House BILL NO. 519

INTRODUCED BY Zolnikov

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING AN ADVANCED PRACTICE REGISTERED NURSE TO PROVIDE SERVICES AS A TREATING PROVIDER AND A PRIMARY CARE PROVIDER UNDER THE WORKERS' COMPENSATION ACT; CHANGING THE TERM "TREATING PHYSICIAN" TO "TREATING PROVIDER" AND "PRIMARY CARE PHYSICIAN" TO "PRIMARY CARE PROVIDER"; AND AMENDING SECTIONS 39-71-116, 39-71-315, 39-71-701, 39-71-704, 39-71-711, 39-71-1101, 39-71-1102, 39-71-1105, 39-71-1106, 39-71-1107, 39-71-1108, AND 39-72-303, MCA."

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

Section 1. Section 39-71-116, MCA, is amended to read:

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

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "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) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

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

(3) "Aid or sustenance" means any public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

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

(5) "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 18 years of age;

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

(d) an invalid child over 18 years of age 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 a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

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

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

(8) "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, salespersons, 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.

(9) "Days" means calendar days, unless otherwise specified.

(10) "Department" means the department of labor and industry.

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

(12) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include employment beyond the scope of normal household or domestic duties, such as home health care or

domiciliary care.

(13) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(14) "Invalid" means one who is physically or mentally incapacitated.

(15) "Limited liability company" is as defined in 35-8-102.

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

(17) "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.

(18) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

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

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

(21) "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 has not operated a sufficient or any length of time during 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 average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of 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.

(22) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

(23) "Permanent total disability" means a physical condition resulting from injury as defined in this

chapter, after a worker reaches maximum medical healing, in which a worker 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.

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

(25) "Primary medical services" means treatment prescribed by a treating ~~physician~~ provider, for conditions resulting from the injury, necessary for achieving medical stability.

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

(27) "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.

(28) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

(29) (a) "Secondary medical services" means those medical services or appliances that are 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 programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection (29), "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.

(ii) Disability does not mean a purely medical condition.

(30) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

(31) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

(32) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(33) "Temporary total disability" means a physical 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.

(34) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(35) "Treating ~~physician"~~ provider" 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 (35)(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; or

(f) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8.

(36) "Year", unless otherwise specified, means calendar year."

Section 2. Section 39-71-315, MCA, is amended to read:

"**39-71-315. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating ~~physician~~ provider with an ownership interest in a managed care organization that has been certified by the department."

Section 3. Section 39-71-701, MCA, is amended to read:

"**39-71-701. Compensation for temporary total disability -- exception.** (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:

(a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing; or

(b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.

(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.

(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).

(4) If the treating ~~physician~~ provider releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an

equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available for any reason to the worker and the worker continues to be temporarily totally disabled, as defined in 39-71-116.

(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301."

Section 4. Section 39-71-704, MCA, is amended to read:

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

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

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

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

(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a

medical provider for treatment of an injury 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.

(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~~ provider 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~~ provider shall first request approval from the insurer for the treatment. If approval is not granted, the treating ~~physician~~ provider may request approval from the department for the treatment. The department shall appoint a panel of ~~physicians~~ providers, including at least one treating ~~physician~~ provider 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 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 39-71-1109.

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

workers. Beginning January 1, 1995, the rates 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) 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~~ provider;

(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 5. 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 healing;

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

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

(d) must be established by objective medical findings.

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

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

Section 6. Section 39-71-1101, MCA, is amended to read:

"**39-71-1101. Choice of ~~physician~~ providers by worker -- change of ~~physician~~ provider -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating ~~physician~~ provider within the state of Montana.

(2) Authorization by the insurer is required to change treating ~~physicians~~ providers. 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~~ provider, who shall then serve as the worker's treating ~~physician~~ provider.

(3) A medical service provider who otherwise qualifies as a treating ~~physician~~ provider 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 39-71-1104. The designated treating ~~physician~~ provider in the managed care organization then becomes the worker's treating ~~physician~~ provider. 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."

Section 7. Section 39-71-1102, MCA, is amended to read:

"**39-71-1102. 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 suppliers of soft and durable medical goods and 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~~ provider under 39-71-1101(1)."

Section 8. Section 39-71-1105, MCA, is amended to read:

"**39-71-1105. 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~~ providers 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~~ provider 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~~ provider 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~~ provider 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"~~ provider" means a ~~physician~~ provider who is qualified to be a treating ~~physician~~ provider and who is a family practitioner, a general practitioner, an internal medicine practitioner, ~~or~~ a chiropractor, or an advanced practice registered nurse.

