

SENATE BILL NO. 78

INTRODUCED BY M. MCNALLY

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING AN INJURED WORKER WITH A 90-DAY NOTICE OF A WORKERS' COMPENSATION CLAIM CLOSURE AND NOTICE OF REMEDIES; AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

Section 1. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates

-- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury or occupational disease and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services, including prescription drugs for conditions that are a direct result of the compensable injury or occupational disease, for those periods specified in this section.

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

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

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a health care provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable

1 for the worker's medical condition. The rules must exclude from reimbursement:

2 (A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by
3 the insurer pursuant to 39-71-605;

4 (B) travel to a health care provider within the community in which the worker resides;

5 (C) travel outside the community in which the worker resides if comparable medical treatment is available
6 within the community in which the worker resides, unless the travel is requested by the insurer; and

7 (D) travel for unauthorized treatment or disallowed procedures.

8 (iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel
9 or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the
10 travel and treatment were required.

11 (e) Pursuant to rules adopted by the department, an insurer shall reimburse a catastrophically injured
12 worker's family or, if a family member is unavailable, a person designated by the injured worker or approved by
13 the insurer for travel assistance expenditures in an amount not to exceed \$2,500 to be used as a match to those
14 funds raised by community service organizations to help defray the costs of travel and lodging expenses incurred
15 by the family member or designated person when traveling to be with the injured worker. These funds must be
16 paid in addition to any travel expenses paid by an insurer for a travel companion when it is medically necessary
17 for a travel companion to accompany the catastrophically injured worker.

18 (f) (i) The benefits provided for in this section terminate 60 months from the date of injury or diagnosis
19 of an occupational disease. A worker may request reopening of medical benefits that were terminated under this
20 subsection (1)(f) as provided in 39-71-717.

21 (ii) Subsection (1)(f)(i) does not apply to a worker who is permanently totally disabled as a result of a
22 compensable injury or occupational disease or for the repair or replacement of a prosthesis furnished as a direct
23 result of a compensable injury or occupational disease.

24 (iii) If an injured worker has received medical benefits within 12 months of when the injured worker's
25 medical benefits are due to terminate under subsection (1)(f)(i), the insurer shall notify the injured worker between
26 90 and 120 days prior to the date of benefit termination that the injured worker's benefits are due to expire. The
27 notification under this subsection (1)(f)(iii) must also describe available remedies for addressing the termination
28 of benefits.

29 (g) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has
30 achieved medical stability, palliative or maintenance care except:

1 (i) when provided to a worker who has been determined to be permanently totally disabled and for whom
2 it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically
3 stationary condition;

4 (ii) when necessary to monitor the status of a prosthetic device; or

5 (iii) when the worker's treating physician believes that the care that would otherwise not be compensable
6 under this subsection (1)(g) is appropriate to enable the worker to continue current employment or that there is
7 a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or
8 maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers'
9 compensation court has jurisdiction.

10 (h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice
11 of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any
12 medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

13 (2) (a) The department shall annually establish a schedule of fees for medical services that are
14 necessary for the treatment of injured workers. Regardless of the date of injury, payment for medical services
15 is based on the fee schedule rates in this section in effect on the date on which the medical service is provided.
16 Charges submitted by providers must be the usual and customary charges for nonworkers' compensation
17 patients. The department may require insurers to submit information to be used in establishing the schedule.

18 (b) (i) The department may not set the rate for medical services at a rate greater than 10% above the
19 average of the conversion factors used by up to the top five insurers or third-party administrators providing group
20 health insurance coverage within this state who use the resource-based relative value scale to determine fees
21 for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy
22 at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

23 (ii) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their
24 standard conversion rates to the department.

25 (iii) The department may use the conversion rates only for the purpose of determining average conversion
26 rates under this subsection (2).

27 (iv) The department shall maintain the confidentiality of the conversion rates.

