed as a percentage of the whole person.~~

~~(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.~~

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is certified as an evaluator under chapter 12.~~

~~(4)~~ (3) ~~Disputes over impairment ratings are not subject~~

~~to 39-71-605.~~"

Section 4. Section 39-71-727, MCA, is amended to read:

"39-71-727. Payment for prescription drugs -- limitations. (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the physician specifies no substitutions~~ or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the ~~physician specified no substitutions or that the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section 7 6] are limited to the average wholesale price of the product at the time of

dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5.** **Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed

care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9 8]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 6.** **Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in

39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with ~~physicians-or-physician-groups-or~~ clinics, hospitals, pharmacies, ~~physical--therapists,~~ suppliers of soft and durable medical goods, and other medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. THIS SECTION DOES NOT PROHIBIT THE WORKER FROM CHOOSING THE INITIAL TREATING PHYSICIAN UNDER [SECTION 5(1)].

NEW SECTION. **Section 7.** **Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6 5], through appropriate health care professionals.

(2) The department shall develop criteria pursuant to [section ~~10~~ 9] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A WORKER WHO IS SUBJECT TO MANAGED CARE MAY CHOOSE FROM MANAGED CARE ORGANIZATIONS IN THE WORKER'S COMMUNITY THAT HAVE A CONTRACT WITH THE INSURER RESPONSIBLE FOR THE WORKER'S MEDICAL SERVICES.

NEW SECTION. **Section 8. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in [section ~~10~~ 9]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 9. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a

workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the

applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the

injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner, OR A CHIROPRACTOR.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care

provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 10.** **Compliance with medical treatment required -- termination of compensation benefits for noncompliance.** An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization OR TREATING PHYSICIAN;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 11.** **Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an

industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal

year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing ~~minimum~~ hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 12.** Physician self-referral prohibition. A treating physician may not refer a claimant to a health care facility outside the physician's office practice at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer OR THE CLAIMANT is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 13.** Medical advisory committees -- composition -- function. (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

(3) THE DEPARTMENT MAY SEEK RECOMMENDATIONS FOR REPRESENTATIVES FROM THE STATE LICENSING BOARDS GOVERNING THE PROVIDERS.

NEW SECTION. **Section 14.** Codification instruction. [Sections 6 through ~~14~~ 13] 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 6 through ~~14~~ 13].

NEW SECTION. **Section 15.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16.** Retroactive applicability. Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the

conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before [the effective date of this act].

NEW SECTION. **Section 17.** Effective date. [This act] is effective July 1, 1993.

-End-

HOUSE SELECT COMMITTEE REPORT

March 11, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that Senate Bill 347 (third reading copy -- blue) do be concurred in as amended, and that the House refer the bill with amendments to the House Committee on Labor and Employment Relations for its consideration as part of the Workers' Compensation package.

Signed: Chase Hibbard, Chair

And that such amendments read:

1. Page 15, line 6.
Following: "for"
Insert: "20%, but not to exceed"
Following: "$10"
Insert: ","

2. Page 15, line 8.
Following: "disease"
Insert: ", 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"

3. Page 20, lines 3 and 4.
Following: "~~or~~" on line 3
Strike: the remainder of line 3 through "pharmacies," on line 4

4. Page 20, line 5.
Following: "goods"
Strike: ","
Following: "and"
Strike: "other"

5. Page 27, line 8.
Following: "prohibition."
Strike: "A"
Insert: "Unless authorized by the insurer, a"

6. Page 27, lines 9 and 10.
Following: "facility" on line 9
Strike: the remainder of line 9 through "practice" on line 10

HOUSE

Committee Vote:
Yes 5, No 1.

SB 347
551221SC.Hpf

HOUSE STANDING COMMITTEE REPORT

March 19, 1993

Mr. Speaker: We, the committee on Labor report that Senate Bill 347 (third reading copy -- blue) be concurred in as amended .

Signed: Tom Nelson, Chair

And, that such amendments read: Carried by: Rep. Mercer

1. Page 22, line 3.
Following: "care."
Insert: "When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought."

Committee Vote:
Yes 9, No 7.

