SENATE BILL NO. 243

INTRODUCED BY R. ZINKE

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; PROVIDING A PROCESS FOR CLOSING WORKERS' COMPENSATION CLAIMS; OUTLINING CONDITIONS FOR REOPENING AND MEDIATING A CLAIM; PROVIDING EXCEPTIONS TO THE COURSE AND SCOPE OF EMPLOYMENT; REDUCING THE TIME FOR INSURERS TO ACCEPT OR DENY A CLAIM; REVISING THE PROCESS FOR PROVIDING COSTS AND ATTORNEY FEES FOR DISPUTED MEDICAL BENEFITS AWARDED BY A COURT; PROVIDING SPECIFIC GUIDANCE FOR IMPAIRMENT RATINGS AND ALLOWING THE DEPARTMENT TO CHANGE GUIDANCE BY RULE; EXTENDING CERTAIN BENEFITS UPON CERTIFICATION OF LOSS COST RATIO REDUCTIONS; ALLOWING RETROACTIVE BENEFIT PAYMENTS TO CERTAIN WORKERS; REVISING MEDICAL CLAIM SETTLEMENTS AND LUMP-SUM PAYMENTS; REVISING VOCATIONAL REHABILITATION SERVICES AND TERMS TO ASSIST AN EMPLOYEE IN STAYING AT WORK OR RETURNING TO WORK; ALLOWING THE EXCHANGE OF INFORMATION AMONG INTERESTED PARTIES; CREATING A STAY-AT-WORK/RETURN-TO-WORK ASSISTANCE FUND AND ASSESSMENTS FOR THE FUND; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 39-71-116, 39-71-118, 39-71-407, 39-71-606, 39-71-611, 39-71-612, 39-71-614, 39-71-703, 39-71-704, 39-71-711, 39-71-712, 39-71-721, 39-71-736, 39-71-737, 39-71-741, 39-71-1011, 39-71-1025, AND 39-71-1031, MCA; AND PROVIDING EFFECTIVE DATES AND APPLICABILITY DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Claim closure -- reopening -- procedure.** (1) When a worker has submitted a claim for an injury or occupational disease under this chapter and an insurer has accepted liability or made payments pursuant to 39-71-608 or 39-71-615 on that claim, the claim is eligible for closure 3 years after the latest of:

(a) the date of the injury;

(b) the date of the last indemnity payment; or

(c) the date of the last use of medical benefits pursuant to 39-71-704.

(2) The 3-year period for closure of a claim provided for in subsection (1) begins when the insurer gives

written notice to the claimant and the department that the claim is eligible to be closed pursuant to this section. Notice must be given at the time the insurer, based on its records, reasonably believes the 3-year period will begin.

(3) Except as provided by subsection (6), if the insurer does not pay indemnity benefits or the worker does not use medical benefits on the claim during the 3 years after the insurer has given written notice of the claim's eligibility for closure, the claim is closed by operation of law pursuant to this section. Once a claim is closed pursuant to this section, the insurer is not liable for the payment of any additional benefits unless the claim is reopened as provided in subsection (4).

(4) (a) Within 2 years of claim closure, a claimant may ask that a claim closed pursuant to this section be reopened by making a request to the insurer. A claimant is entitled to have a claim reopened if the claimant can prove by a preponderance of the evidence that there has been a substantial or material change in the claimant's condition, and the condition is a result of the injury or disease on which the claim was filed under subsection (1).

(b) A claim reopened under subsection (4)(a) may be closed again following the procedures in subsections (2) and (3).

(5) Any dispute regarding closure of a claim or reopening of a claim is considered a dispute that, after mediation pursuant to department rules, is subject to the jurisdiction of the workers' compensation court.

(6) If there is a dispute regarding whether benefits are due under the claim and if a party to the dispute has requested mediation pursuant to department rules, the period for closure of a claim provided for in subsection (2) is tolled until the 2-year limitation period of 39-71-2905 expires or there is a final judicial decision regarding the dispute, whichever is later. If the parties otherwise resolve the dispute, the tolling of the period ceases.

(7) This section does not apply to those benefits that have been settled pursuant to 39-71-741 or to court-ordered closures.

(8) If the time for reopening under subsection (4) has passed, the closure of a claim pursuant to this section terminates benefits for all purposes.

Section 2. Section 39-71-116, MCA, is amended to read:

"39-71-116. Definitions. Unless the context otherwise requires, in this chapter, the following definitions apply:

(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker

reaches maximum healing are less than the actual wages the worker received at the time of the injury.

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act necessary to:

(a) investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(3) "Aid or sustenance" means a public or private subsidy made to provide a means of support, maintenance, or subsistence for the recipient.

(4) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under 18 years of age;

(c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;

(e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (4)(a) through (4)(d), does not exist; and

(f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (4)(a) through (4)(e), does not exist.

(5) "Business partner" means the community, governmental entity, or business organization that provides the premises for work-based learning activities for students.

(6) "Casual employment" means employment not in the usual course of the trade, business, profession, or occupation of the employer.

(7) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

~~(8) (a) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major~~

~~group 23 in the North American Industry Classification System Manual.~~

~~(b) The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.~~

~~(9)~~(8) (a) "Claims examiner" means an individual who, as a paid employee of the department, of a plan No. 1, 2, or 3 insurer, or of an administrator licensed under Title 33, chapter 17, examines claims under chapter 71 to:

(i) determine liability;

(ii) apply the requirements of this title;

(iii) settle workers' compensation or occupational disease claims; or

(iv) determine survivor benefits.

(b) The term does not include an adjuster as defined in 33-17-102.

(9) (a) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors listed in major group 23 in the North American Industry Classification System Manual.

(b) The term does not include office workers, design professionals, salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(10) "Days" means calendar days, unless otherwise specified.

(11) "Department" means the department of labor and industry.

(12) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(13) (a) "Household or domestic employment" means employment of persons other than members of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's family, including but not limited to housecleaning and yard work.

(b) The term does not include employment beyond the scope of normal household or domestic duties, such as home health care or domiciliary care.

(14) (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 as defined in 39-71-1011, auxiliary benefits, or expense reimbursements for items such as meals, travel, or lodging.

~~(14)~~(15) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

~~(15)~~(16) "Invalid" means one who is physically or mentally incapacitated.

~~(16)~~(17) "Limited liability company" has the meaning provided in 35-8-102.

~~(17)~~(18) "Maintenance care" means treatment designed to provide the optimum state of health while minimizing recurrence of the clinical status.

~~(18)~~(19) "Medical stability", "maximum healing", or "maximum medical healing" means a point in the healing process when further material improvement would not be reasonably expected from primary medical treatment.

~~(19)~~(20) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

~~(20)~~(21) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the course and scope of employment caused by events occurring on more than a single day or work shift.

