

Amendments to House Bill No. 334
3rd Reading Copy

Requested by Representative Scott Reichner

For the Senate Business, Labor, and Economic Affairs Committee

Prepared by Pat Murdo
March 25, 2011 (2:47pm)

1. Title, page 1, line 11.

Following: "BIENNIUM;"**Insert:** "requiring the legislative auditor to submit reports on the Montana State Fund to the insurance commissioner; revising vocational rehabilitation services and terms to assist an employee in staying at work or returning to work; creating a stay-at-work/return-to-work assistance fund and providing for assessments; extending rulemaking authority;"

2. Title, page 1, line 12.

Following: "39-71-320,"**Insert:** "39-71-403,"

3. Title, page 1, line 13.

Following: "39-71-1011,"**Insert:** "39-71-1025, 39-71-1031,"**Following:** "39-71-1102,"**Strike:** "AND"

4. Title, page 1, line 14.

Following: "39-71-1106,"**Insert:** "AND 39-71-2361,"

5. Page 1, line 25.

Following: "~~disease.~~"**Insert:** "Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease."

6. Page 4, line 26.

Strike: subsection (15) in its entirety**Renumber:** subsequent subsections

7. Page 5.

Following: line 1**Insert:** "(16) (a) "Indemnity benefits" means any payment made directly to the worker or the worker's beneficiaries, other

than a medical benefit. The term includes payments made pursuant to a reservation of rights.

(b) The term does not include stay-at-work/return-to-work assistance, auxiliary benefits, or expense reimbursements for items such as meals, travel, or lodging."

Renumber: subsequent subsections

8. Page 5, line 7.

Strike: "or treatment" through "healing"

Insert: "while minimizing recurrence of the clinical status"

9. Page 5, lines 9 through 11.

Strike: "initial" on line 9

Strike: "as established" on line 9 through "findings" on line 10

Strike: "A" on line 10 through "improvement." on line 11

10. Page 6, line 1.

Strike: "Class 2 or greater class of"

11. Page 6, line 14.

Following: "injury"

Insert: "or occupational disease"

Strike: "the initial achievement of"

Insert: "achieving"

12. Page 7, line 24.

Strike: "designated by the insurer to be"

Insert: "who, subject to the requirements of 39-71-1101, is "

13. Page 17.

Following: line 4

Insert: "Section 7. Section 39-71-403, MCA, is amended to read:

"39-71-403. Plan three exclusive for state agencies -- election of plan by public corporations -- financing of self-insurance fund -- exemption for university system -- definitions -- rulemaking. (1) (a) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

(b) (i) Subject to subsection (5), the department of

administration, provided for in 2-15-1001, shall manage workers' compensation insurance coverage for all state agencies.

(ii) The state fund shall provide the department of administration with all information regarding the state agencies' coverage.

(iii) Notwithstanding the status of a state agency as employer in subsection (1)(a) and contingent upon mutual agreement between the department of administration and the state fund, the state fund shall issue one or more policies for all state agencies.

(iv) In any year in which the workers' compensation premium due from a state agency is lower than in the previous year, the appropriation for that state agency must be reduced by the same amount that the workers' compensation premium was reduced and the difference must be returned to the originating fund instead of being applied to other purposes by the state agency submitting the premium.

(2) A public corporation, other than a state agency, may elect coverage under compensation plan No. 1, plan No. 2, or plan No. 3, separately or jointly with any other public corporation, other than a state agency. A public corporation electing compensation plan No. 1 may purchase reinsurance or issue bonds or notes pursuant to subsection (3)(b). A public corporation electing compensation plan No. 1 is subject to the same provisions as a private employer electing compensation plan No. 1.

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

(b) (i) A public corporation, other than a state agency, separately or jointly with another public corporation, other than a state agency, may issue and sell its bonds and notes for the purpose of establishing, in whole or in part, the self-insurance workers' compensation fund provided for in subsection (3)(a) and to pay the costs associated with the sale and issuance of the bonds. Bonds and notes may be issued in an amount not exceeding 0.18% of the total assessed value of taxable property, determined as provided in 15-8-111, of the public corporation as of the date of issue. The bonds and notes must be authorized by resolution of the governing body of the public corporation and are payable from an annual property tax levied in the amount necessary to pay principal and interest on the bonds or notes. This authority to levy an annual property tax exists despite any provision of law or maximum levy limitation, including 15-10-420, to the contrary.

