



AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; PROVIDING FOR CLOSURE OF CLAIMS; PROVIDING A PROCESS TO REOPEN MEDICAL CLAIMS; ESTABLISHING A MEDICAL DIRECTOR AND MEDICAL REVIEW PANEL; REVISING PERMANENT PARTIAL DISABILITY DEFINITION AND BENEFITS; CLARIFYING WHAT CONSTITUTES COURSE AND SCOPE OF EMPLOYMENT; ALLOWING RETROACTIVE BENEFIT PAYMENTS TO CERTAIN WORKERS; PROVIDING FOR SETTLEMENTS OF MEDICAL CLAIMS; PROVIDING FOR INSURER DESIGNATION OF TREATING PHYSICIANS; PROVIDING PAY SCALES FOR TREATING PHYSICIANS AND HEALTH CARE PROVIDERS; PROVIDING CERTAIN LIMITATIONS ON MEDICAL PAY SCHEDULES FOR THE BIENNIUM; REQUIRING THE LEGISLATIVE AUDITOR TO SUBMIT REPORTS ON THE MONTANA STATE FUND TO THE INSURANCE COMMISSIONER; REVISING VOCATIONAL REHABILITATION SERVICES AND TERMS TO ASSIST AN EMPLOYEE IN STAYING AT WORK OR RETURNING TO WORK; CREATING A STAY-AT-WORK/RETURN-TO-WORK ASSISTANCE FUND AND PROVIDING FOR ASSESSMENTS; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 39-71-105, 39-71-116, 39-71-118, 39-71-225, 39-71-315, 39-71-320, 39-71-403, 39-71-407, 39-71-703, 39-71-704, 39-71-711, 39-71-721, 39-71-736, 39-71-741, 39-71-1011, 39-71-1025, 39-71-1031, 39-71-1101, 39-71-1102, 39-71-1106, AND 39-71-2361, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATES.

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

Section 1. Section 39-71-105, MCA, is amended to read:

"39-71-105. Declaration of public policy. For the purposes of interpreting and applying this chapter, the following is the public policy of this state:

(1) An objective of the Montana workers' compensation system is to provide, without regard to fault, wage-loss and medical benefits to a worker suffering from a work-related injury or disease. Wage-loss benefits are not intended to make an injured worker whole but are intended to ~~assist~~ provide assistance to a worker at a reasonable cost to the employer. ~~Within that limitation, the wage-loss benefit should bear a reasonable~~

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

(2) It is the intent of the legislature to assert that a conclusive presumption exists that recognizes that a holder of a current, valid independent contractor exemption certificate issued by the department is an independent contractor if the person is working under the independent contractor exemption certificate. The holder of an independent contractor exemption certificate waives the rights, benefits, and obligations of this chapter unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3.

(3) A worker's removal from the workforce because of a work-related injury or disease has a negative impact on the worker, the worker's family, the employer, and the general public. Therefore, an objective of the workers' compensation system is to return a worker to work as soon as possible after the worker has suffered a work-related injury or disease.

(4) Montana's workers' compensation and occupational disease insurance systems are intended to be primarily self-administering. Claimants should be able to speedily obtain benefits, and employers should be able to provide coverage at reasonably constant rates. To meet these objectives, the system must be designed to minimize reliance upon lawyers and the courts to obtain benefits and interpret liabilities.

(5) This chapter must be construed according to its terms and not liberally in favor of any party.

(6) It is the intent of the legislature that:

(a) stress claims, often referred to as "mental-mental claims" and "mental-physical claims", are not compensable under Montana's workers' compensation and occupational disease laws. The legislature recognizes that these claims are difficult to objectively verify and that the claims have a potential to place an economic burden on the workers' compensation and occupational disease system. The legislature also recognizes that there are other states that do not provide compensation for various categories of stress claims and that stress claims have presented economic problems for certain other jurisdictions. In addition, not all injuries are compensable under the present system, and it is within the legislature's authority to define the limits of the workers' compensation and occupational disease system.

(b) for occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims

reflect consideration of when the worker knew or should have known that the worker's condition resulted from an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that it is within the legislature's authority to define an occupational disease and establish the causal connection to the workplace."