(b) The term does not include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity.

~~(21)~~(22) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at by the department.

~~(22)~~(23) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(23)~~(24) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

~~(24)~~(25) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment rating greater than 0% established by objective medical findings;

(b) is able to return to work in some capacity but the permanent impairment impairs the worker's ability

to work; and

(c) has an actual wage loss as a result of the injury.

~~(25)~~(26) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. ~~Regular employment means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state.~~ Lack of immediate job openings is not a factor to be considered in determining if a worker ~~is permanently totally disabled~~ has a permanent total disability.

~~(26)~~(27) "Primary medical services" means treatment prescribed by a treating physician, for conditions resulting from the injury, necessary for achieving medical stability.

~~(27)~~(28) "Public corporation" means the state or a county, municipal corporation, school district, city, city under a commission form of government or special charter, town, or village.

~~(28)~~(29) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

~~(29)~~(30) "Reasonably safe tools or appliances" are tools and appliances that are adapted to and that are reasonably safe for use for the particular purpose for which they are furnished.

(31) "Regular employment" means work on a recurring basis performed for remuneration in a trade, business, profession, or other occupation in this state.

~~(30)~~(32) (a) "Secondary medical services" means those medical services or appliances that are considered not medically necessary for medical stability. The services and appliances include but are not limited to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or rehabilitation facilities.

(b) (i) As used in this subsection ~~(30)~~ (32), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

(ii) Disability does not mean a purely medical condition.

~~(31)~~(33) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~(34) "State's average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the department before July 1 and rounded to the nearest whole dollar number.

~~(33)~~(35) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:

(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;

(b) returns to work in a modified or alternative employment; and

(c) suffers a partial wage loss.

~~(34)~~(36) "Temporary service contractor" means a person, firm, association, partnership, limited liability company, or corporation conducting business that hires its own employees and assigns them to clients to fill a work assignment with a finite ending date to support or supplement the client's workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(35)~~(37) "Temporary total disability" means a physical condition resulting from an injury, as defined in this chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

~~(36)~~(38) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

~~(37)~~(39) "Treating physician" means a person who is primarily responsible for the treatment of a worker's compensable injury and is:

(a) a physician licensed by the state of Montana under Title 37, chapter 3, ~~and~~ who has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;

(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;

(c) a physician assistant licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection ~~(37)(a)~~ (39)(a), in the area where the physician assistant is located;

(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;

(e) a dentist licensed by the state of Montana under Title 37, chapter 4;

(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in

subsections ~~(37)(a)~~ (39)(a) through ~~(37)(e)~~ (39)(e) who is licensed or certified in another state; or

(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8.

~~(38)~~(40) "Work-based learning activities" means job training and work experience conducted on the premises of a business partner as a component of school-based learning activities authorized by an elementary, secondary, or postsecondary educational institution.

~~(39)~~(41) "Year", unless otherwise specified, means calendar year."

Section 3. Section 39-71-118, MCA, is amended to read:

"39-71-118. Employee, worker, volunteer, and volunteer firefighter defined. (1) As used in this chapter, the term "employee" or "worker" means:

(a) each person in this state, including a contractor other than an independent contractor, who is in the service of an employer, as defined by 39-71-117, under any appointment or contract of hire, expressed or implied, oral or written. The terms include aliens and minors, whether lawfully or unlawfully employed, and all of the elected and appointed paid public officers and officers and members of boards of directors of quasi-public or private corporations, except those officers identified in 39-71-401(2), while rendering actual service for the corporations for pay. ~~Casual employees~~ Persons in casual employment, as defined by 39-71-116, are included as employees if they are not otherwise covered by workers' compensation and if an employer has elected to be bound by the provisions of the compensation law for these casual employments, as provided in 39-71-401(2). Household or domestic employment is excluded.

(b) any juvenile who is performing work under authorization of a district court judge in a delinquency prevention or rehabilitation program;

(c) a person who is receiving on-the-job vocational rehabilitation training or other on-the-job training under a state or federal vocational training program, whether or not under an appointment or contract of hire with an employer, as defined in 39-71-117, and, except as provided in subsection (9), whether or not receiving payment from a third party. However, this subsection (1)(c) does not apply to students enrolled in vocational training programs, as outlined in this subsection, while they are on the premises of a public school or community college.

(d) an aircrew member or other person who is employed as a volunteer under 67-2-105;

(e) a person, other than a juvenile as described in subsection (1)(b), who is performing community service for a nonprofit organization or association or for a federal, state, or local government entity under a court

order, or an order from a hearings officer as a result of a probation or parole violation, whether or not under appointment or contract of hire with an employer, as defined in 39-71-117, and whether or not receiving payment from a third party. For a person covered by the definition in this subsection (1)(e):

(i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an impairment award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part 4, for a full-time employee at the time of the injury; and

(ii) premiums must be paid by the employer, as defined in 39-71-117(3), and must be based upon the minimum wage established under Title 39, chapter 3, part 4, for the number of hours of community service required under the order from the court or hearings officer.

(f) an inmate working in a federally certified prison industries program authorized under 53-30-132;

(g) a volunteer firefighter as described in 7-33-4109 or a person who provides ambulance services under Title 7, chapter 34, part 1;

(h) a person placed at a public or private entity's worksite pursuant to 53-4-704. The person is considered an employee for workers' compensation purposes only. The department of public health and human services shall provide workers' compensation coverage for recipients of financial assistance, as defined in 53-4-201, or for participants in the food stamp program, as defined in 53-2-902, who are placed at public or private worksites through an endorsement to the department of public health and human services' workers' compensation policy naming the public or private worksite entities as named insureds under the policy. The endorsement may cover only the entity's public assistance participants and may be only for the duration of each participant's training while receiving financial assistance or while participating in the food stamp program under a written agreement between the department of public health and human services and each public or private entity. The department of public health and human services may not provide workers' compensation coverage for individuals who are covered for workers' compensation purposes by another state or federal employment training program. Premiums and benefits must be based upon the wage that a probationary employee is paid for work of a similar nature at the assigned worksite.

(i) a member of a religious corporation, religious organization, or religious trust while performing services for the religious corporation, religious organization, or religious trust, as described in 39-71-117(1)(d).

(2) The terms defined in subsection (1) do not include a person who is:

~~(a) participating in recreational activity and who at the time is relieved of and is not performing prescribed duties, regardless of whether the person is using, by discount or otherwise, a pass, ticket, permit, device, or other~~

~~emolument of employment;~~

~~(b)~~(a) performing voluntary service at a recreational facility and who receives no compensation for those services other than meals, lodging, or the use of the recreational facilities;

~~(c)~~(b) performing services as a volunteer, except for a person who is otherwise entitled to coverage under the laws of this state. As used in this subsection ~~(2)(c)~~ (2)(b), "volunteer" means a person who performs services on behalf of an employer, as defined in 39-71-117, but who does not receive wages as defined in 39-71-123.