HOUSE
SB 347
621827SC.Hss

3-30-93
1:30

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS---REGARDING---IMPAIRMENT---EVALUATIONS;~~ REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711,~~ AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

Section 1. 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 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~~ the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section 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."

Section 2. Section 39-71-116, MCA, is amended to read:

"**39-71-116. Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is a full-time student in an accredited school or is enrolled

in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related employment that is not directly involved on a regular basis

in the provision of physical labor at a construction or renovation site.

~~(7)--"Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is located or a board-certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.~~

~~(7)~~(8)(7) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9)(8) "Department" means the department of labor and industry.

(9) "DISABILITY" MEANS A CONDITION IN WHICH A WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT IS DIMINISHED AS A RESULT OF PHYSICAL RESTRICTIONS RESULTING FROM AN INJURY. THE RESTRICTIONS MAY BE COMBINED WITH FACTORS, SUCH AS THE WORKER'S AGE, EDUCATION, WORK HISTORY, AND OTHER FACTORS THAT AFFECT THE WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT. DISABILITY DOES NOT MEAN A PURELY MEDICAL CONDITION.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting

business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work-related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer ~~shall~~ has not ~~have~~ operated a sufficient or any

length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~ (18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~ (19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be

considered in determining if a worker is permanently totally disabled.

~~(17) The term "physician" includes "surgeon" and in either case means one authorized by law to practice his profession in this state.~~

~~(18)~~ (20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment PRESCRIBED BY A TREATING PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability. ~~The term includes medical, surgical, hospital, nursing, and ambulance services and drugs or medicine.~~

~~(19)~~ (22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~ (23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~ (24) "Reasonably safe tools and appliances" are ~~such~~ tools and appliances as are adapted to and are reasonably

safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, ~~physical--restoration,--physical--conditioning,--or-exercise programs~~ PHYSICAL RESTORATION PROGRAMS AND OTHER RESTORATION PROGRAMS DESIGNED TO ADDRESS DISABILITY AND NOT IMPAIRMENT, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is

primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. 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 ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection--(1)~~(d) this chapter, the insurer shall furnish~~,--without--limitation--as--to length--of--time--or--dollar--amount,~~ reasonable primary medical services ~~by--a--physician--or--surgeon,--reasonable--hospital services--and--medicines--when--needed,--and--such--other--treatment as--may--be--approved--by--the--department--for--the--injuries sustained,--subject--to--the--requirements--of--39-71-727~~ 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.

~~(b)~~(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.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to--rules adopted--by--the--department~~ only if the travel is incurred at the request of the insurer. Reimbursement must be at the

rates allowed for reimbursement of travel by state employees.

~~(d)~~(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; or

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

(g) If the worker's treating physician believes that palliative or maintenance 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, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department for the treatment. The department shall appoint a panel of

physicians, INCLUDING AT LEAST ONE TREATING PHYSICIAN FROM THE AREA OF SPECIALTY IN WHICH THE INJURED WORKER IS BEING TREATED, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(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) The department shall annually establish a schedule of fees for medical nonhospital services ~~and--hospital outpatient-services-that--are--available--in--a--nonhospital setting--and-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. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section ~~14~~ 13].

(3) ~~Beginning-January-1,-1988,-the~~ The department shall establish rates for hospital services necessary for the

treatment of injured workers. Beginning January 1, 1995, the rates ~~must~~ MAY be based on per diem or diagnostic-related groups. THE RATES ESTABLISHED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION MAY NOT BE LESS THAN MEDICAID REIMBURSEMENT RATES. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities. 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.

(4) ~~Notwithstanding--subsection--(2),-beginning-January 1,-1988,-through-December-31,-1991,-the-maximum-fees-payable by-insurers-must-be-limited-to-the-fee-schedule--established in--January--1987,-Notwithstanding-subsection-(3),-beginning January-1,-1988,-through-December--31,--1991,--the--hospital rates--payable--by--insurers-must-be-limited-to-those-set-in January-1988,-After-December-31,-1991,--the~~ 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 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 to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(c) "Visit", as used in subsection (7)(a) and (7)(b), means each time 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."