The revenue derived from the sale of the bonds and notes may not be used for any other purpose.

(ii) The bonds and notes:

(A) may be sold at public or private sale;

(B) do not constitute debt within the meaning of any statutory debt limitation; and

(C) may contain other terms and provisions that the governing body determines.

(iii) Two or more public corporations, other than state agencies, may agree to exercise their respective borrowing powers jointly under this subsection (3)(b) or may authorize a joint board to exercise the powers on their behalf.

(iv) The fund established from the proceeds of bonds and notes issued and sold under this subsection (3)(b) may, if sufficient, be used in lieu of a surety bond, reinsurance, specific and aggregate excess insurance, or any other form of additional security necessary to demonstrate the public corporation's ability to discharge all liabilities as provided in subsection (3)(a). Subject to the total assessed value limitation in subsection (3)(b)(i), a public corporation may issue bonds and notes to establish a fund sufficient to discharge liabilities for periods greater than 1 year.

(4) All money in the fund established under subsection (3)(a) not needed to meet immediate expenditures must be invested by the governing body of the public corporation or the joint board created by two or more public corporations as provided in subsection (3)(b)(iii), and all proceeds of the investment must be credited to the fund.

(5) For the purposes of subsection (1)(b), the judicial branch or the legislative branch may choose not to have the department of administration manage its workers' compensation policy.

(6) The department of administration may adopt rules to implement subsection (1)(b)(i).

(7) As used in this section, the following definitions apply:

(a) "Public corporation" includes the Montana university system.

(b) (i) "State agency" means:

(A) the executive branch and its departments and all boards, commissions, committees, bureaus, and offices;

(B) the judicial branch; and

(C) the legislative branch.

(ii) The term does not include the Montana university system."

{ Internal References to 39-71-403:

39-71-2201 x }

Renumber: subsequent sections

14. Page 17, lines 12 through 22.

Strike: subsection (2) in its entirety

Insert: "(2) An injury does not arise out of and in the course of employment when the employee is:

(a) on a paid or unpaid break, is not at a worksite of the employer, and is not performing any specific tasks for the employer during the break; or

(b) engaged in a social or recreational activity, regardless of whether the employer pays for any portion of the activity. The exclusion from coverage of this subsection (2)(b) does not apply to an employee who, at the time of injury, is on paid time while participating in a social or recreational activity or whose presence at the activity is required or requested by the employer. For the purposes of this subsection (2)(b), "requested" means the employer asked the employee to assume duties for the activity so that the employee's presence is not completely voluntary and optional and the injury occurred in the performance of those duties."

15. Page 17, lines 27 through 28.

Strike: subsection (b) in its entirety

Renumber: subsequent subsection

16. Page 19, line 2.

Strike: "(a)"

17. Page 19, line 3.

Strike: "(i)"

Insert: "(a)"

18. Page 19, line 4.

Strike: "(ii)"

Insert: "(b)"

19. Page 19, lines 8 through 9.

Strike: subsection (b) in its entirety

20. Page 20, line 2.

Strike: "Class 2 or greater class of"

Following: "rating"

Insert: "rating"

21. Page 20, line 5.

Strike: "and"

22. Page 20, line 6.

Following: "and"
Insert: "; and
(iii) is more than zero."

23. Page 20, line 8.

Strike: "."

24. Page 20, lines 10 through 11.

Strike: "A" on line 10

Insert: "When a worker receives a Class 2 or greater class of impairment as converted to the whole person, as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition, and has no actual wage loss as a result of the compensable injury or occupational disease, the"

Following: "only"

Strike: "if the" on line 10 through "(1)" on line 11

25. Page 23, line 5.

Strike: "20"

Insert: "29"

26. Page 23, line 24.

Following: "workers."

Insert: "Regardless of the date of injury, payment for medical services is based on the fee schedule rates in this section in effect on the date on which the medical service is provided."

