IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

2005 MTWCC 33

WCC No. 2004-1091

JANIE L. ROBINSON

Petitioner

vs.

MONTANA STATE FUND

Respondent/Insurer.

ORDER GRANTING PARTIAL SUMMARY JUDGMENT

Summary: Cross-motions for summary judgment were filed with respect to the petitioner's constitutional challenge to the managed care provisions found in Title 39, ch. 71, part 11, MCA (1995).

Held: Petitioner lacks standing to challenge the constitutionality of statutes which have not been applied to her and where she has not been threatened with their application.

Topics:

Constitutional Law: Standing. Only those affected by a statute can challenge the constitutionality of the statute.

Constitutional Law: Standing. Where the claimant has not been required to seek her medical care from a managed care organization or preferred provider organization, and there is no indication that she will ever be required to do so, she lacks standing to challenge the constitutionality of statutes authorizing insurers to refer claimants to managed care organizations and preferred provider organizations for medical care related to their industrial injuries.

Managed Care Organizations. Where a claimant has not been required to seek her medical care from a managed care organization or preferred provider organization, and there is no indication that she will ever be required

to do so, she lacks standing to challenge the constitutionality of statutes authorizing insurers to refer claimants to managed care organizations and preferred provider organizations for medical care related to their industrial injuries.

¶1 The petition herein sets out two causes of action. The first challenges the constitutionality of sections 39-71-1101 through 39-71-1108, MCA (1995). The second alleges that medical benefits have been unreasonably delayed and seeks a penalty. Both parties have moved for summary judgment with respect to the first cause of action.

Uncontested Facts

¶2 The respondent, Montana State Fund (State Fund), filed the first motion for summary judgment. The motion was supported by two affidavits, as well as the pleadings in the case. The motion sets forth five facts. None have been controverted by the petitioner (claimant), therefore, they are deemed true for purposes of the motion. Those facts, as appear from the affidavits and pleadings, are as follows:[1]

¶2a The petitioner has filed several workers' compensation claims; however, the only claim at issue in the present case is one for an alleged injury on July 4, 1996.

¶2b The alleged injury was for a possible heat stroke suffered by the claimant while baling hay on July 4, 1996.

¶2c The claimant's employer was insured by the State Fund on the date of the alleged injury.

¶2d The State Fund utilizes a managed care organization (hereinafter "MCO" or "MCOs") in the management of some of its claims. The MCO it uses is Montana Health Systems. However, the claimant has never used that MCO.

¶2e With respect to the July 4, 1996 claim, the claimant's only involvement with a preferred provider organization (hereinafter "PPO" or "PPOs") has been since May 2004 with Plaza Pharmacy in Great Falls, Montana. Plaza Pharmacy became a PPO member pharmacy in May 2004. However, the claimant used the pharmacy prior to its becoming a PPO member.

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[1] The Court has paraphrased the State Fund's statement of facts.

¶3 In addition to the foregoing facts, two other facts are apparent from the pleadings and the parties' briefs, and should be expressly stated. Those facts are:

> ¶3a The State Fund accepted liability for the claimant's July 4, 1996 injury.
>
> ¶3b The State Fund has paid medical benefits with respect to the claim.

¶4 The claimant has, on her part, provided the Court with numerous other facts she contends are uncontested. Those facts relate to specific medical care the claimant has sought or received and the State Fund's involvement in that care by way of questions it put to medical providers, its authorization for specific treatment, and its requests for and monitoring of specific treatment plans. In view of this Court's determination that the claimant lacks standing to pursue her first cause of action, it is unnecessary to sort through all of the facts she proffers. However, specific examples from her proffer will be set out in the discussion that follows:

STANDARD OF REVIEW

¶5 The moving party must establish that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Rule 24.5.329; *Farmers Union Mut. Ins. Co. v. Horton,* 2003 MT 79, ¶ 10, 315 Mont. 43, 67 P.3d 285. The moving party need not demonstrate that all facts are uncontested, only that the facts material to the motion and to the point of law upon which the summary judgment motion is based are not genuinely disputed.

SUMMARY JUDGMENT ISSUES

¶6 In her first cause of action, the claimant requests the Court to enter a declaratory judgment finding sections 39-71-1101 through 39-71-1108, MCA (1995), unconstitutional. She urges that the managed care provisions of these sections violate the Individual Dignity Clause – Article II, § 3 – of the Montana Constitution and the Privacy Clause – Article II, § 10 – of the Montana Constitution.