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) "Direct result" means that a diagnosed condition was caused or aggravated by an injury or occupational disease.

~~(12)~~(13) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(14) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

~~(13)~~(15) (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.

(16) (a) "Indemnity benefits" means any payment made directly to the worker or the worker's beneficiaries, other than a medical benefit. The term includes payments made pursuant to a reservation of rights.

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

~~(14)~~(17) "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)~~(18) "Invalid" means one who is physically or mentally incapacitated.

~~(16)~~(19) "Limited liability company" has the meaning provided in 35-8-102.

~~(17)~~(20) "Maintenance care" means treatment designed to provide the optimum state of health ~~while minimizing recurrence of the clinical status~~ while minimizing recurrence of the clinical status.

~~(18)~~(21) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical healing" means a point in the healing process when further material functional improvement would not be reasonably expected from primary medical ~~treatment~~ services.

~~(19)~~(22) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

~~(20)~~(23) (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)~~(24) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at by the department.

~~(22)~~(25) "Palliative care" means treatment designed to reduce or ease symptoms without curing the underlying cause of the symptoms.

~~(23)~~(26) "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)~~(27) "Permanent partial disability" means a physical condition in which a worker, after reaching maximum medical healing:

(a) has a permanent impairment, as determined by the sixth edition of the American medical association's Guides to the Evaluation of Permanent Impairment, that is established by objective medical findings for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease and may not be based exclusively on complaints of pain;

(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)~~(28) "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.

~~(26)~~(29) "Primary medical services" means treatment prescribed by a the treating physician, for conditions resulting from the injury or occupational disease, necessary for ~~achieving~~ achieving medical stability.

~~(27)~~(30) "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)~~(31) "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)~~(32) "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.

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

~~(30)~~(34) (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)~~ (34), "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)~~(35) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

~~(32)~~(36) "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)~~(37) "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)~~(38) "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)~~(39) "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)~~(40) "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)~~(41) "Treating physician" means ~~a the person who is~~ who, subject to the requirements of 39-71-1101, is primarily responsible for delivery and coordination of the worker's medical services for the treatment of a worker's compensable injury or occupational disease and is:

- (a) a physician licensed by the state of Montana under Title 37, chapter 3, and 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)~~ (41)(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)~~ (41)(a) through ~~(37)(e)~~ (41)(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)~~(42) "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)~~(43) "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, 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)(e)~~ (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 39-71-225, MCA, is amended to read:

"39-71-225. Workers' compensation database system. (1) The department shall develop a workers' compensation database system to generate management information about Montana's workers' compensation system. The database system must be used to collect and compile information from insurers, employers, ~~medical~~ health care providers, claimants, claims examiners, rehabilitation providers, and the legal profession.

(2) Data collected must be used to provide:

(a) management information to the legislative and executive branches for the purpose of making policy and management decisions, including but not limited to:

(i) performance information to enable the state to enact remedial efforts to ensure quality, control abuse, and enhance cost control;

(ii) information on medical, indemnity, and rehabilitation costs, utilization, and trends;

(iii) information on litigation and attorney involvement for the purpose of identifying trends, problem areas, and the costs of legal involvement;

(b) current and prior claim information to any insurer that is at risk on a claim, or that is alleged to be at risk in any administrative or judicial proceeding, to determine claims liability or for fraud investigation. The department may release information only upon written request by the insurer and may disclose only the claimant's name, claimant's identification number, prior claim number, date of injury, body part involved, and name and address of the insurer and claims examiner on each claim filed. Information obtained by an insurer pursuant to this section must remain confidential and may not be disclosed to a third party except to the extent necessary for determining claim liability or for fraud investigation.

(c) current and prior claim information to law enforcement agencies for purposes of fraud investigation or prosecution; and

(d) to any insurer that is at risk on a claim, information identifying whether the claimant has been certified by the department as a person with a disability. Information obtained by an insurer pursuant to this subsection (2)(d) must remain confidential and may not be disclosed to a third party except as necessary to implement the provisions of Title 39, chapter 71, part 9. An insurer may disclose to the employer that the claimant has been certified by the department and of the potential for a limit on the insurer's liability and of potential reimbursement by the subsequent injury fund.