(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."

Section 9. Section 39-71-1106, MCA, is amended to read:

"**39-71-1106. 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~~ provider;

(2) to submit to medical treatment recommended by the treating ~~physician~~ provider, except for

invasive procedures; or

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

Section 10. Section 39-71-1107, MCA, is amended to read:

"**39-71-1107. 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~~ provider 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 hourly wage, and the insurer is not liable for more than 8 hours of care per day."

Section 11. Section 39-71-1108, MCA, is amended to read:

"**39-71-1108. ~~Physician~~ Provider self-referral prohibition.** (1) Unless authorized by the insurer, a treating ~~physician~~ provider may not refer a claimant to a health care facility at which the ~~physician~~ provider does not directly provide care or services when the ~~physician~~ provider 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.

(2) Subsection (1) does not apply to care or services provided directly to an injured worker by a treating ~~physician~~ provider with an ownership interest in a managed care organization that has been certified by the department."

Section 12. Section 39-72-303, MCA, is amended to read:

"**39-72-303. Which employer liable.** (1) Where compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time the occupational disease was first diagnosed by a treating ~~physician~~ provider or medical panel; or

(b) the time the employee knew or should have known that the condition was the result of an occupational disease.

(3) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section."

NEW SECTION. **Section 13. Code commissioner instruction.** Wherever a reference to "treating physician" or "primary care physician" is used in reference to Title 39, chapters 71 or 72, in legislation enacted by the 1997 legislature, the code commissioner is directed to change it to an appropriate reference

to "treating provider" or "primary care provider", respectively.

-END-

HOUSE BILL NO. 519

INTRODUCED BY WYATT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING AN ADVANCED PRACTICE REGISTERED NURSE THAT IS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST TO PROVIDE SERVICES AS A TREATING PROVIDER AND A PRIMARY CARE PROVIDER UNDER THE WORKERS' COMPENSATION ACT; CHANGING THE TERM "TREATING PHYSICIAN" TO "TREATING PROVIDER" AND "PRIMARY CARE PHYSICIAN" TO "PRIMARY CARE PROVIDER"; AND AMENDING SECTIONS 39-71-116, 39-71-315, 39-71-701, 39-71-704, 39-71-711, 39-71-1101, 39-71-1102, 39-71-1105, 39-71-1106, 39-71-1107, 39-71-1108, AND 39-72-303, MCA."

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(2) "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) investigation, review, and settlement of claims;

(b) payment of benefits;

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

(3) "Aid or sustenance" means any public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole

dollar number and must be adopted by the department prior to July 1 of each year.

(5) "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 18 years of age;

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

(d) an invalid child over 18 years of age 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 a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

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

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

(8) "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, salespersons, 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.

(9) "Days" means calendar days, unless otherwise specified.

(10) "Department" means the department of labor and industry.

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

(12) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include

employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(13) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(14) "Invalid" means one who is physically or mentally incapacitated.

(15) "Limited liability company" is as defined in 35-8-102.

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

(17) "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.

(18) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

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

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

(21) "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 has not operated a sufficient or any length of time during 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 average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of 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.

(22) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

(23) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker 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.

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

(25) "Primary medical services" means treatment prescribed by a treating ~~physician~~ provider, for conditions resulting from the injury, necessary for achieving medical stability.

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

(27) "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.

(28) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

(29) (a) "Secondary medical services" means those medical services or appliances that are 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 programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection (29), "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.

(ii) Disability does not mean a purely medical condition.

(30) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

(31) "Temporary partial disability" means a physical condition resulting from an injury, as defined

in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

(32) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(33) "Temporary total disability" means a physical 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.

(34) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(35) "Treating ~~physician"~~ provider" 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 (35)(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; or

(f) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, AND RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST.

(36) "Year", unless otherwise specified, means calendar year."

Section 2. Section 39-71-315, MCA, is amended to read:

"**39-71-315. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating ~~physician~~ provider with an ownership interest in a managed care organization that has been certified by the department."

Section 3. Section 39-71-701, MCA, is amended to read:

"**39-71-701. Compensation for temporary total disability -- exception.** (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:

(a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing; or

(b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.

(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.

(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).

(4) If the treating ~~physician~~ provider releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available for any reason to the worker and the worker continues to be temporarily totally disabled, as defined in 39-71-116.

(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301."

Section 4. Section 39-71-704, MCA, is amended to read:

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

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

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

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in

39-71-119, arising out of and in the course of employment.