~~Section 4. Section 39-71-711, MCA, is amended to read:~~

~~"39-71-711. Impairment evaluation ratings. (1) An impairment rating:~~

~~(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;~~

~~(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and~~

~~(c) must be expressed as a percentage of the whole person.~~

~~(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.~~

~~(3) An evaluator must be a physician licensed under Title 37, chapter 3, except if the claimant's treating~~

~~physician--is--a--chiropractor,--the--evaluator--may--be--a chiropractor-who-is-certified-as-an-evaluator-under--chapter 12.~~

~~(4)~~(3) ~~Disputes-over-impairment-ratings-are-not-subject to-39-71-605.~~"

Section 4. Section 39-71-727, MCA, is amended to read:

"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the-physician-specifies--no--substitutions or~~ the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the ~~physician-specified-no--substitutions~~

~~or-that-the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section ~~7~~ 6] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care organization, if any, or to a medical service provider who

qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9 8]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member

of a managed care organization.

NEW SECTION. **Section 6. Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with ~~physicians-or-physician-groups-or clinics, hospitals, pharmacies, physical therapists,~~ suppliers of soft and durable medical goods, and ~~other~~ medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. THIS SECTION DOES NOT PROHIBIT THE WORKER FROM CHOOSING THE INITIAL TREATING PHYSICIAN UNDER [SECTION 5(1)].

NEW SECTION. **Section 7. Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6 5], through appropriate health care professionals.

(2) The department shall develop criteria pursuant to [section ~~10~~ 9] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A WORKER WHO IS SUBJECT TO MANAGED CARE MAY CHOOSE FROM MANAGED CARE ORGANIZATIONS IN THE WORKER'S COMMUNITY THAT HAVE A CONTRACT WITH THE INSURER RESPONSIBLE FOR THE WORKER'S MEDICAL SERVICES.

NEW SECTION. **Section 8. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in [section ~~10~~ 9]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 9. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to injured workers for injuries that

are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. WHEN A HEALTH CARE PROVIDER, A GROUP OF MEDICAL SERVICE PROVIDERS, OR AN ENTITY WITH A MANAGED CARE ORGANIZATION IS ESTABLISHING A MANAGED CARE ORGANIZATION AND INDEPENDENT PHYSICAL THERAPY PRACTICES EXIST IN THE COMMUNITY, THE MANAGED CARE ORGANIZATION IS ENCOURAGED TO UTILIZE INDEPENDENT PHYSICAL THERAPISTS AS PART OF THE MANAGED CARE ORGANIZATION IF THE INDEPENDENT PHYSICAL THERAPISTS AGREE TO ABIDE BY ALL THE APPLICABLE REQUIREMENTS FOR A MANAGED CARE ORGANIZATION SET FORTH IN THIS SECTION, IN RULES ESTABLISHED BY THE DEPARTMENT, AND IN THE PROVISIONS OF A MANAGED CARE PLAN FOR WHICH CERTIFICATION IS BEING SOUGHT.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required

information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards

prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees

to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, ~~or~~ an internal medicine practitioner, OR A CHIROPRACTOR.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 10. Compliance with medical treatment required -- termination of compensation benefits for noncompliance.** An insurer that provides 14 days' notice

to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization OR TREATING PHYSICIAN;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 11. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond

the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing ~~minimum~~ hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 12.** **Physician self-referral prohibition.** A UNLESS AUTHORIZED BY THE INSURER, A treating physician may not refer a claimant to a health care facility ~~outside--the--physician's--office--practice~~ at which the

physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer OR THE CLAIMANT is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 13.** **Medical advisory committees -- composition -- function.** (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

(3) THE DEPARTMENT MAY SEEK RECOMMENDATIONS FOR REPRESENTATIVES FROM THE STATE LICENSING BOARDS GOVERNING THE PROVIDERS.

NEW SECTION. **Section 14.** **Codification instruction.** [Sections 6 through ~~14~~ 13] 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 6 through ~~14~~ 13].

NEW SECTION. **Section 15. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16. Retroactive applicability.** Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before [the effective date of this act].

NEW SECTION. **Section 17. Effective date.** [This act] is effective July 1, 1993.