27. Page 24.

Following: line 6

Insert: "(c) From July 1, 2011, through June 30, 2013, the fee schedules established in subsection (2)(b) must be based on the following standards as adopted by the centers for medicare and medicaid services and as adopted by the department on December 31, 2010, regardless of where services are provided:

(i) the American medical association current procedural terminology codes;

(ii) the healthcare common procedure coding system;

(iii) the medicare severity diagnosis-related groups;

(iv) the ambulatory payment classifications;

(v) the ratio of costs to charges for each hospital;

(vi) the national correct coding initiative edits; and

(vii) the relative value units as adjusted annually using the most recently published resource-based relative value scale."

ReNUMBER: subsequent subsections

28. Page 24, line 7.

Strike: "The"

Insert: "On or after July 1, 2013, the"

29. Page 24, lines 8.

Strike: "in effect" through "provided"

30. Page 24, line 10.

Following: "codes"

Insert: ", as those codes exist on March 31 of each year"

31. Page 24, line 11.

Following: "system"

Insert: ", as those codes and their relative weights exist on
March 31 of each year"

32. Page 24, line 12.

Following: "groups"

Insert: ", as those codes and their relative weights exist on
October 1 of each year"

33. Page 24, line 13.

Following: "classifications"

Insert: ", as those codes and their relative weights exist on
March 31 of each year"

34. Page 24, line 14.

Following: "hospital"

Insert: ", as those codes exist on October 1 of each year"

35. Page 24, line 15.

Following: "edits"

Insert: ", as those codes exist on March 31 of each year"

36. Page 24, line 16.

Strike: "as adjusted" through "recently"

Insert: "in the"

37. Page 24, line 17.

Following: "scale"

Insert: ", as those codes exist on March 31 of each year"

38. Page 24, line 18.

Following: "codes"

Insert: "and coding standards"

39. Page 24, line 21.

Strike: "January 1, 2011"

Insert: "December 31, 2010"

40. Page 24, line 23.

Following: "presumption that the"

Insert: "adopted"

41. Page 24, lines 24 through 25.

Strike: "established by the department are" on line 24

Strike: "an appropriate" on line 24 through "chapter" on line 25

Insert: "establish compensable medical treatment for an injured worker"

42. Page 24, line 30.

Following: "director"

Strike: "to conduct"

Insert: ". The department may establish by rule"

43. Page 25, line 1.

Strike: ". The independent" through "assess"

Insert: "for"

44. Page 30, line 18.

Strike: "chapter"

Insert: "part"

45. Page 30.

Following: line 18

Insert: "(1) "Assistance fund" means the stay-at-work/return-to-work assistance fund provided for in [section 19]."

Renumber: subsequent subsections

46. Page 30, line 21.

Strike: "practitioners"

Insert: "providers"

47. Page 30.

Following: line 25

Insert: "(4) "Insurer's stay-at-work/return-to-work assistance policy" or "assistance policy" means a written stay-at-work/return-to-work policy that explains to the worker the process of evaluation, planning, implementation, and provision of services by the insurer prior to the determination that the worker meets the definition of a disabled worker. The services are intended to facilitate a

worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan."

Renumber: subsequent subsections

48. Page 31, line 4 through line 8.

Strike: subsection (7) in its entirety

Insert: "(9) "Stay-at-work/return-to-work assistance" or "assistance" means the evaluation, planning, implementation, and provision of appropriate services prior to the determination that the worker meets the definition of a disabled worker that are designed to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan."

49. Page 31.

Following: line 9

Insert: "NEW SECTION. **Section 16. Stay-at-work/return-to-work goals and options -- notification by department -- agreement between worker and insurer.** (1) The goal of stay-at-work/return-to-work assistance is to minimize avoidable disruption caused by a work-related injury or occupational disease by assisting the worker in the worker's return to the same position with the same employer or to a modified position with the same employer as soon as possible after an injury or an occupational disease occurs.

(2) To further the goal in subsection (1), the department shall, upon receipt from the insurer of a report of injury or occupational disease pursuant to 39-71-307(2), distribute to the worker a document that describes the stay-at-work/return-to-work assistance that is available upon request by the worker.