(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury 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.

(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~~ provider 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~~ provider shall first request approval from the insurer for the treatment. If approval is not granted, the treating ~~physician~~ provider may request approval from the department for the treatment. The department shall appoint a panel of ~~physicians~~ providers, including at least one treating ~~physician~~ provider 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 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 39-71-1109.

(3) The department shall establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates 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) 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~~ provider;

(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 5. 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 healing;

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

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

(d) must be established by objective medical findings.

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

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

Section 6. Section 39-71-1101, MCA, is amended to read:

"**39-71-1101. Choice of ~~physician~~ providers by worker -- change of ~~physician~~ provider -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating ~~physician~~ provider within the state of Montana.

(2) Authorization by the insurer is required to change treating ~~physicians~~ providers. 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~~ provider, who shall then serve as the worker's treating ~~physician~~ provider.

(3) A medical service provider who otherwise qualifies as a treating ~~physician~~ provider 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 39-71-1104. The designated treating ~~physician~~ provider in the managed care organization then becomes the worker's treating ~~physician~~ provider. 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."

Section 7. Section 39-71-1102, MCA, is amended to read:

"**39-71-1102. 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 suppliers of soft and durable medical goods and 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~~ provider under 39-71-1101(1)."

Section 8. Section 39-71-1105, MCA, is amended to read:

"**39-71-1105. 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~~ providers 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~~ provider 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~~ provider 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~~ provider 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~~" provider" means a ~~physician~~ provider who is qualified to be a treating ~~physician~~ provider and who is a family practitioner, a general practitioner, an internal medicine practitioner, ~~or~~ a chiropractor, or an advanced practice registered nurse WHO IS RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST.

(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."

Section 9. Section 39-71-1106, MCA, is amended to read:

"**39-71-1106. 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~~ provider;

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

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

Section 10. Section 39-71-1107, MCA, is amended to read:

"**39-71-1107. 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~~ provider 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 hourly wage, and the insurer is not liable for more than 8 hours of care per

day."

Section 11. Section 39-71-1108, MCA, is amended to read:

"**39-71-1108. ~~Physician~~ Provider self-referral prohibition.** (1) Unless authorized by the insurer, a treating ~~physician~~ provider may not refer a claimant to a health care facility at which the ~~physician~~ provider does not directly provide care or services when the ~~physician~~ provider 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.

(2) Subsection (1) does not apply to care or services provided directly to an injured worker by a treating ~~physician~~ provider with an ownership interest in a managed care organization that has been certified by the department."

Section 12. Section 39-72-303, MCA, is amended to read:

"**39-72-303. Which employer liable.** (1) Where compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

(2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time the occupational disease was first diagnosed by a treating ~~physician~~ provider or medical panel; or

(b) the time the employee knew or should have known that the condition was the result of an occupational disease.

(3) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section."

NEW SECTION. **Section 13. Code commissioner instruction.** Wherever a reference to "treating physician" or "primary care physician" is used in reference to Title 39, chapters 71 or 72, in legislation enacted by the 1997 legislature, the code commissioner is directed to change it to an appropriate reference to "treating provider" or "primary care provider", respectively.

-END-

HOUSE BILL NO. 519

INTRODUCED BY WYATT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING AN ADVANCED PRACTICE REGISTERED NURSE THAT IS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST TO PROVIDE SERVICES AS A TREATING PROVIDER AND A PRIMARY CARE PROVIDER UNDER THE WORKERS' COMPENSATION ACT; CHANGING THE TERM "TREATING PHYSICIAN" TO "TREATING PROVIDER" AND "PRIMARY CARE PHYSICIAN" TO "PRIMARY CARE PROVIDER"; AND AMENDING SECTIONS 39-71-116, 39-71-315, 39-71-701, 39-71-704, 39-71-711, 39-71-1101, 39-71-1102, 39-71-1105, 39-71-1106, 39-71-1107, 39-71-1108, AND 39-72-303, MCA."

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

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

APPROVED BY COM ON LABOR
& EMPLOYMENT RELATIONS

HOUSE BILL NO. 519

INTRODUCED BY WYATT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING AN ADVANCED PRACTICE REGISTERED NURSE THAT IS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST TO PROVIDE SERVICES AS A TREATING PROVIDER AND A PRIMARY CARE PROVIDER UNDER THE WORKERS' COMPENSATION ACT; ~~CHANGING THE TERM "TREATING PHYSICIAN" TO "TREATING PROVIDER" AND "PRIMARY CARE PHYSICIAN" TO "PRIMARY CARE PROVIDER";~~ AND AMENDING ~~SECTIONS~~ SECTION 39-71-116, ~~39-71-315, 39-71-701, 39-71-704, 39-71-711, 39-71-1101, 39-71-1102, 39-71-1105, 39-71-1106, 39-71-1107, 39-71-1108, AND 39-72-303,~~ MCA."