(3) The department is authorized to collect from insurers, employers, medical providers, the legal profession, and others the information necessary to generate the workers' compensation database system.

(4) The workers' compensation database system must be designed in accordance with the following principles:

(a) avoidance of duplication and inconsistency;

(b) reasonable availability of data elements;

(c) value of information collected to be commensurate with the cost of retrieving the collected information;

- (d) uniformity to permit efficiency of collection and to allow interstate comparisons;
 - (e) a workable mechanism to ensure the accuracy of the data collected and to protect the confidentiality of collected data;
 - (f) reasonable availability of the data at a fair cost to the user;
 - (g) a broad application to plan No. 1, plan No. 2, and plan No. 3 insurers;
 - (h) compatibility with electronic data reporting;
 - (i) reporting procedures that can be handled through private data collection systems that adhere to the provisions of subsections (4)(a) through (4)(h);
 - (j) implementation of reporting requirements that allow reasonable lead time for compliance.
- (5) The department shall publish an annual report on the information compiled.
- (6) Users of information obtained from the workers' compensation database under this section are liable for damages arising from misuse or unlawful dissemination of database information.
- (7) An insurer or a third-party administrator who submitted 50 or more "first reports of injury" to the department in the preceding calendar year shall electronically submit the reports and any other reports related to the reported claims in a nationally recognized format specified by department rule.
- (8) The department may adopt rules to implement this section."

Section 5. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions -- penalty. (1) The following actions by a ~~medical~~ health care provider constitute violations and are subject to the penalty in subsection (2):

- (a) failing to certify the provision of the services or treatment for which compensation is claimed under this chapter; or
- (b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than \$200 or more than \$500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant

to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

Section 6. Section 39-71-320, MCA, is amended to read:

"39-71-320. Voluntary certification program for claims examiners -- purpose -- rulemaking -- advisory committee -- continuing education. (1) Pursuant to the public policy stated in 39-71-105, accurate and prompt claims handling practices are necessary to provide appropriate service to injured workers, employers, and ~~medical~~ health care providers. In order to further that public policy, the purpose of this section is to authorize the department to establish a voluntary certification program for claims examiners. The department shall administer the voluntary certification program.

(2) The voluntary certification program is intended to improve the handling of workers' compensation claims by:

- (a) establishing minimum qualifications and procedures for certifying claims examiners;
- (b) requiring continuing education for certified claims examiners;
- (c) better educating certified claims examiners about changes in the law; and
- (d) providing standards for the qualifications of instructors, courses, and materials.

(3) The department shall adopt rules for the certification of workers' compensation claims examiners, providing for:

- (a) minimum qualifications;
- (b) examination;
- (c) 2-year certification and renewal;
- (d) continuing education requirements; and
- (e) a waiver of the examination requirement for an individual requesting certification as a claims examiner within the first 12 months after the department has adopted the initial rules under this subsection (3). The waiver is available only to an individual who has been actively engaged in the work of a claims examiner in this state, working on workers' compensation claims for 5 of the 7 years immediately preceding the individual's application for certification under this section.

(4) The department may appoint an advisory committee composed of injured workers, insurers,

self-insured employers, third-party administrators, claims examiners, and members of the public to advise the department on setting standards for certification and continuing education.

- (5) The department shall maintain:
 - (a) a list of all certified claims examiners; and
 - (b) the following records related to certified claims examiners:
 - (i) documentation of current and historical certifications;
 - (ii) beginning and ending dates of certifications; and
 - (iii) continuing education records.

(6) The training curriculum and continuing education used by insurers, self-insured employers, and third-party administrators for claims examiners must relate to the state workers' compensation system or to interactions among injured workers, medical providers, and employers. The training curriculum, course content, instructors, materials, instructional format, and the sponsoring organization must be approved by the department as qualifying for use in certification of claims examiners. The department may offer specialized training for continuing education purposes that is exempt from the approval requirements of this subsection.

(7) The department shall determine the number of credit hours to be awarded for completion of an approved training curriculum or department-approved specialized training. The department may accept continuing education credits approved by the insurance commissioner's office as provided in Title 33, chapter 17, the office of public instruction, or the state bar of Montana to satisfy the continuing education requirements for renewal of the claims examiner certification. The department, in its discretion, may accept continuing education credits from other accrediting sources.