28 (c) The fee schedule rates established in subsection (2)(b), when adopted, must be based on the
29 following standards as adopted by the centers for medicare and medicaid services, regardless of where services
30 are provided:

- 1 (i) the American medical association current procedural terminology codes, as those codes exist on
2 January 1 of each year;
- 3 (ii) the healthcare common procedure coding system, as those codes and their relative weights exist on
4 January 1 of each year;
- 5 (iii) the medicare severity diagnosis-related groups, as those codes and their relative weights exist on
6 January 1 of each year;
- 7 (iv) the ambulatory payment classifications, as those codes and their relative weights exist on January
8 1 of each year;
- 9 (v) the ratio of costs to charges for each hospital, as those codes exist on January 1 of each year;
- 10 (vi) the national correct coding initiative edits, as those codes exist on January 1 of each year; and
- 11 (vii) the relative value units in the published resource-based relative value scale, as those codes exist
12 on January 1 of each year.
- 13 (d) The department may establish additional codes and coding standards for use by providers when
14 billing for medical services under this section.
- 15 (3) (a) The department shall establish by rule evidence-based utilization and treatment guidelines for
16 primary and secondary medical services. There is a rebuttable presumption that the adopted utilization and
17 treatment guidelines establish compensable medical treatment for an injured worker.
- 18 (b) (i) The department may adopt a drug formulary as part of its utilization and treatment guidelines. To
19 implement this section, the department may annually adopt by rule an evidence-based commercial or other
20 evidence-based drug formulary as part of its utilization and treatment guidelines.
- 21 (ii) If the department adopts a commercial drug formulary, the formulary automatically includes all of the
22 changes and updates furnished by the commercial vendor that are made during the year. This process is
23 independent of the provisions of 2-4-307.
- 24 (iii) If the department adopts a drug formulary, the department shall, by rule, provide for:
- 25 (A) an appropriate transition of treatment, if the treatment began prior to the adoption of a drug formulary,
26 to treatment that is consistent with the application of the formulary; and
- 27 (B) a timely and responsive dispute resolution process for disputes related to use of the formulary.
- 28 (c) An insurer is not responsible for treatment or services that do not fall within the utilization and
29 treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer.
30 If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for

1 payment of the medical treatment or services.

2 (d) The department, in consultation with health care providers with relevant experience and education,
3 shall provide for an annual review of the evidence-based utilization and treatment guidelines to consider
4 amendments or changes to the guidelines.

5 (4) The department shall hire a medical director. The department may establish by rule an independent
6 medical review process for treatment or services denied by an insurer pursuant to subsection (3) prior to
7 mediation under 39-71-2401.

8 (5) For services available in Montana, insurers may pay facilities located outside Montana according to
9 the workers' compensation fee schedule of the state where the medical service is performed.

10 (6) (a) An insurer shall make payments at the fee schedule rate within 30 days of receipt of medical bills
11 for which a claim has been accepted and for which no other disputes exist. Disputes must be defined by the
12 department by rule.

13 (b) Any unpaid balance under this subsection (6) accrues interest at 12% a year or 1% a month or a
14 fraction of a month. If the charge is not paid within 30 days, interest on the unpaid balance accrues from the date
15 of receipt of the original billing.

16 (7) Once a determination has been made regarding the correct reimbursement amount, any
17 overpayment made to a health care provider must be reimbursed to the insurer within 30 days of the
18 determination. Any reimbursement amount remaining unpaid after 30 days accrues interest at 12% a year or 1%
19 a month or a fraction of a month. Interest on the reimbursement amount remaining unpaid accrues from the date
20 of receipt of the determination of the correct reimbursement amount.

21 (8) For a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual
22 and customary charge.

23 (9) Payment pursuant to reimbursement agreements between managed care organizations or preferred
24 provider organizations and insurers is not bound by the provisions of this section.

25 (10) After mediation pursuant to department rules, an unresolved dispute between an insurer and a health
26 care provider regarding the amount of a fee for medical services may be brought before the workers'
27 compensation court.

28 (11) (a) After the initial visit, the worker is responsible for \$25 of the cost of each subsequent visit to a
29 hospital emergency department for treatment relating to a compensable injury or occupational disease.

30 (b) "Visit", as used in this subsection (11), means each time that the worker obtains services relating to

- 1 a compensable injury or occupational disease from:
- 2 (i) a treating physician;
- 3 (ii) a physical therapist;
- 4 (iii) a psychologist; or
- 5 (iv) hospital outpatient services available in a nonhospital setting.
- 6 (c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (11)(a) if the visit
- 7 is for treatment requested by an insurer."

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9 NEW SECTION. **Section 2. Effective date.** [This act] is effective July 1, 2019.

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