~~(d)~~(c) serving as a foster parent, licensed as a foster care provider in accordance with 52-2-621, and providing care without wage compensation to no more than six foster children in the provider's own residence. The person may receive reimbursement for providing room and board, obtaining training, respite care, leisure and recreational activities, and providing for other needs and activities arising in the provision of in-home foster care.

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter any volunteer as defined in subsection ~~(2)(c)~~ (2)(b).

(4) (a) The term "volunteer firefighter" means a firefighter who is an enrolled and active member of a governmental fire agency organized under Title 7, chapter 33, except 7-33-4109.

(b) The term "volunteer hours" means all the time spent by a volunteer firefighter in the service of an employer, including but not limited to training time, response time, and time spent at the employer's premises.

(5) (a) If the employer is a partnership, limited liability partnership, sole proprietor, or a member-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any member of the partnership or limited liability partnership, the owner of the sole proprietorship, or any member of the limited liability company devoting full time to the partnership, limited liability partnership, proprietorship, or limited liability company business.

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the partners, sole proprietor, or members to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (5)(d). A partner, sole proprietor, or member is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the

minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $900 a month and not more than 1 1/2 times the state's average weekly wage.

(6) (a) If the employer is a quasi-public or a private corporation or a manager-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any corporate officer or manager exempted under 39-71-401(2).

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the corporate officer or manager to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection ~~(5)(d)~~ (6)(d). A corporate officer or manager is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (6)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $200 a week and not more than 1 1/2 times the state's average weekly wage.

(7) (a) The trustees of a rural fire district, a county governing body providing rural fire protection, or the county commissioners or trustees for a fire service area may elect to include as an employee within the provisions of this chapter any volunteer firefighter. A volunteer firefighter who receives workers' compensation coverage under this section may not receive disability benefits under Title 19, chapter 17.

(b) In the event of an election, the employer shall report payroll for all volunteer firefighters for premium and weekly benefit purposes based on the number of volunteer hours of each firefighter times the average weekly wage divided by 40 hours, subject to a maximum of 1 1/2 times the state's average weekly wage.

(c) A self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer firefighter pursuant to subsection (7)(a) and when injured in the course and scope of employment as a volunteer firefighter, may in addition to the benefits described in subsection (7)(b) be eligible for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080 hours a year. The trustees of a rural fire district, a county governing body providing rural fire protection, or the county commissioners or trustees for a fire service area may make an election for benefits. If an election is made, payrolls must be reported and premiums must be assessed on the assumed wage.

(8) Except as provided in chapter 8 of this title, an employee or worker in this state whose services are furnished by a person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, to an employer, as defined in 39-71-117, is presumed to be under the control and employment of the employer. This presumption may be rebutted as provided in 39-71-117(3).

(9) A student currently enrolled in an elementary, secondary, or postsecondary educational institution who is participating in work-based learning activities and who is paid wages by the educational institution or business partner is the employee of the entity that pays the student's wages for all purposes under this chapter. A student who is not paid wages by the business partner or the educational institution is a volunteer and is subject to the provisions of this chapter.

(10) For purposes of this section, an "employee or worker in this state" means:

(a) a resident of Montana who is employed by an employer and whose employment duties are primarily carried out or controlled within this state;

(b) a nonresident of Montana whose principal employment duties are conducted within this state on a regular basis for an employer;

(c) a nonresident employee of an employer from another state engaged in the construction industry~~, as defined in 39-71-116,~~ within this state; or

(d) a nonresident of Montana who does not meet the requirements of subsection (10)(b) and whose employer elects coverage with an insurer that allows an election for an employer whose:

(i) nonresident employees are hired in Montana;

(ii) nonresident employees' wages are paid in Montana;

(iii) nonresident employees are supervised in Montana; and

(iv) business records are maintained in Montana.

(11) An insurer may require coverage for all nonresident employees of a Montana employer who do not meet the requirements of subsection (10)(b) or (10)(d) as a condition of approving the election under subsection (10)(d)."

Section 4. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee

of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(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 cost of the activity. The exclusion from coverage under this subsection (2)(b) does not apply to an employee who, at the time of injury, is either 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 when the injury occurred in the performance of those duties.

~~(2)~~(3) (a) An insurer is liable for an injury, as defined in 39-71-119, if the injury is established by objective medical findings and if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

~~(3)~~(4) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement and the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(ii) the travel is required by the employer as part of the employee's job duties.

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

~~(4)~~(5) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the

employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

~~(5)~~(6) If there is no dispute that an insurer is liable for an injury but there is a liability dispute between two or more insurers, the insurer for the most recently filed claim shall pay benefits until that insurer proves that another insurer is responsible for paying benefits or until another insurer agrees to pay benefits. If it is later proven that the insurer for the most recently filed claim is not responsible for paying benefits, that insurer must receive reimbursement for benefits paid to the claimant from the insurer proven to be responsible.

~~(6)~~(7) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

~~(7)~~(8) An employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

~~(8)~~(9) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 with an occupational disease that arises out of or is contracted in the course and scope of employment.

~~(9)~~(10) Occupational diseases are considered to arise out of employment or be contracted in the course and scope of employment if:

(a) the occupational disease is established by objective medical findings; and

(b) the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease.

~~(10)~~(11) When compensation is payable for an occupational disease, the only employer liable is the employer in whose employment the employee was last injuriously exposed to the hazard of the disease.

~~(11)~~(12) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time that the occupational disease was first diagnosed by a treating physician or medical panel; or

(b) the time that the employee knew or should have known that the condition was the result of an occupational disease.

~~(12)~~(13) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets of a mine from a person who was an operator of the mine on or after December 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person with respect to miners previously employed in the mine if acquisition had not occurred and that person had continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

~~(13)~~(14) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes."

Section 5. Section 39-71-606, MCA, is amended to read:

"39-71-606. ~~Insurer to accept or deny~~ Acceptance or denial of claim ~~within thirty days of receipt~~ -- notice of benefits and entitlements to claimants -- notice of denial -- notice of reopening -- notice to employer. (1) Each insurer under any plan for the payment of workers' compensation benefits shall, within ~~30~~ 21 days of receipt of a claim for compensation signed by the claimant or the claimant's representative, either accept or deny the claim and, if denied, shall inform the claimant and the department in writing of the denial.

(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlements available under Title 39, chapter 71. Upon receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlements available by providing the claimant a copy of the document prepared by the department.