¶7 The claimant filed a motion for summary judgment on the merits of her claim. On its part, the State Fund has filed a motion for partial summary judgment seeking to dismiss the constitutional challenge on the ground that the claimant lacks standing to attack the managed care statutes. The State Fund further argues that the statutes are in any event constitutional.

STATUTES IN QUESTION

¶8 Part 11, chapter 71 of Title 39, is entitled "Managed Care and Preferred Provider Organizations." A copy of the 1995 version of the part is appended to this decision.

¶9 As a general matter, Part 11 provides that insurers may require claimants to seek medical care for workers' compensation injuries from MCOs and PPOs.

¶10 Part 11 does not define "managed care" or "managed care organization."[2] It does describe a "managed care system" in very general terms as

> a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to 39-71-1101, through appropriate health care professionals.

§ 39-71-1103(1), MCA (1995). "Managed care" is generally understood as signifying "a contractual arrangement whereby a third-party payer (e.g., insurance company, government agency, or corporation) mediates between physicians and patients, negotiating fees for service and overseeing the types of treatment given." *Stedman's Online Medical Dictionary,* 27th ed.

¶11 Similarly, part 11 provides no definition of a PPO. However, the term is generally understood to mean a group or network of health care providers who together contract to provide medical goods or services to PPO members or beneficiaries. *Stedman's Online Medical Dictionary,* 27th ed., defines the term as "a health care delivery model that uses a panel of eligible physicians." The services of preferred providers are typically provided through contracts with insurers, employers, governmental entities, or MCOs.

¶12 Section 39-71-1105, MCA (1995), provides for the establishment and certification of MCOs. Subsection (1) provides in relevant part:

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[2]Section 33-1-801(5), MCA, enacted in 1997 as part of the insurance code, defines an MCO as follows:

> (5) "Managed care organization" means an entity that manages, owns, contracts with, or employs health care providers to provide health care services under a health plan. The term includes a health maintenance organization, as defined in 33-31-102, and an entity that does not itself provide health plans.

> (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. . . .

Certification is through the Department of Labor and Industry. § 39-71-1105(2)-(4), MCA (1995).

¶13 To be certified as an MCO, the organization must provide a list of names of individual providers who will be providing medical services the MCO beneficiaries, the names of those providers who will serve as treating physicians, and descriptions of "the times, places, and manner" the MCOs will provide both primary and secondary medical services.[3] § 39-71-1105(3), MCA (1995).

¶14 The PPO provision allows for the establishment of organizations of providers to provide medical goods and services in conjunction with or supplemental to those provided by an MCO. Section 39-71-1102, MCA (1995), reads in relevant part:

> 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. . . .

(Emphasis added.)

¶15 Part 11 permits but does not require insurers to contract with MCOs to provide medical services to injured workers. Section 39-71-1103(3), MCA (1995), states that "[i]nsurers **may** contract with certified managed care organizations for medical services for injured workers." (Emphasis added.)

¶16 If an insurer does contract with one or more MCOs, it may require the worker to seek medical care through a designated MCO if the injury results in a loss of wages,

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[3]Section 39-71-704, MCA (1995), distinguishes between primary and secondary services. A discussion of those provisions is set out in *Hiett v. Missoula County Public Schools,* 2003 MT 213, 317 Mont. 95, 75 P.3d 341.

permanent impairment, treatment or evaluation by a specialist, or specialized medical testing. Section 39-71-1101(3), MCA (1995), provides:

> (3) A medical service provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:
> (a) the injury results in a total loss of wages for any duration;
> (b) the injury will result in permanent impairment;
> (c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or
> (d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.

While this subsection standing alone appears to mandate care through an MCO where the claimant loses wages, suffers an impairment, or needs specialized care and the insurer has contracted with an MCO, it in fact does not. The next subsection of 39-71-1101(4), MCA (1995), provides:

> (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 in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

(Emphasis added.) On its face, subsection (4) permits the insurer to authorize a claimant to seek medical care outside an established MCO or PPO.