(8) The department shall by rule adopt fees commensurate with the costs of administering the voluntary certification program. All fees collected by the department as provided in this section must be deposited in the workers' compensation administration fund provided for in 39-71-201. The department may charge a fee for the certification program, including but not limited to fees for:

- (a) initial certification, including examination;
- (b) certification renewal;
- (c) approval of training curricula, including continuing education courses, course content, instructors, materials, instructional format, and sponsoring organizations; and
- (d) specialized training offered by the department."

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

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

(b) (i) Subject to subsection (5), the department of administration, provided for in 2-15-1001, shall manage workers' compensation insurance coverage for all state agencies.

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

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

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

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

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are

reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

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

(ii) The bonds and notes:

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

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

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

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

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

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

credited to the fund.

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

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

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

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

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

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

(B) the judicial branch; and

(C) the legislative branch.

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

Section 8. 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 activity. The exclusion from coverage of this subsection (2)(b) does not apply to an employee who, at the time of injury, is on paid time while participating in a social or recreational activity or whose presence at the activity is required or requested by the employer. For the purposes of this subsection (2)(b), "requested" means the employer asked the employee to assume duties for the activity so that the employee's presence is not completely voluntary and optional and the injury occurred in the performance of those duties.

~~(2)(3)~~ (a) An insurer is liable for an injury, as defined in 39-71-119, only 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 has occurred and aggravated a preexisting condition.

~~(b)~~(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 if the employee is diagnosed with an a compensable occupational disease that arises out of or is contracted in the course and scope of employment.

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

(10) An insurer is liable for an occupational disease only if the occupational disease:

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

~~(b)~~(b) arises out of or is contracted in the course and scope of employment. An occupational disease is considered to arise out of or be contracted in the course and scope of employment if 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~~ health care provider; 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 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~~ rating as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease that:

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

(ii) is established by objective medical findings; ~~and; and~~

(iii) is more than zero.

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

(2) ~~When a worker receives an impairment rating as the result of a compensable injury and has no actual wage loss as a result of the injury, the~~ When a worker receives a Class 2 or greater class of impairment as converted to the whole person, as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition, and has no actual wage loss as a result of the compensable injury or occupational disease, the worker is eligible to receive payment for an impairment award only.

(3) The permanent partial disability award must be arrived at by multiplying the percentage arrived at through the calculation provided in subsection (5) by ~~375~~ 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 whole person 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 injury, 0%; if a worker has an actual wage loss of \$2 or less an hour as a result of the industrial injury, 10%; if a worker has an actual wage loss of more than \$2 an hour as a result of the industrial 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) 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. 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 payments~~ 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(5).

(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."

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 or occupational disease and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services, including prescription drugs for conditions ~~resulting from~~ that are a direct result of the compensable injury or occupational disease, for those periods ~~as the nature of the injury or the process of recovery requires~~ specified in this section.

(b) ~~The~~ Subject to the limitations in this chapter, 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~~ health care 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~~ health care 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) (i) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive 60 months from the date of injury or diagnosis of an occupational disease. A worker may request reopening of medical benefits that were terminated under this subsection (1)(f) as provided in [section 29].

(ii) Subsection (1)(f)(i) does not apply to a worker who is permanently totally disabled as a result of a compensable injury or occupational disease or for the repair or replacement of a prosthesis furnished as a direct result of a compensable injury or occupational disease.

(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 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. Regardless of the date of injury, payment for medical services is based on the fee schedule rates in this section in effect on the date on which the medical service is provided. 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 set the rate for medical services at a rate greater than 10% above the 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) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their standard conversion rates to the department.

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

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

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

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

(ii) the healthcare common procedure coding system;

(iii) the medicare severity diagnosis-related groups;

(iv) the ambulatory payment classifications;

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

(vi) the national correct coding initiative edits; and

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

~~(e)(d)~~ The On or after July 1, 2013, the fee schedule rates established in subsection (2)(b) 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, as those codes exist on March 31 of each year;

(ii) the healthcare common procedure coding system, as those codes and their relative weights exist on March 31 of each year;

(iii) the medicare severity diagnosis-related groups, as those codes and their relative weights exist on October 1 of each year;

(iv) the ambulatory payment classifications, as those codes and their relative weights exist on March 31 of each year;

(v) the ratio of costs to charges for each hospital, as those codes exist on October 1 of each year;

(vi) the national correct coding initiative edits, as those codes exist on March 31 of each year; and

(vii) the relative value units as adjusted annually using the most recently in the published resource-based relative value scale, as those codes exist on March 31 of each year.