(3) Upon receipt from the insurer of a report of injury or occupational disease pursuant to 39-71-307(2), the department shall distribute to the worker a document that describes the stay-at-work/return-to-work assistance, as defined in 39-71-1011, that is available upon request by the worker.

~~(3)~~(4) Each insurer under plan No. 2 or No. 3 for the payment of workers' compensation benefits shall notify the employer of the reopening of the claim within 14 days of the reopening of a claim for the purpose of paying compensation benefits.

~~(4)~~(5) Upon the request of an employer that it insures, an insurer shall notify the employer of all compensation benefits that are ongoing and are being charged against that employer's account.

~~(5)~~(6) Failure of an insurer to comply with the time limitations required in this section does not constitute an acceptance of a claim as a matter of law. However, an insurer who fails to comply with 39-71-608 or this

section may be assessed a penalty under 39-71-2907 if a claim is determined to be compensable by the workers' compensation court."

Section 6. Section 39-71-611, MCA, is amended to read:

"39-71-611. Costs and attorney fees payable on denial of claim or termination of benefits later found compensable -- barring of attorney fees under common fund and other doctrines. (1) ~~The~~ For benefits other than medical benefits, the insurer shall pay reasonable costs and attorney fees as established by the workers' compensation court if:

(a) the insurer denies liability for a claim for compensation or terminates compensation benefits;

(b) the claim is later adjudged compensable by the workers' compensation court; and

(c) in the case of attorney fees, the workers' compensation court determines that the insurer's actions in denying liability or terminating benefits were unreasonable.

(2) A finding of unreasonableness against an insurer made under ~~this section~~ subsection (1) does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(3) For medical benefits, the insurer shall pay reasonable costs and attorney fees if the insurer denies liability for a claim for medical benefits or terminates medical benefits and the medical benefits are later adjudged compensable by the workers' compensation court.

(4) The fees referred to under subsection (3) must be calculated using the attorney's contract of employment filed and approved by the department under 39-71-613.

(5) An insurer may not seek reimbursement or contribution from a health care provider for any costs or fees awarded pursuant to this section.

~~(3)~~(6) Attorney fees may be awarded only under the provisions of ~~subsection~~ subsections (1) and (3) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity.

(7) For the purposes of subsection (3), "medical benefits" means those benefits furnished pursuant to 39-71-704."

Section 7. Section 39-71-612, MCA, is amended to read:

"39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge -- barring of attorney fees under common fund or other doctrines. (1) If an insurer

pays or submits a written offer of payment of compensation under this chapter but controversy relates to the amount of compensation due, if the case is brought before the workers' compensation judge for adjudication of the controversy, and if the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

(2) ~~An~~ Except as provided in subsection (4), an award of attorney fees under subsection (1) may be made only if it is determined that the actions of the insurer were unreasonable. Any written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(3) A finding of unreasonableness against an insurer made under ~~this section~~ subsection (2) does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.

(4) (a) For medical benefits, the insurer shall pay reasonable costs and attorney fees as established and ordered by the workers' compensation court if:

(i) the insurer pays or submits a written offer of payment of medical benefits under Title 39, chapter 71, but there is controversy related to the amount of benefits due. A written offer of payment made 30 days or more before the date of hearing must be considered a valid offer of payment for the purposes of this section.

(ii) the case is brought before the workers' compensation judge for adjudication of the controversy; and

(iii) the award granted by the judge is greater than the amount paid or offered by the insurer.

(b) If the insurer denies liability for a claim for medical benefits or terminates medical benefits and the insurer subsequently accepts or settles the claim for medical benefits less than 30 days before the date of hearing, the insurer shall pay reasonable costs and attorney fees.

(5) The fees referred to under subsection (4) must be calculated using the attorney's contract of employment filed and approved by the department under 39-71-613.

(6) An insurer may not seek reimbursement or contribution from a health care provider for any costs or fees awarded pursuant to this section.

~~(4)~~(7) Attorney fees may be awarded only under the provisions of subsections (1) ~~and~~, (2), and (4) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity.

(8) For the purposes of subsection (4), "medical benefits" means those benefits furnished pursuant to 39-71-704."

Section 8. Section 39-71-614, MCA, is amended to read:

"39-71-614. Calculation of attorney fees -- limitation. (1) The amount of ~~an attorney's fee~~ attorney fees assessed against an insurer under 39-71-611 or 39-71-612, when the actions of the insurer were unreasonable, must be based exclusively on the time spent by the attorney in representing the claimant on the issues brought to hearing. The attorney ~~must~~ shall document the time spent, but the judge is not bound by the documentation submitted. The hourly rate applied to the time spent must be based on the attorney's customary and current hourly rate for legal work performed in this state, subject to a maximum established by the department.

(2) The judge shall determine ~~a~~ reasonable attorney ~~fee~~ fees and assess costs. ~~The hourly rate applied to the time spent must be based on the attorney's customary and current hourly rate for legal work performed in this state, subject to a maximum established by the department.~~ The amount of attorney fees assessed against an insurer under 39-71-611 or 39-71-612 for payment of medical benefits when the actions of the insurer were not determined to be unreasonable must be based exclusively on the fee agreement approved by the department under 39-71-613.

(3) This section does not restrict a claimant and an attorney from entering into a contingency fee arrangement under which the attorney receives a percentage of the amount of compensation payments received by the claimant because of the efforts of the attorney. However, an amount equal to any fee and costs assessed against an insurer under 39-71-611 or 39-71-612 and this section must be deducted from the fee an attorney is entitled to from the claimant under a contingency fee arrangement."

Section 9. Section 39-71-703, MCA, is amended to read:

"39-71-703. Compensation for permanent partial disability. (1) If an injured worker suffers a permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the worker is entitled to a permanent partial disability award if that worker:

(a) has an actual wage loss as a result of the injury; and

(b) has a permanent impairment rating that:

(i) is not based exclusively on complaints of pain;

(ii) is established by objective medical findings; and

(iii) is more than zero as determined ~~by the latest edition of the American medical association Guides to~~

~~the Evaluation of Permanent Impairment~~ pursuant to the impairment rating method provided by 39-71-711.

(2) When a worker receives an impairment rating as the result of a compensable injury or occupational disease and has no actual wage loss as a result of the injury, the worker is eligible for an impairment award only.

(3) (a) ~~The~~ Pending the certification provided for in subsection (11), the permanent partial disability award must be arrived at by multiplying the percentage arrived at through the calculation provided in subsection (5) by 375 weeks.

(b) After the certification provided for in subsection (11), the number of weeks used for the calculation for a permanent partial disability award is 400 weeks.

(4) A permanent partial disability award granted an injured worker may not exceed a permanent partial disability rating of 100%.