-End-

Amendments to Senate Bill No. 347
Reference Reading Copy

For the Governor

Prepared by Greg Petesch
April 13, 1993

1. Title, line 22.
Strike: "AND"
Following: "39-71-727,"
Insert: "AND 39-71-743,"

2. Page 28, line 23.
Following: line 22
Insert: "**Section 14.** Section 39-71-743, MCA, is amended to read:

"**39-71-743. Assignment or attachment of payments.** (1) No payments under this chapter shall be assignable, subject to attachment or garnishment, or be held liable in any way for debts, except:

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

(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.

(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 social and rehabilitation services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act or Occupational Disease Act of Montana, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. ~~No~~ Except as provided in 39-71-704(7), a fee or charge ~~shall be~~ is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.""
Renumber: subsequent sections

Gov. Amend.
SB 347

OFFICE OF THE GOVERNOR

STATE OF MONTANA

MARC RACICOT
GOVERNOR

STATE CAPITOL
HELENA, MONTANA 59620-0801

April 16, 1993

The Honorable Fred Van Valkenburg
President of the Senate
State Capitol
Helena MT 59620

The Honorable John Mercer
Speaker of the House
State Capitol
Helena MT 59620

Dear President Van Valkenburg and Speaker Mercer:

In accordance with the power vested in me as Governor by the Constitution and laws of the State of Montana, I hereby return Senate Bill 347, "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS' AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS REGARDING IMPAIRMENT EVALUATIONS;~~ REVISING R]PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711~~ AND 39-71-727, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE," with the attached amendments.

Senate Bill 347 provides for medical cost containment in workers' compensation. Among the bill's provisions is a requirement that a worker, after the initial visit to a medical service provider, pay a portion of the cost of each subsequent visit, with certain exceptions. This "co-payment" provision resulted in an inconsistency with an existing statute, section 39-71-743, MCA. Subsection (3) of that statute states that no charge shall be payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

Senator Harp, the sponsor of Senate Bill 347, has asked that a technical amendment be offered to make the "co-payment" provision consistent with section 39-71-743(3), MCA, and I urge your approval of the amendment.

Sincerely,

Marc Racicot

MARC RACICOT
Governor

SENATE BILL NO. 347

INTRODUCED BY HARP, TOWE, WILSON, KENNEDY, LYNCH, CRIPPEN, AKLESTAD, CHRISTIAENS, BURNETT, KEATING, BLAYLOCK, SWYSGOOD, NATHE, DEVLIN, BECK, VAN VALKENBURG, B. BROWN, HALLIGAN, FORRESTER, TOEWS, DRISCOLL, PAVLOVICH, DAILY, GRINDE, HIBBARD, MERCER, WAGNER, BRANDEWIE, WANZENRIED, T. NELSON, YELLOWTAIL, STANG, KOEHNKE

BY REQUEST OF THE STATE FUND

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAW TO ATTAIN BETTER MEDICAL COST CONTAINMENT; REVISING AN INJURED WORKER'S FREEDOM OF CHOICE OF PHYSICIANS; AMENDING MEDICAL DEFINITIONS; DISTINGUISHING BETWEEN PRIMARY AND SECONDARY MEDICAL SERVICES; ~~REVISING PROVISIONS---REGARDING---IMPAIRMENT---EVALUATIONS;~~ REVISING PROVISIONS REGARDING PAYMENT FOR PRESCRIPTION DRUGS; PROVIDING FOR MANAGED CARE AND A PREFERRED PROVIDERS ORGANIZATION; REQUIRING THE INJURED WORKER TO COMPLY WITH RECOMMENDED MEDICAL TREATMENT; REGULATING DOMICILIARY CARE; LIMITING PHYSICIAN SELF-REFERRAL; CREATING MEDICAL ADVISORY COMMITTEES; AMENDING SECTIONS 33-22-111, 39-71-116, 39-71-704, ~~39-71-711;~~ AND 39-71-727, AND 39-71-743, MCA; AND PROVIDING AN EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

Section 1. 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 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~~ the policies insure against the expense of drugs, the insured ~~shall have~~ has full freedom of choice in the selection of any ~~duly~~ licensed and registered pharmacist.

