IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2000 MTWCC 74

WCC No. 2000-0102

CARL ALOCCO

Petitioner

vs.

CIGNA INSURANCE

Respondent/Insurer for

MONTANA REFINING COMPANY

Employer.

DECISION AND JUDGMENT

Summary: Insurer denied liability for claimant's surgery. The denial was adjudicated and this Court held that it was in fact compensable and that the insurer must pay medical bills. 1999 MTWCC 37. Claimant then filed this petition alleging that since his health insurer paid many of the bills he should be reimbursed for his health care insurance co-payments and deductibles.

Held: The liability of the insurer is governed by statute, which specifies a fee schedule for medical payments. Medical providers are limited to those fees and in light of the insurer's denial of liability it has a duty to assist claimant in recovering amounts he paid which are in excess of co-payments specified in section 39-71-704.

Topics:

Benefits: Medical. An insurer's liability for medical benefits is limited to fee schedules promulgated by the Department of Labor and Industry pursuant to section 39-71-704 (1995). Denial of a claim does not increase its liability.

Benefits: Medical. A claimant's liability to medical providers for medical care related to his industrial injury is limited to the co-payments required by 39-71-704(7). Any amounts paid by a claimant in excess of those co-payments must be refunded by the providers.

Benefits: Medical. Where the insurer denies liability for medical services and claimant pays for those services, in whole or in part, and the insurer is later found liable for the

services, the insurer has a duty to assist claimant in seeking repayment from the medical providers.

Insurers: Duties. Where the insurer denies liability for medical services and claimant pays for those services, in whole or in part, and the insurer is later found liable for the services, the insurer has a duty to assist claimant in seeking repayment from the medical providers.

¶1 The claimant in this matter seeks to enforce a prior judgment of this Court ordering CIGNA to pay medical benefits and temporary total disability benefits. *Alocco v. Cigna Insurance,* 1999 MTWCC 37. Only the medical benefits are at issue here.

The judgment regarding medical benefits was as follows:

¶48 1. Petitioner is entitled to medical benefits for the surgery of May 9, 1997, and all medical treatments as a result of his injury and surgery, including chiropractic treatments in 1996 and 1997 for his low back and Dr. Margaris' April 1997 examination.

In his petition, the claimant alleges that some bills are in dispute and that the insurer has not fully reimbursed him for other bills. He argues that he should be reimbursed in full for all of his out-of-pocket medical expenses by CIGNA. Thus, he would not have to seek to recoup any amounts he already paid to physicians and hospitals.

¶2 The matter is submitted on briefs and attached documents. The facts are not in dispute.

DISCUSSION

¶3 The insurer denied liability for claimant's 1997 surgery. As a result of the denial, claimant's healthcare insurer paid many of his bills. Those payments, however, were subject to co-payments and deductibles, thus, claimant paid the difference between what his health insurer paid and the amount charged by the healthcare providers. He also paid amounts not covered by his health insurance.

¶4 Following this Court's judgment in the first case, the insurer paid claimant's healthcare providers at the rates fixed by the Department of Labor pursuant to section 39-71-704, MCA (1995). Providers reimbursed the claimant's heath care insurer but did not reimburse claimant for amounts he paid. Claimant requests that the Court order CIGNA to make "full payment" of his medical bills.

¶5 In its response, CIGNA agrees it should reimburse the claimant in full for medical bills, including prescription drugs, not covered by his healthcare insurance and which he paid directly. However, it disputes his request for payment with respect to medical bills previously paid by his healthcare insurer.

¶6 Liability for the medical bills of an injured worker is governed by statute. The statutes are unequivocal and clear.

¶7 Except for co-payments specified in section 39-71-704(7), MCA (1995), the insurer, not the injured worker, is responsible for medical bills related to the worker's industrial injury. As relevant to the issues in this case, section 39-71-704(1), MCA (1995), provides in part:

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.

. . . .

Section 39-71-743(3), MCA (1995), confirms the responsibility of the insurer for medical bills except the co-payments specified in section 39-71-704(7), providing:

(3) After determination that the claim is covered under the Workers' Compensation Act or Occupational Disease Act of Montana, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(7), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

Section 39-71-704(7) sets out the claimant's responsibility for co-payments, providing in relevant part:

(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.

. . . .

¶8 As set forth in the quoted sections, claimant is responsible for the co-payments provided in section 39-71-704(7), MCA. He is not entitled to reimbursement for those amounts.

¶9 The question remains whether CIGNA must reimburse claimant for amounts over and above section 31-71-704(7), MCA, which he paid as deductibles or co-payments and for which medical providers have not reimbursed him. Subsections (2) through (6) of section 39-71-704, MCA (1995), provide the answer:

(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 rate setting 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.

These sections require the Department to fix rates of reimbursement to medical providers. In so providing, and in further providing, (1) in subsection (6) that disputes between a medical service provider and an insurer concerning the amount of reimbursement due the provider must be adjudicated by the Department, and (2) in section 39-71-743(3), MCA, that claimants are responsible only for the co-payments set out in section39-71-704(7), MCA, the legislature has made it apparent and clear that medical providers may charge only the fees specified by the Department and the statutory co-payments. It is equally clear that the insurer's liability is limited to the amounts prescribed by the Department. The fact that medical service providers have failed to comply with the statutes by failing to return to claimant the monies exceeding the statutory amounts does not increase the insurer's liability.

¶10 Medical service providers who are retaining amounts in excess of that allowed under the fee schedule promulgated by the Department are violating sections 39-71-704 and 39-71-743, MCA. Certainly, claimant can pursue the providers for reimbursement. Moreover, since its denial of reimbursement forced claimant to make payment in the first place, CIGNA has a duty to claimant to assist him in prosecuting such claims. At a minimum, CIGNA must notify medical providers of the statutory limitations on their fees and that they are prohibited from charging the claimant any fee other than the co-payment provided in section 39-71-704(7), MCA. If that notice does not produce refunds to claimant, then CIGNA must consider whether the receipt of payments in excess of the statutory amounts creates a dispute under 39-71-704(6), MCA, which it should prosecute.

JUDGMENT

¶11 CIGNA is not liable for medical payments in excess of the amounts fixed by the Department of Labor and Industry pursuant to section 39-71-704, MCA (1995).

¶12 CIGNA, however, has a duty to assist claimant in securing repayment of amounts he paid to medical providers in excess of the co-payments required by section 39-71-704(7), MCA (1995). Specifically, CIGNA has a duty to notify the medical service providers that they are prohibited from charging the claimant in excess of the statutory co-payment, and should at least consider whether it has standing to maintain a legal action if repayments are not made to claimant.

¶13 The Court retains continuing jurisdiction with respect to medical bills which claimant alleges should be paid but have not been paid. At present, the Court is unable to discern whether there are any such bills.

¶14 This judgment is certified as final for purposes of appeal pursuant to ARM 24.5.348.

DATED in Helena, Montana, this 6th day of December, 2000.

(SEAL)

/s/ Mike McCarter
JUDGE

c: Mr. Cameron Ferguson
Mr. G. Andrew Adamek
Submitted: November 8, 2000