(5) The percentage to be used in subsection (4) must be determined by adding all of the following applicable percentages to the impairment rating:

(a) if the claimant is 40 years of age or younger at the time of injury, 0%; if the claimant is over 40 years of age at the time of injury, 1%;

(b) for a worker who has completed less than 12 years of education, 1%; for a worker who has completed 12 years or more of education or who has received a graduate equivalency diploma, 0%;

(c) if a worker has no actual wage loss as a result of the ~~industrial~~ compensable injury, 0%; if a worker has an actual wage loss of $2 or less an hour as a result of the ~~industrial~~ compensable injury, 10%; if a worker has an actual wage loss of more than $2 an hour as a result of the ~~industrial~~ compensable injury, 20%. Wage loss benefits must be based on the difference between the actual wages received at the time of injury and the wages that the worker earns or is qualified to earn after the worker reaches maximum healing.

(d) if a worker, at the time of the injury, was performing heavy labor activity and after the injury the worker can perform only light or sedentary labor activity, 5%; if a worker, at the time of injury, was performing heavy labor activity and after the injury the worker can perform only medium labor activity, 3%; if a worker was performing medium labor activity at the time of the injury and after the injury the worker can perform only light or sedentary labor activity, 2%.

(6) (a) ~~The~~ Pending the certification provided in subsection (11), the weekly benefit rate for permanent partial disability is 66 2/3% of the wages received at the time of injury, but the rate may not exceed one-half the state's average weekly wage.

(b) After the certification provided in subsection (11), the weekly benefit rate for permanent partial

disability is 66 2/3% of the wages received at the time of injury, but the rate may not exceed one-half the state's average weekly wage for an impairment award and may not exceed 85% of the state's average weekly wage for a permanent partial disability award.

(c) The weekly benefit amount established for an injured worker may not be changed by a subsequent adjustment in the state's average weekly wage for future fiscal years.

(7) An undisputed impairment award may be paid biweekly or in a lump sum at the discretion of the worker. Lump sums paid for impairments are not subject to the requirements of 39-71-741, except that lump-sum conversions for benefits not accrued may be reduced to present value at the rate established by the department pursuant to ~~39-71-741(3)~~ 39-71-741(6).

(8) If a worker suffers a subsequent compensable injury or injuries to the same part of the body, the award payable for the subsequent injury may not duplicate any amounts paid for the previous injury or injuries.

(9) If a worker is eligible for a rehabilitation plan, permanent partial disability benefits payable under this section must be calculated based on the wages that the worker earns or would be qualified to earn following the completion of the rehabilitation plan.

(10) As used in this section:

(a) "heavy labor activity" means the ability to lift over 50 pounds occasionally or up to 50 pounds frequently;

(b) "medium labor activity" means the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently;

(c) "light labor activity" means the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently; and

(d) "sedentary labor activity" means the ability to lift up to 10 pounds occasionally or up to 5 pounds frequently.

(11) (a) Subject to subsection (11)(c), the provisions of subsection (3)(b) apply starting on the July 1 that occurs at least 12 months after the certification by the insurance commissioner to the secretary of state of the effective date of a filing by the advisory organization designated pursuant to 33-16-1023 that contains a loss cost rate reduction amounting to a net reduction of 5% from the loss cost rate in effect on July 1, 2011.

(b) Subject to subsection (11)(c), the provisions of subsection (6)(b) apply starting on the July 1 that occurs at least 12 months after certification by the insurance commissioner to the secretary of state of the effective date of a filing by the advisory organization designated pursuant to 33-16-1023 that contains a loss cost

rate reduction amounting to a net reduction of 15% from the loss cost rate in effect on July 1, 2011.

(c) If a net reduction of 5% and a net reduction of 15% both become effective on the same July 1, both subsections (3)(b) and (6)(b) apply as of that July 1."

Section 10. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

(A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605;

(B) travel to a medical provider within the community in which the worker resides;

(C) travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel

or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the travel and treatment were required.

(e) Pursuant to rules adopted by the department, an insurer shall reimburse a catastrophically injured worker's family or, if a family member is unavailable, a person designated by the injured worker or approved by the insurer for travel assistance expenditures in an amount not to exceed $2,500 to be used as a match to those funds raised by community service organizations to help defray the costs of travel and lodging expenses incurred by the family member or designated person when traveling to be with the injured worker. These funds must be paid in addition to any travel expenses paid by an insurer for a travel companion when it is medically necessary for a travel companion to accompany the catastrophically injured worker.

(f) Except for the repair or replacement of a prosthesis furnished as a result of ~~an industrial~~ a compensable injury, the benefits provided for in this section terminate ~~when they are not used for a period of 60 consecutive months~~ pursuant to [section 1].

(g) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to ~~be permanently totally disabled~~ have a permanent total disability and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

(ii) when necessary to monitor the status of a prosthetic device; or

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable under subsection (1)(g) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

(h) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) (a) The department shall annually establish a schedule of fees for medical services that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

~~(b)~~ (i) The department ~~may not~~ shall set the base rate for facility medical services ~~at a rate~~ as follows:

(A) the base rate for acute care hospitals, both inpatient and outpatient, must be a rate between 135% and 165% of the product of the current medicare base rate multiplied by the current medicare wage index for this state;

(B) the base rate for ambulatory surgery centers may not be more than 75% of the acute care hospital outpatient rate set in subsection (2)(a)(i)(A);

(C) except as provided in subsection (7), all other facilities must be reimbursed at 75% of charges; and

(D) for all facility services, the department may not set the base rates lower than 135% of the product of the medicare base rate multiplied by the medicare wage index as published on January 1, 2011.

(ii) The department shall set the conversion factor for nonfacility medical services at a rate no lower than 10% below and no greater than 10% above the weighted average of the conversion factors used by up to the top five insurers or third-party administrators providing group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

~~(ii)~~(iii) The insurers or third-party administrators included under subsection ~~(2)(b)(i)~~ (2)(a)(ii) shall provide their standard conversion rates to the department.

~~(iii)~~(iv) The department may use the conversion rates only for the purpose of determining ~~average conversion~~ the rates under this subsection (2).

~~(iv)~~(v) The department shall maintain the confidentiality of the conversion rates.

~~(c)~~(b) The fee schedule rates established in subsection ~~(2)(b)~~ (2)(a) must be based on the following standards as adopted by the centers for medicare and medicaid services in effect at the time the services are provided, 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.

~~(d)~~(c) The department may establish additional coding standards for use by providers when billing for medical services under this section.

(3) (a) The department ~~may~~ shall establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the utilization and treatment guidelines established by the department are correct medical treatment for the injured worker.

(b) An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

(c) The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

(4) For services available in Montana, insurers may pay facilities located outside Montana according to the workers' compensation fee schedule of the state where the medical service is performed.