(2) ~~Nothing in this section shall~~ This section 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."

REFERENCE BILL: INCLUDES GOVERNOR'S AMENDMENTS DATED 4-16-93

Section 2. Section 39-71-116, MCA, is amended to read:

"39-71-116. **Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is

a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no beneficiary, as defined in subsections (3)(a) through (3)(d), exists; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no beneficiary, as defined in subsections (3)(a) through (3)(e), exists.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design professionals, salesmen, estimators, or any other related

employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

~~(7)--"Consulting physician" means a medical doctor who has admitting privileges to practice in one or more hospitals, if any, in the area in which the doctor is located or a board certified oral surgeon who examines a worker or a worker's medical record to advise the treating physician regarding the treatment of a worker's compensable injury.~~

~~(7)~~(8) "Days" means calendar days, unless otherwise specified.

~~(8)~~(9) "Department" means the department of labor and industry.

(9) "DISABILITY" MEANS A CONDITION IN WHICH A WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT IS DIMINISHED AS A RESULT OF PHYSICAL RESTRICTIONS RESULTING FROM AN INJURY. THE RESTRICTIONS MAY BE COMBINED WITH FACTORS, SUCH AS THE WORKER'S AGE, EDUCATION, WORK HISTORY, AND OTHER FACTORS THAT AFFECT THE WORKER'S ABILITY TO ENGAGE IN GAINFUL EMPLOYMENT. DISABILITY DOES NOT MEAN A PURELY MEDICAL CONDITION.

~~(9)~~(10) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

~~(10)~~(11) "Insurer" means an employer bound by

compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

~~(11)~~(12) "Invalid" means one who is physically or mentally incapacitated.

~~(12)--"Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work related injury will permit.~~

(13) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

(14) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(13)~~(15) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(16) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(14)~~(17) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the

employer ~~shall~~ has not ~~have~~ operated a sufficient or any length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate is to be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(15)~~(18) "Permanent partial disability" means a condition, after a worker has reached maximum medical healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

~~(16)~~(19) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker ~~has--no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state.

Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

~~(17) The term "physician" includes "surgeon" and in either case means one authorized by law to practice his profession in this state.~~

~~(18)~~(20) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(21) "Primary medical services" means treatment PRESCRIBED BY A TREATING PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability. ~~The term includes medical, surgical, hospital, nursing, and ambulance services and drugs or medicine.~~

~~(19)~~(22) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

~~(20)~~(23) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(21)~~(24) "Reasonably safe tools and appliances" are ~~such~~

tools and appliances as are adapted to and are reasonably safe for use for the particular purpose for which they are furnished.

(25) "Secondary medical services" means those medical services or appliances considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, ~~physical--restoration,--physical--conditioning,--or-exercise programs~~ PHYSICAL RESTORATION PROGRAMS AND OTHER RESTORATION PROGRAMS DESIGNED TO ADDRESS DISABILITY AND NOT IMPAIRMENT, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

~~(22)~~(26) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(27) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(24)~~(28) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

(29) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant-certified licensed by the state of Montana under Title 37, chapter 20, if there is not a physician, as defined in subsection (29)(a), in the area where the physician assistant-certified is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 5; or

(e) a dentist licensed by the state of Montana under Title 37, chapter 4.

~~(25)~~(30) "Year", unless otherwise specified, means calendar year."

Section 3. 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 ~~the~~ a compensable injury and subject to ~~the~~ other provisions of ~~subsection--(1)~~(d) this chapter, the insurer shall furnish~~,--without--limitation--as--to length--of--time--or--dollar--amount,~~ reasonable primary medical services ~~by--a--physician--or--surgeon,--reasonable--hospital services--and--medicines--when--needed,--and--such--other--treatment as--may--be--approved--by--the--department--for--the--injuries sustained,--subject--to--the--requirements--of--39-71-727~~ 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.

~~(b)~~(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.