(3) Services provided as part of stay-at-work/return-to-work assistance are provided in addition to or prior to rehabilitation services and are intended to help a worker return to work."

Insert: "NEW SECTION. **Section 17. Request for and delivery of stay-at-work/return-to-work assistance.** (1) (a) A worker who is claiming an injury or occupational disease, an employer, or a medical provider may ask that the department furnish stay-at-work/return-to-work assistance. After the worker signs a claim for benefits, the department shall promptly attempt to determine which insurer is at risk for the injury or occupational disease and contact that insurer. The department shall advise the insurer of the request for stay-at-work/return-to-work assistance and shall coordinate the assistance with the insurer.

(b) If an insurer has accepted liability for the claim, the insurer shall provide stay-at-work/return-to-work assistance either in accordance with the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation

provider to provide rehabilitation services. The insurer is directly liable for paying for the stay-at-work/return-to-work assistance furnished.

(c) If an insurer at risk has not accepted liability for the claim, the insurer may choose one of the following actions:

(i) The insurer at risk for the claim may initiate stay-at-work/return-to-work assistance either in accordance with the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services and shall notify the department within 3 business days of being contacted by the department that the insurer is acting under this subsection (1)(c)(i). If the insurer provides either type of assistance, the insurer becomes responsible for directly paying for the assistance. Payment of assistance pursuant to this subsection (1)(c)(i) does not constitute admission of liability or a waiver of any right of defense.

(ii) If the insurer at risk for the claim does not notify the department within 3 business days of being contacted by the department that the insurer will provide assistance, the department shall obtain stay-at-work/return-to-work assistance for the worker by designating a rehabilitation provider.

(d) If the department cannot promptly determine which insurer is at risk for coverage, the department shall obtain stay-at-work/return-to-work assistance for the worker by designating a rehabilitation provider.

(e) A rehabilitation provider designated by the department under this section shall bill the department for services provided. The department shall pay for the stay-at-work/return-to-work assistance out of the assistance fund until the maximum allowed amount of assistance is provided or until the insurer denies the claim and notifies the department of the denial.

(f) If an insurer is providing assistance pursuant to the insurer's stay-at-work/return-to-work assistance policy, the insurer shall provide in writing to a worker, with a copy to the department, an explanation of the stay-at-work/return-to-work assistance being provided to the worker under this section and shall include contact information for the person providing the assistance.

(2) Rather than make a request to the department, a worker, an employer, or a medical provider may directly ask the insurer to provide stay-at-work/return-to-work assistance.

(3) In the absence of a request by a worker, an employer, or a medical provider, an insurer may initiate and provide stay-at-work/return-to-work assistance by providing the worker with a copy of the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services.

(4) Stay-at-work/return-to-work assistance requested under this section is available as a service apart from a determination regarding indemnity benefits. A worker or an employer may decline

to accept stay-at-work/return-to-work assistance. The failure of a worker to voluntarily agree to assistance is not a dispute concerning benefits. However, if the assistance provided under this part results in a job offer for a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury and the worker refuses the offer, the workers' indemnity benefits may end as provided in 39-71-701 and 39-71-712.

(5) Stay-at-work/return-to-work assistance is available at any time unless:

(a) the worker, prior to a determination that the worker meets the definition of a disabled worker, has refused a job offer for a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury;

(b) the worker has actually returned to work; or

(c) the claim has been closed pursuant to 39-71-704(1)(f)(i) or indemnity benefits have been settled pursuant to the definition of a settled claim in 39-71-107.

(6) If the insurer determines that the worker has not suffered a compensable injury or occupational disease and denies liability for the claim, the insurer or the department shall terminate any stay-at-work/return-to-work assistance that was initiated before the insurer's denial of liability."

Insert: "NEW SECTION. Section 18. Rehabilitation provider -- evaluation. (1) Stay-at-work/return-to-work assistance must be provided by a rehabilitation provider pursuant to this section if:

(a) the department provides assistance; or

(b) an insurer elects to designate a rehabilitation provider instead of using the insurer's own stay-at-work/return-to-work assistance policy.

