



ADMINISTRATIVE RULES OF MONTANA



37.86.5011 HEALTH MAINTENANCE ORGANIZATIONS: PROVISION OF SERVICES

- (1) An HMO may impose the following requirements in the provision of services:
 - (a) the use of certain types of providers;
 - (b) the preauthorization for services and use of network providers other than emergency services, family planning, immunizations and blood lead testing at a public health clinic;
 - (c) the use of network providers, on a self-referral basis, for obstetrical, gynecological, and maternity services;
 - (d) directing an enrollee to the appropriate level of care for receipt of covered services; and
 - (e) denial of payment to a provider for services provided to an enrollee if the participation requirements in this rule are not met by the enrollee; or
 - (f) if a recipient is mandated into an HMO and chooses to go to an FQHC that is not on the provider panel, approval for services is not required, but the recipient must inform the HMO before receiving services.
- (2) An enrollee must use the participating providers in the enrollee's HMO.
- (3) An enrolled recipient may use a nonparticipating provider in the following circumstances:
 - (a) the HMO authorizes a nonparticipating provider to provide a service;
 - (b) the enrollee receives a family planning service provided by a family planning provider as specified in ARM 37.86.5007(3) ;
 - (c) the enrollee receives an immunization or blood lead level testing provided by a public health clinic; or
 - (d) the enrollee receives services provided for an urgent condition or emergency or emergency room screen.
- (4) An HMO must provide covered services as listed in ARM 37.86.5007 to enrollees in the same manner as those services are provided to non-medicaid enrollees.
- (5) An HMO must make a reasonable effort to inform enrollees of alternate providers for noncovered services.
- (6) An HMO, at a minimum, must provide enrollees the same amount, scope and duration for covered services as would be available under regular medicaid for those covered services.

- (7) An HMO may at its discretion offer services to enrollees beyond the scope of medicaid as defined in ARM 37.85.206.
- (8) An HMO must ensure that services for urgent conditions and emergencies are available on an immediate basis 24 hours a day, 7 days a week.
 - (a) An HMO may require that follow-up treatment to an urgent condition or emergency be provided by HMO participating providers.

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. 1974, Eff. 9/29/95; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.