~~(c)~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury ~~pursuant--to--rules adopted--by--the--department~~ only if the travel is incurred at

the request of the insurer. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

~~(d)~~(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; or

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

(g) If the worker's treating physician believes that palliative or maintenance 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, the treating physician shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician may request approval from the department

for the treatment. The department shall appoint a panel of physicians, INCLUDING AT LEAST ONE TREATING PHYSICIAN FROM THE AREA OF SPECIALTY IN WHICH THE INJURED WORKER IS BEING TREATED, pursuant to rules that the department may adopt, to review the proposed treatment and determine its appropriateness.

(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) The department shall annually establish a schedule of fees for medical nonhospital services ~~and--hospital outpatient-services-that--are--available--in--a--nonhospital setting--and-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. The department shall establish utilization and treatment standards for all medical services provided for under this chapter in consultation with the standing medical advisory committees provided for in [section ~~14~~ 13].

(3) ~~Beginning-January-1,-1988,-the~~ The department shall

establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates ~~must~~ MAY be based on per diem or diagnostic-related groups. THE RATES ESTABLISHED BY THE DEPARTMENT PURSUANT TO THIS SUBSECTION MAY NOT BE LESS THAN MEDICAID REIMBURSEMENT RATES. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities. 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.

(4) ~~Notwithstanding--subsection--(2),-beginning-January 1,-1988,-through-December-31,-1991,-the-maximum-fees-payable by-insurers-must-be-limited-to-the-fee-schedule--established in--January--1987.-Notwithstanding-subsection-(3),-beginning January-1,-1988,-through-December--31,--1991,--the--hospital rates--payable--by--insurers-must-be-limited-to-those-set-in January-1988,-After-December-31,-1991,--the~~ 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 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 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 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."

~~Section 4. Section 39-71-711, MCA, is amended to read:~~

~~"39-71-711. Impairment evaluation ratings. (1) An impairment rating:~~

~~(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum medical healing;~~

~~(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American medical association; and~~

~~(c) must be expressed as a percentage of the whole person.~~

~~(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator who is a medical doctor or from an evaluator who is a chiropractor if the injury falls within the scope of chiropractic practice a physician who qualifies as a treating physician and is a member of a managed care organization, unless a nonmember is authorized by the insurer. If the claimant and insurer cannot agree upon the rating, the mediation procedure in part 24 of this chapter must be followed.~~

~~(3) An evaluator must be a physician licensed under~~

~~Title-37,-chapter--3,--except--if--the--claimant's--treating physician---is--a--chiropractor,--the--evaluator--may--be--a chiropractor-who-is-certified-as-an-evaluator-under--chapter 12.~~

~~(4)~~(3) ~~Disputes-over-impairment-ratings-are-not-subject to-39-71-605.~~"

Section 4. Section 39-71-727, MCA, is amended to read:

"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless ~~the-physician-specifies--no--substitutions~~ or the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the ~~cost~~ reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may only bill the insurer for the ~~cost~~ reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist

shall certify that the ~~physician-specified-no--substitutions or-that-the~~ generic-name drug was unavailable.

(5) Reimbursement rates payable by an insurer subject to an agreement pursuant to [section ~~7~~ 6] are limited to the average wholesale price of the product at the time of dispensing, plus a dispensing fee not to exceed $5.50 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, average wholesale prices must be updated weekly.

~~(5)~~(8) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) AN INSURER MAY NOT REQUIRE A WORKER RECEIVING BENEFITS UNDER THIS CHAPTER TO OBTAIN MEDICATIONS FROM AN OUT-OF-STATE MAIL SERVICE PHARMACY."

NEW SECTION. **Section 5. Choice of physician by worker -- change of physician -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician within the state of Montana.

(2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the insurer shall direct the worker to a managed care

organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's treating physician.

(3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

(a) the injury results in a total loss of wages for any duration;

(b) the injury will result in permanent impairment;

(c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or

(d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with [section 9 8]. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable

injury from a medical service provider who is not a member of a managed care organization.

NEW SECTION. **Section 6.** **Preferred provider organizations -- establishment -- limitations.** In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with ~~physicians or physician groups or clinics, hospitals, pharmacies, physical therapists,~~ suppliers of soft and durable medical goods, and other medical providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that a worker is given written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. THIS SECTION DOES NOT PROHIBIT THE WORKER FROM CHOOSING THE INITIAL TREATING PHYSICIAN UNDER [SECTION 5(1)].