(2) (a) The rehabilitation provider shall evaluate and determine the stay-at-work/return-to-work capabilities of the worker pursuant to the stay-at-work/return-to-work goals listed in [section 16].

(b) If the worker has returned to work, the rehabilitation provider shall provide documentation of the assistance to the worker, the insurer, and the department.

(c) If the worker has not returned to work and has not received a job offer to return to work, the rehabilitation provider shall document the reasons the stay-at-work/return-to-work assistance was unsuccessful. The documentation must be provided to the worker, the insurer, the treating physician, and the department.

(d) The following conditions allow termination of assistance prior to the time a worker meets the definition of a disabled worker:

(i) the worker has returned to work earning wages that are at least as much as at the time of injury;

(ii) the worker has received an offer to return to work at a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury;

(iii) the worker has returned to work in an alternative position that pays less than the worker's wages at the time of injury and that qualifies the worker for temporary partial disability benefits pursuant to 39-71-712; or

(iv) the worker receives a job offer to return to work in a position that is within the worker's physical abilities, for which the worker is qualified, for which the wages are less than the worker's wages at the time of injury, and that qualifies the worker for temporary partial disability benefits under 39-71-712.

(e) If a worker has requested stay-at-work/return-to-work assistance and a rehabilitation plan has been agreed to by the worker and the insurer, the plan continues until completed.

(3) If the worker or insurer disputes the availability or level of assistance, the worker or insurer may, after mediation, petition the workers' compensation court for resolution of the dispute."

Insert: "NEW SECTION. Section 19. Stay-at-work/return-to-work assistance fund -- purpose -- payment process -- rulemaking. (1) There is a stay-at-work/return-to-work assistance fund in the proprietary fund category.

(2) The purpose of the assistance fund is to pay for stay-at-work/return-to-work assistance provided by the department so that assistance may be provided as early as practicable in the workers' compensation claims process.

(3) (a) The department may establish by rule:

(i) the amounts and types of assistance to be provided; and

(ii) the maximum hourly rate that may be charged for stay-at-work/return-to-work assistance obtained by the department and paid for by the assistance fund.

(b) The rules adopted under subsection (3)(a) regarding the payment amounts to rehabilitation providers do not apply if the insurer has taken direct responsibility for providing stay-at-work/return-to-work assistance.

(c) If rules are not adopted to implement subsection (3)(a), the department may not provide more than \$2,000 in assistance."

Insert: "NEW SECTION. Section 20. Assessment for stay-at-work/return-to-work assistance fund -- definition. (1) (a) The assistance fund must be maintained by assessing employers insured by plan No. 1, plan No. 2, and plan No. 3 an amount as provided in subsections (2) through (10).

(b) The board of investments shall invest the money in the assistance fund. The investment income must be deposited in the assistance fund.

(2) The assessment amount is the total amount paid by the

assistance fund in the preceding fiscal year less other realized income that is deposited in the assistance fund. Allocation of the total assessment amount among employers insured by plan No. 1, plan No. 2, and plan No. 3 must be based on each plan's proportionate share of money expended from the assistance fund for the calendar year preceding the year in which the assessment is collected.

(3) On or before May 31 of each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. On or before April 30 of each year, the department shall consult with the advisory organization designated under 33-16-1023 and notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge rate to be effective for policies written or renewed on or after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is the amount actually expended by the assistance fund on behalf of injured workers employed by that plan No. 1 employer. A group of employers insured jointly under plan No. 1 is considered to be an individual employer for the purposes of this subsection.

(5) After subtracting plan No. 1 assessments from the total assessment, the department shall determine the surcharge rate for plan No. 2 insurers and plan No. 3, the state fund, by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided in subsection (9).

(6) Employers insured under plan No. 2 or plan No. 3 shall pay their portion of the assessment in a surcharge on premiums for policies written or renewed annually on or after July 1.

(7) (a) Each plan No. 2 insurer and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (5). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation stay-at-work/return-to-work assistance fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner as the premium for the coverage. The assessment premium surcharge must be excluded from the definition of premium for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for

nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium.