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

(f) The rates in effect through June 30, 2013, may not be less than the rates for medical services in effect as of December 31, 2010.

(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 adopted utilization and treatment guidelines established by the department are correct medical treatment for the injured worker establish compensable medical treatment for an 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~~ shall hire a medical director. The department may establish by rule an independent medical review process ~~for~~ for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

(d) The department, in consultation with health care providers with relevant experience and education, shall provide for an annual review of the evidence-based utilization and treatment guidelines to consider amendments or changes to the guidelines.

(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~~ health care 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~~ health care 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) must be based on the ~~current~~ sixth edition of the American medical association 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 and may not be based exclusively on complaints of pain.

(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."

Section 12. 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(5).

(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 13. 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 is totally disabled and unable to work in any capacity for 21 days or longer, compensation must be paid retroactively 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 in 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 14. Section 39-71-741, MCA, is amended to read:

"39-71-741. ~~Compromise settlements~~ Settlements and lump-sum payments -- legislative intent.

(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)(e)~~ (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~~ payment 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 is inadequate.

(c) permanent total disability benefits if the total of all lump-sum ~~conversions~~ payments 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 following applicable conditions are met:

(i) the insurer and claimant mutually agree to a settlement of all or a portion of medical benefits; and

(ii) a settlement is in the best interest of the parties to the settlement.

(3) The parties to a medical settlement agreement shall set out the rationale that is the basis for the settlement under subsection (2)(f), and the claimant shall indicate by a signed acknowledgment an understanding of what medical benefits will terminate because of that settlement.

~~(2)(4)~~ Any lump-sum conversion of benefits under this section must be converted to present value using the rate prescribed under subsection ~~(3)(b)~~ (5)(b).

~~(3)(5)~~ (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)(6)~~ A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump sum is considered a dispute for which a mediator and the workers' compensation court have jurisdiction to make a determination.

(7) 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 the workers' compensation court to review the department's decision without requesting mediation.

(8) 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 15. 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 19].

~~(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 a disabled worker. The services are intended to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan.

~~(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 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."

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

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

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

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

(b) If an insurer has accepted liability for the claim, the insurer shall provide stay-at-work/return-to-work assistance either in accordance with the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services. The insurer is directly liable for paying for the stay-at-work/return-to-work assistance furnished.

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

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

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

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

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

and notifies the department of the denial.

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

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

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

(4) Stay-at-work/return-to-work assistance requested under this section is available as a service apart from a determination regarding indemnity benefits. A worker or an employer may decline to accept stay-at-work/return-to-work assistance. The failure of a worker to voluntarily agree to assistance is not a dispute concerning benefits. However, if the assistance provided under this part results in a job offer for a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury and the worker refuses the offer, the workers' indemnity benefits may end as provided in 39-71-701 and 39-71-712.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 19. Stay-at-work/return-to-work assistance fund -- purpose -- payment process --

rulemaking. (1) There is a stay-at-work/return-to-work assistance fund in the proprietary fund category.

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

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

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

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

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

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

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

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

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

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

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is the

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

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

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

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

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

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

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

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment

premium surcharges collected during a calendar quarter no later than 20 days following the end of the quarter.

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

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

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

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

Section 21. Rulemaking authority. The department may adopt rules to implement this part.

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

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

(1)(a) search for new employment;

(2)(b) return to work but in a new location;

(3)(c) ~~implement~~ the implementation of a rehabilitation plan that has been filed with the department; ~~and~~

or

(4)(d) ~~attend~~ attendance at an on-the-job training program.