NEW SECTION. **Section 7.** **Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to [section 6 5], through appropriate

health care professionals.

(2) The department shall develop criteria pursuant to [section ~~10~~ 9] for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A WORKER WHO IS SUBJECT TO MANAGED CARE MAY CHOOSE FROM MANAGED CARE ORGANIZATIONS IN THE WORKER'S COMMUNITY THAT HAVE A CONTRACT WITH THE INSURER RESPONSIBLE FOR THE WORKER'S MEDICAL SERVICES.

NEW SECTION. **Section 8. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in [section ~~10~~ 9]. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

NEW SECTION. **Section 9. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to

provide managed care to injured workers for injuries that are covered under this chapter or for occupational diseases that are covered under the Occupational Disease Act of Montana. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. WHEN A HEALTH CARE PROVIDER, A GROUP OF MEDICAL SERVICE PROVIDERS, OR AN ENTITY WITH A MANAGED CARE ORGANIZATION IS ESTABLISHING A MANAGED CARE ORGANIZATION AND INDEPENDENT PHYSICAL THERAPY PRACTICES EXIST IN THE COMMUNITY, THE MANAGED CARE ORGANIZATION IS ENCOURAGED TO UTILIZE INDEPENDENT PHYSICAL THERAPISTS AS PART OF THE MANAGED CARE ORGANIZATION IF THE INDEPENDENT PHYSICAL THERAPISTS AGREE TO ABIDE BY ALL THE APPLICABLE REQUIREMENTS FOR A MANAGED CARE ORGANIZATION SET FORTH IN THIS SECTION, IN RULES ESTABLISHED BY THE DEPARTMENT, AND IN THE PROVISIONS OF A MANAGED CARE PLAN FOR WHICH CERTIFICATION IS BEING SOUGHT.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for

the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that

meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review, AND service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented

history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, or an internal medicine practitioner, OR A CHIROPRACTOR.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

NEW SECTION. **Section 10.** **Compliance with medical treatment required -- termination of compensation benefits**

for noncompliance. An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) to cooperate with a managed care organization OR TREATING PHYSICIAN;

(2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) to provide access to health care information to medical providers, the insurer, or an agent of the insurer.

NEW SECTION. **Section 11.** **Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the prevailing ~~minimum~~ hourly wage, and the insurer is not liable for more than 8 hours of care per day.

NEW SECTION. **Section 12.** Physician self-referral prohibition. A UNLESS AUTHORIZED BY THE INSURER, A treating physician may not refer a claimant to a health care facility

~~outside--the--physician's--office--practice~~ at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer OR THE CLAIMANT is not liable for charges incurred in violation of this section.

NEW SECTION. **Section 13.** Medical advisory committees -- composition -- function. (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;

(b) surgeons;

(c) chiropractors;

(d) physical therapists;

(e) psychologists; and

(f) hospitals.

(2) Committees organized pursuant to this section shall assist the department in the development of utilization and treatment standards for treating injured workers.

(3) THE DEPARTMENT MAY SEEK RECOMMENDATIONS FOR REPRESENTATIVES FROM THE STATE LICENSING BOARDS GOVERNING THE PROVIDERS.

SECTION 14. SECTION 39-71-743, MCA, IS AMENDED TO READ:

"39-71-743. Assignment or attachment of payments. (1)

No payments under this chapter shall be assignable, subject to attachment or garnishment, or be held liable in any way for debts, except:

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

(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.

(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 social and rehabilitation services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is approved for payment on the basis of a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act or Occupational Disease Act of Montana, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. No Except as provided in 39-71-704(7), a fee or

charge ~~shall be~~ is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer."

NEW SECTION. **Section 15.** Codification instruction. [Sections 6 5 through ~~14~~ 13] 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 6 5 through ~~14~~ 13].

NEW SECTION. **Section 16.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 17.** Retroactive applicability. Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1], intends that [section 1] apply retroactively, within the meaning of 1-2-109, to all causes of action arising before

[the effective date of this act].

NEW SECTION. **Section 18.** Effective date. [This act] is effective July 1, 1993.

-End-