(5) (a) An insurer shall make payments at the fee schedule rate within 30 days of receipt of medical bills for which a claim has been accepted and for which no other disputes exist. Disputes must be defined by the department by rule.

(b) Any unpaid balance under this subsection (5) accrues interest at 12% a year or 1% a month or a fraction of a month. If the charge is not paid within 30 days, interest on the unpaid balance accrues from the date of receipt of the original billing.

(6) Once a determination has been made regarding the correct reimbursement amount, any overpayment made to a medical provider must be reimbursed to the insurer within 30 days of the determination. Any reimbursement amount remaining unpaid after 30 days accrues interest at 12% a year or 1% a month or a fraction of a month. Interest on the reimbursement amount remaining unpaid accrues from the date of receipt of the determination of the correct reimbursement amount.

(7) For a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual and customary charge.

(8) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(9) After mediation pursuant to department rules, an unresolved dispute between an insurer and a

medical service provider regarding the amount of a fee for medical services may be brought before the workers' compensation court.

(10) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(b) "Visit", as used in this subsection (10), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (10)(a) if the visit is for treatment requested by an insurer."

Section 11. Section 39-71-711, MCA, is amended to read:

"39-71-711. Impairment evaluation -- ratings. (1) An impairment rating:

(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;

(b) except as provided in subsection (5), must be based on the ~~current~~ fifth edition of the Guides to the Evaluation of Permanent Impairment published by the American medical association;

(c) must be expressed as a percentage of the whole person; and

(d) must be established by objective medical findings.

(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator if the injury falls within the scope of the evaluator's practice and if the evaluator is one of the following:

(a) a physician or an osteopath licensed under Title 37, chapter 3, with admitting privileges to practice in one or more hospitals, if any, in the area where the physician or osteopath is located;

(b) a chiropractor licensed under Title 37, chapter 12;

(c) a physician assistant licensed under Title 37, chapter 20, if there is not a physician as provided for in subsection (2)(a) in the area where the physician assistant is located;

(d) a dentist licensed under Title 37, chapter 4;

(e) an advanced practice registered nurse licensed under Title 37, chapter 8; or

(f) for a claimant residing out of state or upon approval of the insurer, an evaluator referred to in subsections (2)(a) through (2)(e) who is licensed or certified in another state.

(3) If the claimant and insurer cannot agree upon the rating, the mediation procedure in Title 39, chapter 71, part 24, must be followed.

(4) Disputes over impairment ratings are subject to the provisions of 39-71-605.

(5) The department, in consultation with an advisory body appointed under 2-15-122, may by administrative rule adopt or change to another system or method for the evaluation and rating of permanent impairment. The department may adopt a different edition of the Guides to the Evaluation of Permanent Impairment published by the American medical association or a system or method of rating developed by another state or well-recognized medical association. The department may change the system or method as often as the department considers a change advisable because of improvements in the methods of evaluating and rating permanent impairment."

Section 12. Section 39-71-712, MCA, is amended to read:

"39-71-712. Temporary partial disability benefits. (1) Subject to the provisions of subsection ~~(5)~~ (6), if prior to maximum healing an injured worker has a physical restriction and is approved to return to a modified or alternative employment that the worker is able and qualified to perform and the worker suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial disability benefits. For the purposes of this subsection, an actual wage loss is the difference between the worker's average weekly wage at the time of injury and the actual weekly wages received from the alternative employment the worker is able to perform.

(2) An insurer's liability for temporary partial disability benefits must be the difference between the ~~injured~~ worker's average weekly wage received at the time of the injury, subject to a maximum of 40 hours a week, and the actual weekly wages earned during the period that the claimant ~~is temporarily partially disabled~~ has a temporary partial disability, not to exceed the injured worker's temporary total disability benefit rate.

(3) Except as provided in subsection ~~(5)~~ (6), a worker is not eligible for temporary partial disability benefits or temporary total disability benefits if:

(a) the worker has been released by the treating physician to return to a modified or alternative position that the individual is able and qualified to perform with the same employer;

(b) the wages payable in the modified or alternative position, when combined with the temporary partial

disability benefits, would result in an equivalent or higher wage than the worker received at the time of injury; and

(c) the worker refuses to accept the modified or alternative position.

(4) A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available to the worker for any reason except for the worker's incarceration as provided ~~for~~ in 39-71-744, resignation, or termination for disciplinary reasons caused by a violation of the employer's policies that provide for termination of employment and if the worker continues to ~~be temporarily totally disabled~~ have a temporary total disability ~~as defined in 39-71-116~~.

~~(4)~~(5) Temporary partial disability may not be credited against any permanent partial disability award or settlement under 39-71-703.

~~(5)~~(6) Unless a collective bargaining agreement precludes an injured worker from working in a modified or alternative position with a different employer or includes criteria different from those outlined in this subsection ~~(5)~~ (6), an injured worker who has not reached maximum healing and who has a physical restriction may return to a modified or alternative position with a different employer at the same or a lower rate of wages as the rate paid by the employer at the time of injury if:

(a) a modified or alternative employment with the employer at the time of injury is not provided and the injured worker and that employer agree to the modified or alternative position with a different employer;

(b) a written description and all required duties of the modified or alternative position with a different employer are approved by the treating physician;

(c) both the employer at the time of injury and the injured worker agree to the type of alternative work, the alternative employer, and the terms and conditions of employment, including payment of benefits and employment taxes for the modified or alternative position with a different employer;

(d) an employee is not displaced as a result of the injured worker's placement in the modified or alternative position with a different employer; and

(e) the employer at the time of injury, the different employer, and the injured worker agree in writing to the terms and conditions, including payment of benefits, covering the injured worker for subsequent injury, unemployment insurance, employment taxes, and liability and provide a copy of the agreement to the injured employee.

~~(6)~~(7) Any additional expenses related to the modified or alternative position, including travel, equipment, or training, must be paid by either the employer at the time of injury or the different employer and may not be charged to or deducted from the wages or benefits of the injured employee.

~~(7)~~(8) Notwithstanding a written agreement between the employer at the time of injury and a different employer, the employer at the time of injury is the primary employer if a dispute over wages, benefits, employment taxes, workers' compensation insurance, or other terms or conditions of employment occurs.

~~(8)~~(9) The injured worker may refuse to accept a modified or alternative position with an employer other than the employer at the time of injury without penalty. If the injured worker is offered a modified or alternative position with a different employer, the injured worker must be given written notice of the right of refusal from the employer at the time of injury and the insurer prior to beginning work with the different employer."

Section 13. Section 39-71-721, MCA, is amended to read:

"39-71-721. Compensation for injury causing death -- limitation. (1) (a) If an injured employee dies and the injury was the proximate cause of the death, the beneficiary of the deceased is entitled to the same compensation as though the death occurred immediately following the injury. A beneficiary's eligibility for benefits commences after the date of death, and the benefit level is established as set forth in subsection (2).