(b) If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge described in 39-71-201 first, then to the assessment premium surcharge in this section, and then to the surcharge in 39-71-915, with any remaining amount applied to the premium due.

(8) (a) The department shall deposit all assessments due under this section into the assistance fund.

(b) Each plan No. 1 employer shall pay its assessment due under this section by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter no later than 20 days following the end of the quarter.

(d) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of \$100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the assistance fund.

(9) Each year, the department shall compare the amount of the assessment premium surcharge actually collected pursuant to subsection (5) with the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator for the following year's assessment premium surcharge as provided in subsection (5).

(10) If the total assessment is less than \$100,000 for any year, the department may defer the assessment for that year and add that amount to the assessment amount for the subsequent year.

(11) As used in this section, "money expended" means expenditures for stay-at-work/return-to-work assistance from the assistance fund."

Insert: "NEW SECTION. Section 21. Rulemaking authority. The department may adopt rules to implement this part."

Insert: "**Section 22.** Section 39-71-1025, MCA, is amended to read:

"39-71-1025. Auxiliary rehabilitation benefits. (1) In addition to benefits otherwise provided in this chapter, separate benefits not exceeding a total of \$4,000, adjusted as provided in subsection (2), may be paid by the insurer for specialized job modification, reasonable travel, and relocation expenses used to for any of the following:

(1)(a) search for new employment;

~~(2)~~(b) return to work but in a new location;
~~(3)~~(c) implement the implementation of a rehabilitation
plan that has been filed with the department; and or
~~(4)~~(d) attend attendance at an on-the-job training program.

(2) The separate benefit may be adjusted by an amount that is the percentage increase, if any, in the current state's average weekly wage over the state's average weekly wage adopted for the previous year."

{Internal References to 39-71-1025:

39-71-1006x 39-71-1011 a}"

Insert: "Section 23. Section 39-71-1031, MCA, is amended to read:

"39-71-1031. **Exchange of information.** The insurer's designated insurer, the rehabilitation provider, and the department shall provide to one another case information as necessary to carry out the purposes of this part."

{Internal References to 39-71-1031: None.}"

50. Page 31, line 11.

Following: "designation"

Insert: "or approval"

51. Page 31, line 13.

Following: "designation"

Insert: "or approval"

52. Page 31, line 15.

Strike: "health care provider"

Insert: "person who is listed in 39-71-116(41) "

Following: "treatment."

Insert: "Subject to subsection (2), if the person listed under 39-71-116(41) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician."

53. Page 31, line 16.

Strike: "Upon receipt of a claim for benefits and"

Insert: "Any time after"

54. Page 31, line 17.

Following: "designate"

Insert: "or approve"

Following: "designated"

Insert: "or approved"

55. Page 31, line 22.

Strike: "and"

56. Page 31.

Following: line 22

Insert: "(c) shall provide or arrange for treatment within the utilization and treatment guidelines or obtain prior approval for other treatment; and"

57. Page 31, line 23.

Strike: "(c)"

Insert: "(d)"

58. Page 31, line 28.

Following: "designated"

Insert: "or approved"

59. Page 32, line 2.

Following: "designation"

Insert: "or approval"

60. Page 32.

Following: line 5

Insert: "(7) Regardless of the date of injury, the medical fee schedule rates in effect as adopted by the department in 39-71-704 and the percentages referenced in subsections (4) through (6) apply to the medical service on the date on which the medical service was provided. "

61. Page 32, line 19.

Strike: "to a managed care organization"

62. Page 32, line 20.

Strike: "managed care"

63. Page 32, line 21.

Following: "accordance with"

Insert: "39-71-1102 and"

Strike: "managed care"

64. Page 32, line 24.

Following: "organization"

Insert: "or a preferred provider organization"

65. Page 32, line 28.

Following: "injury"

Insert: "or occupational disease"

66. Page 34.

Following: line 6

Insert: "Section 27. Section 39-71-2361, MCA, is amended to read:

"39-71-2361. Legislative audit of state fund -- annual review of audit and rate review by insurance commissioner. The legislative auditor shall annually:

(1) conduct or have conducted a financial and compliance audit of the state fund, including its operations relating to claims for injuries resulting from accidents that occurred before July 1, 1990. The audit must include evaluations of the claims reservation process, the amounts reserved, and the current report of the state fund's actuary. The evaluations may be conducted by persons appointed under 5-13-305. Audit and evaluation costs are an expense of and must be paid by the state fund and must be allocated between those claims for injuries resulting from accidents that occurred before July 1, 1990, and those claims for injuries resulting from accidents that occur on or after that date.