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

Section 1. Section 39-71-116, MCA, is amended to read:

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

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "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) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

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

(3) "Aid or sustenance" means any public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole

dollar number and must be adopted by the department prior to July 1 of each year.

(5) "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 18 years of age;

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

(d) an invalid child over 18 years of age 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 a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

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

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

(8) "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, salespersons, 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.

(9) "Days" means calendar days, unless otherwise specified.

(10) "Department" means the department of labor and industry.

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

(12) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include

employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(13) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(14) "Invalid" means one who is physically or mentally incapacitated.

(15) "Limited liability company" is as defined in 35-8-102.

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

(17) "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.

(18) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

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

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

(21) "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 has not operated a sufficient or any length of time during 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 average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of 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.

(22) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

(23) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker 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.

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

(25) "Primary medical services" means treatment prescribed by a treating ~~physician~~ ~~provider~~ PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability.

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

(27) "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.

(28) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

(29) (a) "Secondary medical services" means those medical services or appliances that are 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 programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection (29), "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.

(ii) Disability does not mean a purely medical condition.

(30) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

(31) "Temporary partial disability" means a physical condition resulting from an injury, as defined

in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

(32) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(33) "Temporary total disability" means a physical 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.

(34) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(35) "Treating ~~physician~~ ~~provider~~ 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 (35)(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; or

(f) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, ~~AND~~ RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST, AND PRACTICING IN CONSULTATION WITH A PHYSICIAN LICENSED UNDER TITLE 37,

CHAPTER 3, IF THERE IS NOT A TREATING PHYSICIAN, AS DEFINED IN SUBSECTION (35)(A), IN THE AREA IN WHICH THE ADVANCED PRACTICE REGISTERED NURSE IS LOCATED.

(36) "Year", unless otherwise specified, means calendar year."

~~**Section 2.** Section 39-71-315, MCA, is amended to read:~~

~~"**39-71-315. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):~~

~~(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or~~

~~(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.~~

~~(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty.~~

~~(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician~~ provider ~~with an ownership interest in a managed care organization that has been certified by the department."~~

~~**Section 3.** Section 39-71-701, MCA, is amended to read:~~

~~"**39-71-701. Compensation for temporary total disability -- exception.** (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:~~

~~(a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing; or~~

~~(b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.~~

~~(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.~~

~~(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for~~

~~the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).~~

~~(4) If the treating physician~~ provider ~~releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available for any reason to the worker and the worker continues to be temporarily totally disabled, as defined in 39-71-116.~~

~~(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.~~

~~(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.~~

~~(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301."~~

~~**Section 4.** Section 39-71-704, MCA, is amended to read:~~

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

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

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

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

~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury 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.~~

~~(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~~ provider ~~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~~ provider ~~shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician~~ provider ~~may request approval from the department for the treatment. The department shall appoint a panel of physicians~~ providers, ~~including at least one treating physician~~ provider ~~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 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 39-71-1109.~~

~~(3) The department shall establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates 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) 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~~ provider;

~~(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 5.** 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 healing;~~

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

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

~~(d) must be established by objective medical findings.~~

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

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

~~**Section 6.** Section 39-71-1101, MCA, is amended to read:~~

~~"**39-71-1101. Choice of physician providers by worker -- change of physician provider -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician provider within the state of Montana.~~

~~(2) Authorization by the insurer is required to change treating physicians providers. 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 provider, who shall then serve as the worker's treating physician provider.~~

~~(3) A medical service provider who otherwise qualifies as a treating physician provider 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 39-71-1104. The designated treating physician provider in the managed care organization then becomes the worker's treating physician provider. 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."~~

~~**Section 7.** Section 39-71-1102, MCA, is amended to read:~~

~~"**39-71-1102. 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 suppliers of soft and durable medical goods and 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 provider under 39-71-1101(1)."~~

~~**Section 8.** Section 39-71-1105, MCA, is amended to read:~~

~~"**39-71-1105. 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~~ providers ~~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~~ provider ~~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~~ provider ~~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~~ provider ~~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"~~ provider" ~~means a physician~~ provider ~~who is qualified to be a treating physician~~ provider ~~and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor~~, ~~or an advanced practice registered nurse WHO IS RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST~~.