(b) The insurer is entitled to recover any overpayments or compensation paid in a lump sum to a worker prior to death but not yet recouped. The insurer shall recover the payments from the beneficiary's biweekly payments as provided in ~~39-71-741(3)~~ 39-71-741(6).

(2) To beneficiaries as defined in 39-71-116(4)(a) through (4)(d), weekly compensation benefits for an injury causing death are 66 2/3% of the decedent's wages. The maximum weekly compensation benefit may not exceed the state's average weekly wage at the time of injury. The minimum weekly compensation benefit is 50% of the state's average weekly wage, but in no event may it exceed the decedent's actual wages at the time of death.

(3) To beneficiaries as defined in 39-71-116(4)(e) and (4)(f), weekly benefits must be paid to the extent of the dependency at the time of the injury, subject to a maximum of 66 2/3% of the decedent's wages. The maximum weekly compensation may not exceed the state's average weekly wage at the time of injury.

(4) If the decedent leaves no beneficiary, a lump-sum payment of $3,000 must be paid to the decedent's surviving parent or parents.

(5) If any beneficiary of a deceased employee dies, the right of the beneficiary to compensation under this chapter ceases. Death benefits must be paid to a surviving spouse for 500 weeks subsequent to the date of the deceased employee's death or until the spouse's remarriage, whichever occurs first. After benefit payments cease to a surviving spouse, death benefits must be paid to beneficiaries, if any, as defined in 39-71-116(4)(b)

through (4)(d).

(6) In all cases, benefits must be paid to beneficiaries.

(7) Benefits paid under this section may not be adjusted for cost of living as provided in 39-71-702."

Section 14. Section 39-71-736, MCA, is amended to read:

"39-71-736. Compensation -- from what dates paid. (1) (a) ~~Compensation~~ Except as provided in subsection (1)(c), compensation may not be paid for the first 32 hours or 4 days' loss of wages, whichever is less, that the ~~claimant~~ worker is ~~totally disabled and~~ unable to work because of an injury. A ~~claimant~~ worker is eligible for compensation starting with the 5th day.

(b) Separate benefits of medical and hospital services must be furnished from the date of injury.

(c) If the worker has a temporary total disability or a permanent total disability and is unable to work in any capacity for 21 days or longer, compensation must be paid retroactive to the first day of total wage loss unless the worker waives the payment as provided in subsection (2)(b)(ii).

(2) (a) For the purpose of this section, except as provided in subsection (3), ~~an injured~~ a worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 4-day waiting period.

(b) A worker who is entitled to receive retroactive compensation benefits pursuant to subsection (1)(c) but who took sick leave as provided by subsection (2)(a) may elect to either:

(i) repay the employer the amount of salary for the sick leave received; or

(ii) waive the retroactive payment of benefits attributable to any days or hours for which the worker received sick leave.

(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective bargaining agreement may not disqualify a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by ~~an injured~~ a worker may not affect the worker's eligibility for temporary total disability benefits."

Section 15. Section 39-71-737, MCA, is amended to read:

"39-71-737. Compensation to run consecutively -- exceptions. Compensation must run consecutively and not concurrently, and payment may not be made for two classes of disability over the same period, except that impairment awards and auxiliary ~~rehabilitation~~ benefits may be paid concurrently with other classes of

benefits."

Section 16. Section 39-71-741, MCA, is amended to read:

"39-71-741. ~~Compromise settlements~~ Settlements and lump-sum payments. (1) By written agreement, a claimant and an insurer may convert benefits under this chapter ~~may be converted~~ in whole or in part into a lump sum. An agreement that settles a claim for any type of benefit is subject to department approval as provided in subsection (2). Lump-sum advances and payment of accrued benefits in a lump sum, except permanent total disability benefits under subsection ~~(1)(c)~~ (2)(c), are not subject to department approval. ~~If the department fails to approve or disapprove the agreement in writing within 14 days of the filing with the department, the agreement is approved.~~

(2) The department shall directly notify a claimant of a department order approving or disapproving a claimant's ~~compromise~~ settlement or lump-sum payment. Upon approval, the agreement constitutes a compromise and release settlement and may not be reopened by the department. The department may approve ~~an~~ a settlement agreement to convert the following benefits to a lump sum only under the following conditions:

(a) all benefits if a claimant and an insurer dispute the initial compensability of an injury and there is a reasonable dispute over compensability;

(b) permanent partial disability benefits if an insurer has accepted initial liability for an injury. The total of any ~~permanent partial~~ lump-sum ~~conversion~~ payments in part that is awarded to a claimant prior to the claimant's final award may not exceed the anticipated award under 39-71-703. The department may disapprove an agreement under this subsection ~~(1)(b)~~ (2)(b) only if the department determines that the lump-sum ~~conversion amount~~ payment is inadequate.

(c) permanent total disability benefits if the total of all lump-sum conversions in part that are awarded to a claimant do not exceed $20,000. The approval or award of a lump-sum permanent total disability payment in whole or in part by the department or court must be the exception. It may be given only if the worker has demonstrated financial need that:

(i) relates to:

(A) the necessities of life;

(B) an accumulation of debt incurred prior to the injury; or

(C) a self-employment venture that is considered feasible under criteria set forth by the department; or

(ii) arises subsequent to the date of injury or arises because of reduced income as a result of the injury.

(d) except as otherwise provided in this chapter, all other ~~compromise~~ settlements and lump-sum payments agreed to by a claimant and insurer; ~~or~~

(e) medical benefits on an accepted claim if an insurer disputes the insurer's continued liability for medical benefits and there is a reasonable dispute over the medical treatment or medical compensability; or

(f) medical benefits on an accepted claim if the claimant has reached maximum medical improvement and the insurer and claimant mutually agree to a settlement of all or a portion of medical benefits and a settlement is in the best interest of the parties to the settlement. The parties to the settlement agreement shall set out the amount of the anticipated future medical costs included in the settlement agreement and the rationale that is the basis for the settlement. The claimant shall also indicate by a signed acknowledgment an understanding of which medical benefits will terminate because of the settlement. If the amount of the settlement agreement attributable to the medical portion is for $25,000 or more, department approval may be given if the agreement is in the best interest of the parties to the settlement and is not grossly inadequate.

(3) If any settlement of medical benefits under this section is subject to a medicare-approved set-aside for payment of future medical expenses, the department may not approve the settlement unless the settlement language is expressly contingent on medicare's approval of the set-aside. If the department approves a settlement and medicare approval is subsequently denied, the agreement between the parties is void and the insurer shall notify the department that the settlement is no longer in effect.