(2) provide the results of the financial and compliance audit for operations related to claims for injuries resulting from accidents on or after July 1, 1990, as provided in subsection (1), and the rate review as provided in 39-71-2362 to the insurance commissioner. The insurance commissioner shall review the financial and compliance audit and rate review and report any concerns or recommendations based on the review to the governor, the legislative audit committee, and the economic affairs interim committee."

{Internal References to 39-71-2361: None.}"

67. Page 34, lines 8 through 16.

Strike: section 18 in its entirety

Renumber: subsequent sections

68. Page 34, line 18.

Strike: "Work ability"

Insert: "Medical status"

Following: "create a"

Strike: "work ability"

Insert: "medical status"

69. Page 35, line 4.

Strike: "work ability"

70. Page 35, line 5.

Strike: "work ability"

71. Page 35, line 12.

Strike: "surgery"

Insert: "medical treatment"

Following: "continue to work"

Insert: "or return to work"

72. Page 35, line 23.

Strike: "2"

Insert: "5"

73. Page 35, lines 24 through 25.

Strike: "A petition" on line 24 through "reopening." on line 25

Insert: "A petition may not be filed more than 90 days before benefits are to terminate."

74. Page 35, lines 29 through 30.

Strike: "to a high" on line 29 through "certainty" on line 30

Insert: "a preponderance of the evidence"

75. Page 36, line 6.

Strike: "a maximum of"

76. Page 36, line 7.

Strike: "surgery"

Insert: "or the recommended medical treatment"

Following: "first."

Insert: "If the medical panel specifically approves treatment beyond 2 years, medical benefits remain open for as long as recommended by the medical panel. The petitioner and the insurer shall submit updated information to the medical panel every 2 years, and every subsequent 2 years the medical panel shall review the claims that were reopened for longer than 2 years to determine whether to change the previous recommendation."

77. Page 36.

Following: line 11

Insert: "NEW SECTION. **Section 30. Transition for stay-at-work/return-to-work assistance fund.** (1) The department of labor and industry shall transfer \$100,000 from the administration fund provided for by 39-71-201 to the stay-at-work/return-to-work assistance fund established in [section 19] to provide the initial funding for the fund.

(2) Effective for policies written or renewed in state fiscal year 2012 only, the premium surcharge rate to be levied by insurers on workers' compensation insurance premiums pursuant to [section 20] is 0.00082."

Renumber: subsequent sections

78. Page 36, line 13.

Strike: "18 and 19"

Insert: "16 through 21 and 28"

79. Page 36, line 15.

Strike: "18 and 19"

Insert: "16 through 21 and 28"

80. Page 36, line 16.

Strike: "20"

Insert: "29"

81. Page 36, line 17.

Strike: "20"

Insert: "29"

82. Page 36, line 23.

Following: "**Severability**"

Insert: "-- **nonseverability**"

83. Page 36.

Following: line 25

Insert: "(2) It is the intent of the legislature that [sections 15 through 23] are essentially dependent upon each other and that if one or more of these sections are held invalid or unconstitutional, the other sections specified in this subsection are also invalid.

(3) It is the intent of the legislature that if any one of the amendments made by [section 14] regarding settlement of undisputed medical benefits is held invalid or unconstitutional, the other amendments in [section 14] and [section 35(4)] regarding settlement of undisputed medical benefits are invalid so that settlement of undisputed medical benefits is no longer permitted."

84. Page 37, line 4.

Strike: "13"

Insert: "14"

85. Page 37.

Following: line 5

Insert: "(4) The provisions of [sections 15 through 23] apply to injuries occurring on or after July 1, 2012."

- END -