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

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

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

Section 24. Section 39-71-1101, MCA, is amended to read:

"39-71-1101. Choice of physician health care provider by worker -- change insurer designation or approval of treating physician -- receipt of care from or managed care organization -- payment terms -- definition. (1) ~~Subject to subsection (3),~~ Prior to the insurer's designation or approval of a treating physician as provided in subsection (2) or a referral to a managed care organization or preferred provider organization as provided in subsection (7), a worker may choose the a person who is listed in 39-71-116(41) for initial treating physician within the state of Montana treatment. Subject to subsection (2), if the person listed under 39-71-116(41) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician.

(2) Any time after acceptance of liability by an insurer, the insurer may designate or approve a treating physician who agrees to assume the responsibilities of the treating physician. The designated or approved treating physician:

(a) is responsible for coordinating the worker's receipt of medical services as provided in 39-71-704;

(b) shall provide timely determinations required under this chapter, including but not limited to maximum medical healing, physical restrictions, return to work, and approval of job analyses, and shall provide documentation;

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

(d) shall conduct or arrange for timely impairment ratings.

(3) The treating physician may refer the worker to other health care providers for medical services, as provided in 39-71-704, for the treatment of a worker's compensable injury or occupational disease. A health care provider to whom the worker is referred by the designated treating physician is not responsible for coordinating care or providing determinations as required of the treating physician.

(4) The treating physician designated or approved by the insurer must be reimbursed at 110% of the department's fee schedule.

(5) A health care provider to whom the worker is referred by the treating physician must be reimbursed at 90% of the department's fee schedule.

(6) A health care provider providing health care on a compensable claim prior to the designation or approval of the treating physician by the insurer must be reimbursed at 100% of the department's fee schedule.

~~— (2) Authorization by the insurer is required to change treating physicians. If authorization is not granted, the~~

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

~~(8) The insurer shall may direct the worker to a managed care organization, if any, or to a medical service provider who qualifies as a treating physician, who shall then serve as the worker's or a preferred provider organization for designation of the treating physician.~~

~~(3)(9) A medical service~~ After the insurer directs a worker to a managed care organization or preferred provider organization, a health care provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer, if:

~~— (a) the injury results in a total loss of wages for any duration;~~

~~— (b) the injury will result in permanent impairment;~~

~~— (c) the injury results in the need for a referral to another medical provider for specialized evaluation or treatment; or~~

~~— (d) specialized diagnostic tests, including but not limited to magnetic resonance imaging, computerized axial tomography, or electromyography, are required.~~

~~(4)(10)~~ After the date that a worker whose injury is subject to the provisions of subsection (3) (8) receives individual written notice of a referral to a managed care organization, the worker must, unless otherwise authorized by the insurer, receive medical services from the managed care organization designated by the insurer, in accordance with 39-71-1102 and 39-71-1104. The designated treating physician in the managed care organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury

from a ~~medical service~~ health care provider who is not a member of a managed care organization or a preferred provider organization.

~~(5)(11)~~ Posting of managed care requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to a managed care organization must be provided to the worker in written form by mail or in person after the date ~~that the~~ of injury or occupational disease ~~meets the provisions of subsection (3)~~. ~~The notice must advise the worker of the worker's right to choose the initial treating physician under subsection (1).~~

~~(6) Any postings or other information regarding referral to a managed care organization on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means and any individual notice of referral to a managed care organization, whether before or after the occurrence of an injury, must include in prominent type advice of the worker's right to choose the initial treating physician pursuant to subsection (1)."~~

Section 25. Section 39-71-1102, MCA, is amended to read:

"39-71-1102. Preferred provider organizations -- establishment -- limitations. (1) In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with suppliers of soft and durable medical goods and medical health care providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that an injured worker is given an individual written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers. ~~This section does not prohibit the worker from choosing the initial treating physician under 39-71-1101(1).~~

(2) Posting of preferred provider requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to preferred providers must be provided to the worker in written form by mail or in person after the date of injury. ~~The notice must advise the worker of the worker's right to choose the initial treating physician under 39-71-1101(1).~~

~~(3) Any postings or other information regarding referral to preferred providers on bulletin boards, in~~

~~personnel policies, in company manuals, or by other general or broadcast means and any individual notice of referral to preferred providers, whether before or after the occurrence of an injury, must include in prominent type advice of the worker's right to choose the initial treating physician pursuant to subsection 39-71-1101(1)."~~

Section 26. Section 39-71-1106, MCA, is amended to read:

"39-71-1106. Compliance with medical treatment required -- termination of compensation benefits for noncompliance. An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

- (1) to cooperate with a managed care organization, a preferred provider organization, or the treating physician;
- (2) to submit to medical treatment recommended by the treating physician, except for invasive procedures; or
- (3) to provide access to health care information to ~~medical~~ health care providers, the insurer, or an agent of the insurer."

