

State of Montana
Department of Labor & Industry
Brian Schweitzer, Governor

BUSINESS, LABOR & ECONOMIC AFFAIRS
EXHIBIT No. 2
DATE 1-26-07
BILL No. SB 304



Employment Relations Division

WC Claims Assistance Bureau
Claims Unit

TO: Attorneys, Insurers, Claims Examiners, Medical Providers and Interested Parties

RE: **First Report of Injury, release of medical information**

Thompson, et al, v. State of Montana
2005 MTWCC 53 (WCC No. 2004-1089)

In a recent decision on a petition for declaratory ruling, the Workers' Compensation Court held that section 39-71-604(3), MCA (2003), and section 50-16-527(5), MCA (2003), violate claimants' constitutional right of privacy as guaranteed by Mont. Const., Art. II, section 10, and no compelling state interest exists to justify such a violation. The Court also found that section 39-71-604(3) and section 50-16-527(5), MCA (2003), violate claimants' constitutional right to due process as guaranteed by Mont. Const., Art. II, section 17, and no rational basis exist to justify such a violation. *Thompson, et al, v. State of Montana*, 2005 MTWCC 53 (decided October 18, 2005).

In accordance with the *Thompson* decision, the Department has developed a revised **First Report of Injury or Occupational Disease Form (FROI)** – available on our website, <http://erd.dli.state.mt.us/>, under "Features", with the following release statement:

"This is my claim for worker' compensation benefits due to the on-the-job injury, occupational disease, or death of the above-named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records, and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

The language used in the revised form reflects the practices in place prior to the 2003 amendments to sections 39-71-604(3), MCA and 50-16-527(5), MCA. The claimant's signature on the FROI authorizes the release of information "directly relevant" to the claim to the workers' compensation insurer and the insurer's agents.

The Department believes, based on its reading of the *Thompson* decision, that an insurer is not required to obtain the consent of the claimant to seek medical information or to channel all its requests through the claimant or the claimant's attorney. It requires only that claimant or the attorney be notified in advance of any interview so that he or she may be present during the interview. In the case of correspondence, it requires that the claimant or the attorney be copied with the correspondence. *Linton v. City of Great Falls*, 230 Mont. 122, 134, P.2d 55, 63 (1988). The decision can be located on our web page, <http://erd.dli.state.mt.us/>, under "Features".

If you have questions, please contact: Carol Gleed (406) 444-6539 or Debra Blossom (406) 444-7732.

Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH		SOCIAL SECURITY NUMBER	
HOME ADDRESS				CITY		STATE	POSTAL CODE	
PHONE NUMBER	EDUCATION <input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARRIAGE STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> NOT MARRIED <input type="checkbox"/> UNKNOWN		NUMBER OF DEPENDANTS	

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY		DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT /	
EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER		NUMBER OF DAYS WORKED PER WEEK	WAGE	<input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED <input type="checkbox"/> ROOM & BOARD <input type="checkbox"/> OVERTIME <input type="checkbox"/> BONUS <input type="checkbox"/> COMMISSIONS <input type="checkbox"/> OTHER			ESTIMATED VALUE IF ANY	TIME EMPLOYEE BEGAN WORK
WORKED NEXT SCHEDULED SHIFT <input type="checkbox"/> YES <input type="checkbox"/> NO	OFF WORK MORE THAN 4 WORK DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO

Accident Description

JOB TITLE	DESCRIPTION OF ACCIDENT						
CAUSE OF INJURY	CAUSE CODE	PART OF BODY	PART CODE	NATURE OF INJURY	NATURE CODE	DATE OF INJURY	TIME OF INJURY
DATE DISABILITY BEGAN	DATE OF DEATH	NAMES OF WITNESSES 1) _____ 2) _____ 3) _____					
ACCIDENT ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT ADDRESS OR LOCATION CITY _____ STATE _____ POSTAL CODE _____						
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO			SAFETY EQUIPMENT PROVIDED <input type="checkbox"/> YES <input type="checkbox"/> NO		SAFETY EQUIPMENT USED <input type="checkbox"/> YES <input type="checkbox"/> NO	

Medical

ATTENDING PHYSICIAN'S NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
HOSPITAL NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
TYPE OF INITIAL MEDICAL TREATMENT RECEIVED <input type="checkbox"/> NO TREATMENT <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF <input type="checkbox"/> CLINIC/DR. OFFICE <input type="checkbox"/> HOSPITAL				

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary _____

Date _____

Employer

EMPLOYER NAME		DOING BUSINESS AS		FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID)	
MAILING ADDRESS		CITY	STATE	POSTAL CODE	PHONE NUMBER
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS			NATURE OF BUSINESS SIC/NAICS CODE		SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY		INJURED WORKER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY <input type="checkbox"/> A MEMBER OF THE EMPLOYER'S (SOLE PROPRIETOR OR PARTNER) FAMILY LIVING IN THE EMPLOYER'S HOUSEHOLD			
DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT THIS ACCIDENT? IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE				<input type="checkbox"/> YES <input type="checkbox"/> NO	
PREPARED BY		OFFICIAL TITLE	PHONE NUMBER	DATE	
PAYROLL CLASSIFICATION CODE UNDER WHICH YOU REPORT EMPLOYEE'S WAGES		AUTHORIZED EMPLOYER'S SIGNATURE _____		DATE _____	

Insurer

CLAIM ADMINISTRATOR CLAIM NUMBER	DATE REPORTED TO CLAIM ADMINISTRATOR	THE ABOVE INFORMATION IS CORRECT WITH THE FOLLOWING EXCEPTIONS <input type="checkbox"/> (ATTACH EXTRA SHEETS IF BOX AT RIGHT IS CHECKED)	
THIRD PARTY ADMINISTRATOR'S NAME	CLAIM ADMINISTRATOR ADDRESS		INSURER FEIN
INSURER NAME		THIRD PARTY ADMINISTRATOR FEIN	
POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	