~~(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."~~

~~Section 9.~~ ~~Section 39-71-1106, MCA, is amended to read:~~

~~"39-71-1106. 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 provider;~~

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

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

~~**Section 10.** Section 39-71-1107, MCA, is amended to read:~~

~~"**39-71-1107. 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 provider 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 hourly wage, and the insurer is not liable for more than 8 hours of care per day."~~

~~**Section 11.** Section 39-71-1108, MCA, is amended to read:~~

~~"**39-71-1108. Physician Provider self-referral prohibition.** (1) Unless authorized by the insurer, a treating physician provider may not refer a claimant to a health care facility at which the physician provider does not directly provide care or services when the physician provider 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.~~

~~(2) Subsection (1) does not apply to care or services provided directly to an injured worker by a treating physician provider with an ownership interest in a managed care organization that has been certified by the department."~~

~~**Section 12.** Section 39-72-303, MCA, is amended to read:~~

~~"**39-72-303. Which employer liable.** (1) Where compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.~~

~~(2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:~~

~~(a) the time the occupational disease was first diagnosed by a treating physician provider or medical panel; or~~

~~(b) the time the employee knew or should have known that the condition was the result of an occupational disease.~~

~~(3) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any~~

~~liability under this section."~~

~~NEW SECTION. **Section 13. Code commissioner instruction.** Whenever a reference to "treating physician" or "primary care physician" is used in reference to Title 39, chapters 71 or 72, in legislation enacted by the 1997 legislature, the code commissioner is directed to change it to an appropriate reference to "treating provider" or "primary care provider", respectively.~~

-END-

HOUSE BILL NO. 519

INTRODUCED BY WYATT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING AN ADVANCED PRACTICE REGISTERED NURSE THAT IS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST TO PROVIDE SERVICES AS A TREATING PROVIDER AND A PRIMARY CARE PROVIDER UNDER THE WORKERS' COMPENSATION ACT; ~~CHANGING THE TERM "TREATING PHYSICIAN" TO "TREATING PROVIDER" AND "PRIMARY CARE PHYSICIAN" TO "PRIMARY CARE PROVIDER";~~ AND AMENDING ~~SECTIONS~~ SECTION 39-71-116, ~~39-71-315, 39-71-701, 39-71-704, 39-71-711, 39-71-1101, 39-71-1102, 39-71-1105, 39-71-1106, 39-71-1107, 39-71-1108, AND 39-72-303,~~ MCA."

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

Section 1. Section 39-71-116, MCA, is amended to read:

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

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "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) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

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

(3) "Aid or sustenance" means any public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department. It is established at the nearest whole

dollar number and must be adopted by the department prior to July 1 of each year.

(5) "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 18 years of age;

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

(d) an invalid child over 18 years of age 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 a beneficiary, as defined in subsections (5)(a) through (5)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (5)(a) through (5)(e), does not exist.

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

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

(8) "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, salespersons, 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.

(9) "Days" means calendar days, unless otherwise specified.

(10) "Department" means the department of labor and industry.

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

(12) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work, but does not include

employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(13) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

(14) "Invalid" means one who is physically or mentally incapacitated.

(15) "Limited liability company" is as defined in 35-8-102.

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

(17) "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.

(18) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

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

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

(21) "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 has not operated a sufficient or any length of time during 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 average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of 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.

(22) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work; and

(c) has an actual wage loss as a result of the injury.

(23) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker 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.

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

(25) "Primary medical services" means treatment prescribed by a treating ~~physician~~ ~~provider~~ PHYSICIAN, for conditions resulting from the injury, necessary for achieving medical stability.

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

(27) "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.

(28) "Reasonably safe tools and appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

(29) (a) "Secondary medical services" means those medical services or appliances that are 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 programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection (29), "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.

(ii) Disability does not mean a purely medical condition.

(30) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

(31) "Temporary partial disability" means a physical condition resulting from an injury, as defined

in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

(32) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(33) "Temporary total disability" means a physical 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.

(34) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

(35) "Treating ~~physician" provider"~~ 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 (35)(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; or

(f) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8, ~~AND~~ RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST, AND PRACTICING IN CONSULTATION WITH A PHYSICIAN LICENSED UNDER TITLE 37,

CHAPTER 3, IF THERE IS NOT A TREATING PHYSICIAN, AS DEFINED IN SUBSECTION (35)(A), IN THE AREA IN WHICH THE ADVANCED PRACTICE REGISTERED NURSE IS LOCATED.