¶17 Even where a claimant is directed to an MCO, there are specific provisions which allow the claimant to select a non-MCO treating physician in certain instances. Section 39-71-1101(3), MCA, quoted earlier, permits the insurer to authorize a non-MCO treating physician. Section 39-71-1105(4)(f), MCA (1995), requires the MCO to authorize a claimant to select a non-MCO primary physician where the claimant has previously been treated by the non-MCO physician and that physician agrees to refer the claimant back to

the MCO for specialized treatment and to comply with the MCO terms regarding services which would otherwise be performed by the MCO.[4]

¶18 Part 11 also sets out provisions for termination of benefits for a claimant's failure to cooperate with an MCO or treating physician, § 39-71-1106, MCA (1995); requirements concerning domiciliary care, § 39-71-1107, MCA (1995); a prohibition against a treating physician referring a claimant to a health facility in which the physician has a financial interest, § 39-71-1108, MCA (1995); and authorization for the Department of Labor and Industry to set up medical advisory committees. The provision authorizing medical advisory committees was repealed in 1997. 1997 Montana Laws, ch. 310, § 13.

Analysis and Decision

I. Standing

¶19 "[T]he rule is well settled that only those affected by an unconstitutional act will be heard to assert its invalidity." *Merchants' Nat'l Bank of Glendive v. Dawson County,* 93 Mont. 310, 19 P.2d 892, 900 (1933); *accord Thompson v. Tobacco Root Co-op. State Grazing Dist.*, 121 Mont. 445, 193 P.2d 811, 814 (1948) ("It is well settled that only those adversely affected by the operation of a statute will be heard to question its validity.").

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[4]The full text of 39-71-1105(4)(f), MCA (1995), reads:

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

Standing is a jurisdictional and threshold requirement to any constitutional challenge to a state statute. "The constitutional aspect of standing requires the plaintiff to show that plaintiff has been **personally** injured or threatened with immediate injury by the alleged constitutional . . . violation." *Missoula City-County Air Pollution Control Bd. v. Board of Environmental Review,* 282 Mont. 255, 937 P.2d 463, 466 (1997) (emphasis added). "The injury alleged must be personal to the plaintiff, as distinguished from an injury suffered by the community in general." *Carter v. Montana Dep't of Transp.,* 274 Mont. 39, 41-42, 905 P.2d 1102, 1104 (1995) (citing *Warth v. Seldin*, 422 U.S. 490 (1975).

¶20 The State Fund asserts that since the claimant has never been referred to an MCO and no threat has been made that she ever will be, she has not shown the prerequisite personal stake or injury to challenge managed care statutes. The Court agrees. Claimant has presented no facts indicating that she has been compelled to seek medical care from an MCO or through any PPO, nor has she presented any evidence that there is either a threat or reasonable likelihood that she will be compelled to do so at a later date.

¶21 The fact that the claimant has couched her constitutional challenge in terms of a request for declaratory judgment does not exempt her from standing requirements:

> The courts have no jurisdiction to determine matters purely speculative, enter anticipatory judgments, declare social status, deal with theoretical problems, give advisory opinions, answer moot questions, adjudicate academic matters, provide for contingencies which may hereafter arise, or give abstract opinions. The Uniform Declaratory Judgment Act does not license litigants to fish in judicial ponds for legal advice.

Montana Dep't of Natural Resources and Conservation v. Intake Water Co., 171 Mont. 416, 440, 558 P.2d 1110, 1123 (1976) (citation and quotation marks omitted).

¶22 The claimant asserts that her care has in fact been "managed" by the State Fund since it has requested information from her health care providers, has had her examined by providers it designated, and has directed her care by requiring, at least on one occasion, a treating physician to provide a treatment plan incorporating recommendations of one of the physicians who conducted an independent medical examination (IME) (see Ex. 7 to Petitioner's Memorandum in Opposition to Insurer's Motion for Summary Judgment and in Support of Petitioner's Motion for Summary Judgment). Those facts, however, do not confer standing for the claimant to attack statutes that are unrelated to the State Fund's actions. There is no allegation or fact showing that the IME physicians who examined the claimant were part of any MCO or PPO to which the claimant was referred. The claimant has not identified any provision of part 11 which authorized the State Fund to seek independent medical examinations, obtain the claimant's medical records, communicate with her physicians, or require treating physicians to provide treatment plans. Thus, the

claimant has presented no facts which would give her standing to attack the provisions for the establishment of MCOs and PPOs or the requirement that the claimant seek medical care from MCOs and PPOs when required by the insurer.

¶23 Moreover, the claimant has failed to identify any non-MCO provision of part 11 which is implicated in any of the actions she ascribes to the State Fund. As noted earlier, section 39-71-1106, MCA (1995), permits termination of benefits where a worker unreasonably fails to cooperate with her treating physician. However, there are no allegations that the claimant has failed to cooperate with her physicians or has been threatened with a cutoff of benefits on account of any such failure. Section 39-71-1108, MCA (1995), governs domiciliary benefits; however, there are no allegations indicating that the claimant is in need of domiciliary care. Finally, there are no allegations which implicate the prohibitions set out in section 39-71-1108, MCA (1995), concerning physician interest in health care facilities.

¶24 Even though the claimant has failed to identify any specific provision involved in the actions she finds objectionable, she argues that she has been subjected to "managed care" under the terms of part 11 because managed care is defined in section 39-71-1103(1), MCA (1995), as "managing the delivery of medical services for a defined population of injured workers . . . ." (Petitioner's Memorandum in Opposition to Insurer's Motion for Summary Judgment and in Support of Petitioner's Motion for Summary Judgment at 8.) The definition of "managed care," however, is simply that – a definition. In itself it confers no authority on the State Fund or other insurer to take the sort of actions to which the claimant objects.

¶25 The claimant urges that the State Fund's "only authority" for its actions is the "managed care" definition of section 39-71-1103(1), MCA. The claimant is mistaken.

¶26 Section 50-16-527(4), MCA (1995), provides that the claimant's signed claim constitutes authorization for medical care providers to furnish workers' compensation insurers with medical information relevant to the claim. Both sections 50-16-527 and 39-71-604, MCA, were amended in 2003 to authorize insurers to communicate directly with health care providers without prior notice to the claimant. The amendments were expressly retroactive.

¶27 Section 39-71-605, MCA, in 1995 and continuing to the present, requires a claimant to submit to an IME when requested by an insurer.

¶28 Moreover, insurers are liable only for "reasonable" medical services. § 39-71-704, MCA (1995). An insurer must have access to medical information adequate to determine what is reasonable.

¶29 Finally, even prior to the adoption of section 39-71-1106, MCA (1995), a claimant could not unreasonably refuse to submit to reasonable medical care. *Small v. Combustion Eng'g,* 209 Mont. 387, 681 P.2d 1081 (1984). The requirement stems from causation requirements of the Workers' Compensation Act. *See id.*

¶30 I conclude that the actions of the State Fund to which the claimant objects did not arise under part 11 of chapter 71, Title 39, and that the claimant lacks standing to challenge the constitutionality of that part. Her constitutional challenge must therefore be dismissed.

ORDER

¶31 The respondent's motion for partial summary judgment is **granted**. The claimant's cross-motion for partial summary judgment is **denied**.

¶32 The claimant's constitutional challenge to part 11, chapter 71, Title 39 is **dismissed**.

¶33 The claimant's request for a penalty regarding medical expenses shall be set for trial. A new scheduling order will follow this order.

DATED in Helena, Montana, this 29th day of June, 2005.

(SEAL)

MIKE McCARTER
JUDGE

c: Mr. Lawrence A. Anderson
Mr. Daniel B. McGregor
Attachment: §§ 39-71-1101 - 39-71-1109, MCA (1995)
Submitted: February 22, 2005

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

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

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

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

(b) the injury will result in permanent impairment;

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

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

(4) A worker whose injury is subject to the provisions of subsection (3) shall, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with 39-71-1104. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a medical service provider who is not a member of a managed care organization.

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 under 39-71-1101(1).

39-71-1103. Workers' compensation managed care. (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to 39-71-1101, through appropriate health care professionals.

(2) The department shall develop criteria pursuant to 39-71-1105 for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A worker who is subject to managed care may choose from managed care organizations in the worker's community that have a contract with the insurer responsible for the worker's medical services.

39-71-1104. Managed care organizations -- notification. Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in 39-71-1105. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

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 and who will be responsible for the coordination of medical services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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;

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

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

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 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.

39-71-1108. Physician self-referral prohibition. (1) Unless authorized by the insurer, a treating physician may not refer a claimant to a health care facility at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer or the claimant is not liable for charges incurred in violation of this section.

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

39-71-1109. Medical advisory committees -- composition -- function. (1) The department shall organize committees of representatives from the following medical provider groups:

(a) physicians;
(b) surgeons;
(c) chiropractors;
(d) physical therapists;
(e) psychologists; and
(f) hospitals.

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

(3) The department may seek recommendations for representatives from the state licensing boards governing the providers.