



ADMINISTRATIVE RULES OF MONTANA



37.86.5013 HEALTH MAINTENANCE ORGANIZATIONS: REIMBURSEMENT OF PROVIDERS

- (1) An HMO must reimburse a federally qualified health center or a rural health clinic which is a participating provider either the same payment per enrollee or service made to other primary care providers or the facility specific medicaid interim rate for each enrollee visit.
- (2) An HMO need not reimburse, except as otherwise provided in this rule, claims for medically necessary services provided by non-participating providers if the same service is covered by the HMO under its contract with the department.
- (3) An HMO must reimburse medically necessary family planning services as defined in ARM 37.86.5007(3) provided by a nonparticipating family planning provider to an enrollee who sought the services without referral.
- (4) An HMO must reimburse immunizations and blood lead testing provided by a public health clinic to an enrollee.
- (5) An HMO must reimburse nonparticipating providers for services for urgent conditions, emergencies or emergency room screenings provided to an enrollee.
- (6) An HMO, owned, controlled or sponsored by or affiliated with a religious organization, must reimburse a covered service received by an enrollee that the HMO does not make available due to the service constituting a violation of the religious tenets of the organization, to which the HMO is related.
- (7) An HMO is not responsible for reimbursement of the disproportionate share payments for inpatient hospital services provided to an enrollee.
- (8) An HMO must reimburse services for an urgent condition, emergency or emergency room screens in an amount that is not less than the department's medicaid rates for those services.

Authorizing statute(s): Sec. 53-2-201 and 53-6-113, MCA

Implementing statute(s): Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-116, MCA

History: NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481.