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

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

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

(2) provide the results of the financial and compliance audit for operations related to claims for injuries resulting from accidents on or after July 1, 1990, as provided in subsection (1), and the rate review as provided in 39-71-2362 to the insurance commissioner. The insurance commissioner shall review the financial and

compliance audit and rate review and report any concerns or recommendations based on the review to the governor, the legislative audit committee, and the economic affairs interim committee."

Section 28. Medical status form. (1) The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease.

(2) The form must contain, at a minimum, the following information:

- (a) the worker's first and last names and claim number;
- (b) the diagnosed condition that is a direct result of the compensable injury or occupational disease;
- (c) the treatment plan for the worker;
- (d) identification of any medications prescribed for treatment of the worker;
- (e) the timeframe during which the treating physician recommends that the worker be completely off

work;

- (f) the date or anticipated date of the worker's release to modified duty;
- (g) the date or anticipated date of the worker's release to full duty;
- (h) any temporary work restrictions applicable to the worker;
- (i) any permanent work restrictions applicable to the worker;
- (j) the anticipated date of maximum medical improvement; and
- (k) the date of the worker's next appointment.

(3) An insurer may request additional information from the health care provider not contained in the department's form.

(4) The treating physician or a designee shall complete the form following every office visit with the worker.

Section 29. Reopening of terminated medical benefits -- medical review. (1) A petition to reopen medical benefits that terminate under 39-71-704(1)(f) must be reviewed as provided in this section.

(2) Medical benefits may be reopened only if the worker's medical condition is a direct result of the compensable injury or occupational disease and requires medical treatment in order to allow the worker to continue to work or return to work. Medical benefits closed by settlement or court order are not subject to reopening.

(3) A review of a petition to reopen medical benefits must be conducted by a medical review panel as provided in subsection (4) or, if stipulated by the worker and the insurer, solely by the department's medical director.

(4) The medical review panel must be composed of the department's medical director and two additional physicians who are licensed to practice medicine in Montana and who have expertise and experience in the area of medicine that is relevant to the worker's condition. The department's medical director shall serve as the presiding officer of the medical review panel. Participants on the medical review panel must be reimbursed as provided in 2-18-501 through 2-18-503 if travel is required for a review and must be paid a reasonable fee for services.

(5) A petition for reopening of medical benefits must be filed with the department within 5 years of the termination of medical benefits pursuant to 39-71-704(1)(f). A petition may not be filed more than 90 days before benefits are to terminate.

(6) Upon receipt of a petition to reopen medical benefits, the department shall request from the insurer a copy of the worker's medical records contained in the insurer's claim file. The worker or the insurer may submit additional information that is relevant to the petition to reopen medical benefits.

(7) The proof necessary to support reopening of medical benefits must be a preponderance of the evidence.

(8) Within 60 days of the submission of a petition to reopen medical benefits, the medical review panel or the department's medical director shall issue a report. The report must provide the rationale for the decision reached. A report issued by the medical review panel must be supported by a majority of the panel members. If the report concludes that medical benefits must be reopened, the report must state the extent to which the benefits must be reopened consistent with the utilization and treatment guidelines. Benefits reopened pursuant to this section remain open for 2 years or until maximum medical improvement is achieved following surgery or the recommended medical treatment, whichever occurs first. If the medical panel specifically approves treatment beyond 2 years, medical benefits remain open for as long as recommended by the medical panel. The petitioner and the insurer shall submit updated information to the medical panel every 2 years, and every subsequent 2 years the medical panel shall review the claims that were reopened for longer than 2 years to determine whether to change the previous recommendation.

(9) A party aggrieved by a decision of the department's medical director or medical review panel may,

after satisfying the dispute resolution requirements provided in this chapter, file a petition with the workers' compensation court. The report of the department's medical director or the medical review panel is presumed to be correct and may be overcome only by clear and convincing evidence.