(36) "Year", unless otherwise specified, means calendar year."

~~**Section 2.** Section 39-71-315, MCA, is amended to read:~~

~~**"39-71-315. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):~~

~~(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or~~

~~(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.~~

~~(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty.~~

~~(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician provider with an ownership interest in a managed care organization that has been certified by the department."~~

~~**Section 3.** Section 39-71-701, MCA, is amended to read:~~

~~**"39-71-701. Compensation for temporary total disability -- exception.** (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:~~

~~(a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing; or~~

~~(b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.~~

~~(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.~~

~~(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for~~

~~the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).~~

~~(4) If the treating physician provider releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available for any reason to the worker and the worker continues to be temporarily totally disabled, as defined in 39-71-116.~~

~~(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.~~

~~(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.~~

~~(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301."~~

~~**Section 4.** Section 39-71-704, MCA, is amended to read:~~

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

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

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

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

~~(d) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury 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.~~

~~(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~~ provider ~~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~~ provider ~~shall first request approval from the insurer for the treatment. If approval is not granted, the treating physician~~ provider ~~may request approval from the department for the treatment. The department shall appoint a panel of physicians~~ providers, ~~including at least one treating physician~~ provider ~~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 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 39-71-1109.~~

~~(3) The department shall establish rates for hospital services necessary for the treatment of injured workers. Beginning January 1, 1995, the rates 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) 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 provider;~~

~~(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 5.** 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 healing;~~

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

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

~~(d) must be established by objective medical findings.~~

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

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

~~**Section 6.** Section 39-71-1101, MCA, is amended to read:~~

~~"**39-71-1101. Choice of physician providers by worker -- change of physician provider -- receipt of care from managed care organization.** (1) Subject to subsection (3), a worker may choose the initial treating physician provider within the state of Montana.~~

~~(2) Authorization by the insurer is required to change treating physicians providers. 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 provider, who shall then serve as the worker's treating physician provider.~~

~~(3) A medical service provider who otherwise qualifies as a treating physician provider 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 39-71-1104. The designated treating physician~~ provider in the ~~managed care organization then becomes the worker's treating physician~~ provider. ~~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."~~

~~**Section 7.** Section 39-71-1102, MCA, is amended to read:~~

~~"**39-71-1102. 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 suppliers of soft and durable medical goods and 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~~ provider ~~under 39-71-1101(1)."~~

~~**Section 8.** Section 39-71-1105, MCA, is amended to read:~~

~~"**39-71-1105. 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~~ providers ~~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~~ provider ~~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~~ provider ~~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~~ provider ~~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"~~ provider" ~~means a physician~~ provider ~~who is qualified to be a treating physician~~ provider ~~and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor, or an advanced practice registered nurse WHO IS RECOGNIZED BY THE BOARD OF NURSING AS A NURSE PRACTITIONER OR A CLINICAL NURSE SPECIALIST.~~

~~(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."~~

~~**Section 9.** Section 39-71-1106, MCA, is amended to read:~~

~~**"39-71-1106. 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 provider;~~

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

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

~~**Section 10.** Section 39-71-1107, MCA, is amended to read:~~

~~"**39-71-1107. 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 provider 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 hourly wage, and the insurer is not liable for more than 8 hours of care per day."~~

~~**Section 11.** Section 39-71-1108, MCA, is amended to read:~~

~~"**39-71-1108. Physician Provider self-referral prohibition.** (1) Unless authorized by the insurer, a treating physician provider may not refer a claimant to a health care facility at which the physician provider does not directly provide care or services when the physician provider 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.~~

~~(2) Subsection (1) does not apply to care or services provided directly to an injured worker by a treating physician provider with an ownership interest in a managed care organization that has been certified by the department."~~

~~**Section 12.** Section 39-72-303, MCA, is amended to read:~~

~~"**39-72-303. Which employer liable.** (1) Where compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.~~

~~(2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:~~

~~(a) the time the occupational disease was first diagnosed by a treating physician provider or medical panel; or~~

~~(b) the time the employee knew or should have known that the condition was the result of an occupational disease.~~

~~(3) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any~~

~~liability under this section."~~

~~NEW SECTION. **Section 13. Code commissioner instruction.** Wherever a reference to "treating physician" or "primary care physician" is used in reference to Title 39, chapters 71 or 72, in legislation enacted by the 1997 legislature, the code commissioner is directed to change it to an appropriate reference to "treating provider" or "primary care provider", respectively.~~

-END-