(4) For any settlement subject to this section, the parties may agree that the settlement funds be paid into a trust that is specifically established for the payment of medical expenses due to the injury.

~~(2)~~(5) Any lump-sum conversion of benefits under this section must be converted to present value using the rate prescribed under subsection ~~(3)(b)~~ (6)(b).

~~(3)~~(6) (a) An insurer may recoup any lump-sum ~~payment~~ advance amortized at the rate established by the department, prorated biweekly over the projected duration of the compensation period.

(b) The rate adopted by the department must be based on the average rate for United States 10-year treasury bills in the previous calendar year.

(c) If the projected compensation period is the claimant's lifetime, the life expectancy must be determined by using the most recent table of life expectancy as published by the United States national center for health statistics.

~~(4)~~(7) A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump sum or settlement of medical benefits under subsection (2)(a) or (2)(e) is considered a dispute for which

a mediator and the workers' compensation court have jurisdiction to make a determination. A request for mediation must be filed with the department. Upon any review by a court, the court shall use the standards for approval established under this section.

(8) If an insurer and a claimant agree to a ~~compromise and release~~ settlement or a lump-sum payment but the department disapproves the agreement, the parties may request that the workers' compensation court ~~to~~ review the department's decision without requesting mediation.

(9) The legislature does not intend to allow settlement of undisputed medical claims under subsection (2)(f) unless all parties willingly agree to the settlement. The failure of the parties to willingly agree to a settlement does not constitute a dispute concerning benefits."

Section 17. Section 39-71-1011, MCA, is amended to read:

"39-71-1011. Definitions. As used in this ~~chapter~~ part, the following definitions apply:

(1) "Assistance fund" means the stay-at-work/return-to-work assistance fund provided for in [section 24].

~~(1)~~(2) "Commission on rehabilitation counselor certification" means the nonprofit, independent, fee-structured organization that is a member of the national commission for health certifying agencies and that is established to certify rehabilitation ~~practitioners~~ providers.

~~(2)~~(3) "Disabled worker" means a worker who has a permanent impairment, established by objective medical findings, resulting from a work-related injury that precludes the worker from returning to the job the worker held at the time of the injury or to a job with similar physical requirements and who has an actual wage loss as a result of the injury.

(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 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.

~~(3)~~(5) "Rehabilitation benefits" means benefits provided in 39-71-1006 and 39-71-1025.

~~(4)~~(6) "Rehabilitation plan" means a written individualized plan that assists a disabled worker in acquiring skills or aptitudes to return to work through job placement, on-the-job training, education, training, or specialized job modification and that reasonably reduces the worker's actual wage loss.

~~(5)~~(7) "Rehabilitation provider" means a rehabilitation counselor certified by the commission on

rehabilitation counselor certification and designated by the insurer.

~~(6)~~(8) "Rehabilitation services" means a program of evaluation, planning, and implementation of a rehabilitation plan to assist a disabled worker to return to work.

(9) "Stay-at-work/return-to-work assistance" or "assistance" means the evaluation, planning, implementation, and provision of other 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."

NEW SECTION. **Section 18. 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.

NEW SECTION. **Section 19. 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 in accordance with either 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 in accordance with either 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) Any 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 [section 1] 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.

NEW SECTION. **Section 20. 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 18].

(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.

Section 21. 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) a search for new employment;

~~(2)~~(b) a 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."

Section 22. 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."

NEW SECTION. **Section 23. Exchange of information regarding stay-at-work/return-to-work assistance.** (1) In order to protect the privacy rights of an injured worker, health care information related to a workplace injury or occupational disease may not be released by health care providers to the worker's employer without an authorization for the release of information from the worker. A written authorization provided for in this subsection for the release of stay-at-work/return-to-work information to the employer by health care providers must be signed by the worker and must comply with 50-16-526. The written authorization may be executed without the need for either the worker or the employer to have already completed a first report of injury or occupational disease.

(2) After satisfying the release of information requirements provided in subsection (1), only the following written information, which may constitute health care information as defined in 50-16-504, may be released by health care providers to the worker's employer:

(a) the workers' restrictions related to the claim;

(b) the date or anticipated date when the worker is released to return to work;

(c) the approval or disapproval of work activities or job descriptions for the worker;

(d) the date or anticipated date of maximum medical healing; and

(e) the worker's next appointment date.

(3) An employer receiving information regarding a worker's medical condition pursuant to this section shall exercise due care to prevent unauthorized use or redisclosure of that information.

(4) This section does not prohibit health care providers from discussing return-to-work issues with an employer if the worker is present and consents to the discussion or if the worker separately signs and consents in the release as provided in subsection (1) to verbal communications between the worker's employer and the worker's health care provider.

NEW SECTION. **Section 24. 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 can 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.

NEW SECTION. **Section 25. 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 and 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.

NEW SECTION. **Section 26. Rulemaking authority.** The department may adopt rules to implement this part.

NEW SECTION. **Section 27. 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 24] 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 25] is 0.00082.

NEW SECTION. **Section 28. Notification to tribal governments.** The secretary of state shall send a copy of [this act] to each tribal government located on the seven Montana reservations and to the Little Shell Chippewa tribe.

NEW SECTION. **Section 29. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [section 1].

(2) [Sections 18 through 20 and 23 through 26] are intended to be codified as an integral part of Title 39, chapter 71, part 10, and the provisions of Title 39, chapter 71, part 10, apply to [sections 18 through 20 and 23 through 26].

NEW SECTION. **Section 30. Severability -- nonseverability.** (1) Except as provided in subsections

(2) through (4), if a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

(2) It is the intent of the legislature that [sections 15, 17 through 22, and 24 through 27] 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 [sections 6 through 8] 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.

(4) It is the intent of the legislature that if any one of the amendments to [section 16] regarding settlement of undisputed medical benefits is held invalid or unconstitutional, the other amendments in [section 16] and [section 32(4)] regarding settlement of undisputed medical benefits are invalid so that settlement of undisputed medical benefits is no longer permitted.

NEW SECTION. **Section 31. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2011.

(2) [Sections 27 through 30 and 32] and this section are effective on passage and approval.

NEW SECTION. **Section 32. Applicability.** (1) Except as provided in subsections (2) through (4) and unless otherwise specifically stated, [this act] applies to injuries and occupational diseases occurring on or after July 1, 2011.

(2) [Sections 6 through 8] apply to disputes arising on or after July 1, 2011.

(3) [Section 10], except for subsection (1)(f), applies to service provided on or after July 1, 2011, regardless of the date of injury or occupational disease.

(4) [Section 16] applies retroactively, within the meaning of 1-2-109, to claims for injuries or occupational diseases for which all benefits have not been settled.

- END -