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

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

Section 31. Codification instruction. (1) [Sections 16 through 21 and 28] 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 16 through 21 and 28].

(2) [Section 29] 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 29].

Section 32. Saving clause. Except as provided in [section 24], [this act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

Section 33. Severability -- nonseverability. (1) 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 through 23] are essentially dependent upon each other and that if one or more of these sections are held invalid or unconstitutional, the other sections specified in this subsection are also invalid.

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

Section 34. Effective date. [This act] is effective on passage and approval.

Section 35. Applicability -- retroactive applicability. (1) Except as provided in subsections (2) and (3), [this act] applies to injuries and occupational diseases occurring on or after July 1, 2011.

(2) The use of the sixth edition of the American medical association's Guides to the Evaluation of Permanent Impairment, referenced in 39-71-116, 39-71-703, and 39-71-711, as amended by [this act], is retroactive to January 1, 2008, for impairment ratings issued after that date.

(3) [Section 14] applies retroactively, within the meaning of 1-2-109, to claims for injuries or occupational diseases for which all benefits have not been settled.

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

- END -

I hereby certify that the within bill,
HB 0334, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day
of _____, 2011.

President of the Senate

Signed this _____ day
of _____, 2011.

HOUSE BILL NO. 334

INTRODUCED BY S. REICHNER, G. BENNETT, BUTTREY, TAYLOR, J. PETERSON, O'HARA, ZINKE, INGRAHAM, MCGILLVRAY, CLARK, MILBURN, SONJU, CONNELL, ARNTZEN, ROSENDALE, HENDRICK, COOK, HOVEN, HANSEN, BURNETT, O'NEIL, HALE, HOLLANDSWORTH, KLOCK, HOWARD, EVANS, KERNS, OLSON, VANCE, BANGERTER, BECK, WARBURTON, MORE, HARRIS, WELBORN, READ, BERRY, SMALL, STEINBEISSER, ROBERTS, RIPLEY, REGIER, BALYEAT, JACKSON, BLYTON, MILLER, SKATTUM, BLASDEL, MCNIVEN, BRODEHL, ANKNEY, SALOMON, OSMUNDSON, RANDALL, EHLI, C. SMITH, SKEES, WAGNER

AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; PROVIDING FOR CLOSURE OF CLAIMS; PROVIDING A PROCESS TO REOPEN MEDICAL CLAIMS; ESTABLISHING A MEDICAL DIRECTOR AND MEDICAL REVIEW PANEL; REVISING PERMANENT PARTIAL DISABILITY DEFINITION AND BENEFITS; CLARIFYING WHAT CONSTITUTES COURSE AND SCOPE OF EMPLOYMENT; ALLOWING RETROACTIVE BENEFIT PAYMENTS TO CERTAIN WORKERS; PROVIDING FOR SETTLEMENTS OF MEDICAL CLAIMS; PROVIDING FOR INSURER DESIGNATION OF TREATING PHYSICIANS; PROVIDING PAY SCALES FOR TREATING PHYSICIANS AND HEALTH CARE PROVIDERS; PROVIDING CERTAIN LIMITATIONS ON MEDICAL PAY SCHEDULES FOR THE BIENNIUM; REQUIRING THE LEGISLATIVE AUDITOR TO SUBMIT REPORTS ON THE MONTANA STATE FUND TO THE INSURANCE COMMISSIONER; REVISING VOCATIONAL REHABILITATION SERVICES AND TERMS TO ASSIST AN EMPLOYEE IN STAYING AT WORK OR RETURNING TO WORK; CREATING A STAY-AT-WORK/RETURN-TO-WORK ASSISTANCE FUND AND PROVIDING FOR ASSESSMENTS; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 39-71-105, 39-71-116, 39-71-118, 39-71-225, 39-71-315, 39-71-320, 39-71-403, 39-71-407, 39-71-703, 39-71-704, 39-71-711, 39-71-721, 39-71-736, 39-71-741, 39-71-1011, 39-71-1025, 39-71-1031, 39-71-1101, 39-71-1102, 39-71-1106, AND 39-71-2361, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATES.