HOUSE BILL NO. 678

INTRODUCED BY N. NICOL, D. SALOMON, S. FITZPATRICK, J. SMALL

A BILL FOR AN ACT ENTITLED: “AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS; PROVIDING EVIDENTIARY STANDARDS; REVISING LAWS RELATED TO CLAIMS EXAMINERS; ALLOWING A CLAIMS EXAMINER TO AUTHORIZE AND PAY ALL CLAIMS-RELATED VENDOR CHARGES; REVISING THE DEFINITION OF "TREATING PHYSICIAN"; REVISING LAWS RELATED TO MEDICAL INFORMATION; REVISING LAWS RELATED TO CERTAIN PAYMENTS BY INSURERS; REVISING LAWS RELATING TO ATTORNEY FEES; REVISING LAWS RELATED TO INDEPENDENT MEDICAL EXAMINATIONS; REVISING LAWS RELATED TO COMPLIANCE WITH MEDICAL TREATMENT; AMENDING SECTIONS 39-71-107, 39-71-116, 39-71-604, 39-71-605, 39-71-606, 39-71-608, 39-71-609, 39-71-610, 39-71-613, 39-71-615, 39-71-703, 39-71-704, AND 39-71-1106, MCA; AND REPEALING SECTIONS 39-71-611, 39-71-612, 39-71-614, AND 39-71-2907, MCA.”

WHEREAS, pertaining to workers' compensation in this state, the purpose of this act is to eliminate predatory bill review practices, overrule the court's holdings in National Fire Insurance of Pittsburgh v. Rainey, 2021 MTWCC 10, Andell v. Victory Insurance Co., 2022 MTWCC 9, and Godat v. Sentry Ins. Co., 2022 MTWCC 10, eliminate abusive discovery practices against independent medical examiners, establish fair evidentiary standards, limit the applicability of section 39-71-610, MCA, eliminate obstructionist legal tactics, and clarify the intent of the legislature and eliminate unnecessary discovery disputes.

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

NEW SECTION. **Section 1. Evidentiary standard.** (1) The claimant has the burden of proof on a more probable than not basis for all matters at issue.

(2) Opinions of the treating physician are not entitled to deference.

(3) Testimony of a health care professional must be weighed based on the individual's education, training, experience, expertise in the medical field in question, and credibility.

(4) Rule 30(b)(6) of the Montana Rules of Civil Procedure relating to depositions and discovery may not be permitted under this title.

(5) Discovery related to an independent medical examiner is limited to the provider's training, educational background, the number of independent medical exams performed each year, the number of independent medical exams for the particular insurer named as a respondent, and payments received from the particular insurer named as the respondent.

(6) Discovery requests regarding the independent examiner's personal finances are prohibited.

Section 2. Section 39-71-107, MCA, is amended to read:

"**39-71-107. Insurers to act promptly on claims -- in-state claims examiners -- third-party agents -- penalties.** (1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act must be examined by a claims examiner in Montana. For a claim to be considered as examined by a claims examiner in Montana, the claims examiner examining the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, authorize and pay all claims-related vendor charges, manage the claim, have authority to settle the claim, maintain an office located in Montana, and examine Montana claims from that office. An insurer may not charge a fee for processing claim-related expenses. Use of a mailbox or maildrop in Montana does not constitute maintaining an office in Montana.

(3) An insurer shall maintain the documents related to each claim filed with the insurer under the Workers' Compensation Act at the Montana office of the claims examiner examining the claim in Montana until the claim is settled. The documents may be either original documents or duplicates of the original documents and must be maintained in a manner that allows the documents to be retrieved from that office and copied at the request of the claimant or the department. Settled claim files stored outside of the claims examiner's office must be made available within 48 hours of a request for the file. Electronic or optically imaged documents are permitted.

(4) (a) An insurer that uses a third-party agent to provide the insurer with claim examination

services shall notify the department in writing of a change of a third-party agent at least 14 days in advance of the change.

(b) The department may assess a penalty not to exceed $200 against an insurer that does not comply with the advance notice provision in subsection (4)(a). The penalty may be assessed for each failure by an insurer to give the required advance notice.

(5) (a) Except for those medical benefits provided by a managed care organization or a preferred provider organization in Title 39, chapter 71, part 11, or paid pursuant to 39-71-704(5), an insurer that uses a third-party agent to review medical bills shall, when first using the agent's services and annually in subsequent years, obtain written certification from the agent that, for each bill the agent reviews, the agent agrees to calculate the payment due based on the Montana workers' compensation medical fee schedules, provided for under 39-71-704, that were in effect on the date the service was provided.

(b) Except for those medical benefits provided by a managed care organization or a preferred provider organization in Title 39, chapter 71, part 11, or paid pursuant to 39-71-704(5), an insurer whose agent neglects or fails to use the proper fee schedule may be assessed a penalty of not less than $200 or more than $1,000 for each bill that its agent reviews under a fee schedule other than the proper Montana fee schedule.

(c) An insurer that without good cause neglects or fails to pay undisputed medical bills on an accepted liability claim within 60 days of receipt of the bill may be assessed a penalty of not less than $200 or more than $1,000 for each bill that is the subject of a delay as provided in this subsection (5)(c).

(6) An insurer shall provide to the claimant:

(a) a written statement of the reasons that a claim is being denied at the time of denial;

(b) whenever benefits are denied to a claimant, a written explanation of how the claimant may appeal an insurer's decision;

(c) a written explanation of the amount of wage-loss benefits being paid to the claimant, along with an explanation of the calculation used to compute those benefits. The explanation must be sent within 7 days of the initial payment of the benefit.

(d) a written notice advising the claimant when a change is made to the claims examiner handling the claim, including the name and contact information of the new claims examiner. The notice must be sent within 14 days of the change in claims examiner.

(7) An insurer shall:

(a) begin making payments that are due on a claim within 14 days of acceptance of the claim, unless the insurer promptly notifies the claimant that the insurer needs additional information in order to begin paying benefits and specifies the information needed; and

(b) pay settlements within 30 days of the date the department issues an order approving the settlement.

(8) An insurer may contest a penalty assessed pursuant to subsection (4) or (5) in a hearing conducted according to department rules. A party may appeal the final agency order to the workers' compensation court. The court shall review the order pursuant to the requirements of 2-4-704.

(9) The department may adopt rules to implement this section.

(10) (a) For the purposes of this section, "settled claim" means a department-approved or court-ordered compromise of benefits between a claimant and an insurer or a claim that was paid in full.

(b) The term does not include a claim in which there has been only a lump-sum advance of benefits."

Section 3. 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) "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.

(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.

(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.

(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.

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

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

(20) "Maintenance care" means treatment designed to provide the optimum state of health while

minimizing recurrence of the clinical status.

(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 services.

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

(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.

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

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

(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.

(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.

(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. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

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

(30) "Prosthetic device" or "prosthesis" means an artificial substitute for a missing body part.

(31) "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.

(32) "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.

(33) "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.

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

(35) (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 (35), "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.

(36) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of

a business enterprise.

(37) "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.

(38) "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.

(39) "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.

(40) "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.

(41) "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.

(42) "Treating physician" means the person 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 (42)(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 (42)(a) through (42)(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.

(43) "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.

(44) "Year", unless otherwise specified, means calendar year."

Section 4. Section 39-71-604, MCA, is amended to read:

"**39-71-604. Application for compensation -- disclosure and communication without prior notice of health care information.** (1) If a worker is entitled to benefits under this chapter, the worker shall file with the insurer all reasonable information needed by the insurer to determine compensability. It is the duty of the worker's attending physician to lend all necessary assistance in making application for compensation and proof of other matters that may be required by the rules of the department without charge to the worker. The filing of forms or other documentation by the attending physician does not constitute a claim for compensation.

(2) A signed claim for workers' compensation or occupational disease benefits authorizes disclosure to the workers' compensation insurer, as defined in 39-71-116, or to the agent of a workers' compensation insurer by the health care provider. The disclosure authorized by this subsection authorizes the physician or other health care provider to disclose or release only information relevant to the claimant's condition. Health care information relevant to the claimant's condition may include past history of the complaints of or the treatment of a condition that is similar to that presented in the claim, conditions for which benefits are subsequently claimed, other conditions related to the same body part, or conditions that may affect recovery. A release of information related to workers' compensation must be consistent with the provisions of this subsection. Authorization under this section is effective only as long as the claimant is claiming benefits. This

subsection may not be construed to restrict the scope of discovery or disclosure of health care information, as allowed under the Montana Rules of Civil Procedure, by the workers' compensation court or as otherwise provided by law.

(3) A signed claim for workers' compensation or occupational disease benefits or a signed release authorizes a workers' compensation insurer, as defined in 39-71-116, or the agent of the workers' compensation insurer to communicate with a physician or other health care provider about relevant health care information, as authorized in subsection (2), by telephone, letter, electronic communication, in person, or by other means, about a claim and to receive from the physician or health care provider the information authorized in subsection (2) without prior notice to the injured employee, to the employee's authorized representative or agent, or in the case of death, to the employee's personal representative or any person with a right or claim to compensation for the injury or death.

(4) If death results from an injury, the parties entitled to compensation or someone in their behalf shall file a claim with the insurer. The claim must be accompanied with proof of death and proof of relationship, showing the parties entitled to compensation, certificate of the attending physician, if any, and such other proof as may be required by the department.

(5) An insurer is entitled to medical information relating to prior workers' compensation claims, restrictions, injuries, and impairments, regardless of body part."

Section 5. Section 39-71-605, MCA, is amended to read:

"**39-71-605. Examination of employee by physician -- effect of refusal to submit to examination -- report and testimony of physician -- cost.** (1) (a) Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, the employee shall, upon the written request of the insurer, submit ~~from time to time~~ to examination by a physician, psychologist, or panel that must be provided and paid for by the insurer and shall likewise submit to examination from time to time by any physician, psychologist, or panel selected by the department or as ordered by the workers' compensation judge. The insurer is entitled to an independent medical examination on a change in condition, expiration of 90 days, or a new issue of medical causation arising.

(b) The request or order for an examination must fix a time and place for the examination, with

regard for the employee's convenience, physical condition, and ability to attend at the time and place that is as close to the employee's residence as is practical. An examination that is conducted by a physician, psychologist, or panel licensed in another state is not precluded under this section. The employee is entitled to have a physician present at any examination. If the employee, after written request, fails or refuses to submit to the examination or in any way obstructs the examination, the employee's right to compensation must be suspended and is subject to the provisions of 39-71-607. Any physician, psychologist, or panel employed by the insurer or the department who makes or is present at any examination may be required to testify as to the results of the examination.

(2) In the event of a dispute concerning the physical condition of a claimant or the cause or causes of the injury or disability, if any, the department or the workers' compensation judge, at the request of the claimant or insurer, as the case may be, shall require the claimant to submit to an examination as it considers desirable by a physician, psychologist, or panel within the state or elsewhere that has had adequate and substantial experience in the particular field of medicine concerned with the matters presented by the dispute. The physician, psychologist, or panel making the examination shall file a written report of findings with the claimant and insurer for their use in the determination of the controversy involved. The requesting party shall pay the physician, psychologist, or panel for the examination.

(3) As used in this section, a panel includes a practitioner having substantial experience in the field of medicine concerned with the matters presented by the dispute ~~and whose licensure would qualify the practitioner to act as a treating physician, as defined in 39-71-116,~~ and may include a psychologist.

(4) A claimant is required, upon a written request of an insurer, to submit to a functional capacities evaluation conducted by a licensed physical or occupational therapist."

Section 6. Section 39-71-606, MCA, is amended to read:

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

writing of the denial.

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

(b) The department may provide information to claimants regarding nonstatutory programs or benefits offered to injured workers or the families of injured workers by a nonprofit organization. The department may not provide the contact information of an injured worker to such an organization without the express consent of the injured worker.

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

(4) (a) When requested by an employer that an insurer currently insures or has insured in the immediately preceding 5 years or when requested by the employer's designated insurance producer, an insurer shall provide the loss information listed in subsection (4)(b) within 10 days of the request.

(b) Loss information provided under this subsection (4) must include for the period requested:

(i) all date of injury or occupational disease data for the employer's claims;

(ii) payment data on the employer's closed claims; and

(iii) payment data and loss reserve amounts on the employer's open claims, including all compensation benefits that are ongoing and are being charged against that employer's account.

(c) The information provided under this subsection (4) is confidential insurance information. The information may be used by the employer for internal management purposes or for procuring insurance products but may not be disclosed for any other purpose without the express written consent of the insurer.

(5) Failure of an insurer to comply with the time limitations required in subsections (1) and (3) does not constitute an acceptance of a claim as a matter of law. ~~However, an insurer who fails to comply with 39-71-608 or subsections (1) and (3) of this section may be assessed a penalty under 39-71-2907 if a claim is determined to be compensable by the workers' compensation court.~~"

Section 7. Section 39-71-608, MCA, is amended to read:

"**39-71-608. Payments within 30 days by insurer without admission of liability or waiver of defense authorized -- notice -- limitations on payments over 90 days.** (1) An insurer may, after written notice to the claimant and the department, make payment of compensation benefits ~~within 30 days of~~ subject to a reservation of rights on receipt of a claim for compensation without the payments being construed as an admission of liability or a waiver of any right of defense.

(2) An insurer may not make payments pursuant to this section for more than 90 days without:

(a) written consent of the claimant; or

(b) approval of the department."

Section 8. Section 39-71-609, MCA, is amended to read:

"**39-71-609. Denial of claim after payments made or termination of all benefits or reduction to partial benefits by insurer -- 14-day notice required -- criteria for conversion of benefits.** (1) Except as provided in subsection (2), if an insurer determines to deny a claim on which payments have been made under 39-71-608 during a time of further investigation or, after a claim has been accepted, terminates all biweekly compensation benefits, it may do so only after 14 days' written notice to the claimant, the claimant's authorized representative, if any, and the department. For injuries occurring prior to July 1, 1987, an insurer shall give 14 days' written notice to the claimant before reducing benefits from total to partial. However, if an insurer has knowledge that a claimant has returned to work, compensation benefits may be terminated as of the time the claimant returned to work.

(2) Temporary total disability benefits may be terminated on the date that the worker has been released to return to work in some capacity. Unless the claimant is found, at maximum healing, to be without a permanent physical impairment from the injury, the insurer, prior to converting temporary total disability benefits or temporary partial disability benefits to permanent partial disability benefits:

(a) must have a physician's determination that the claimant has reached medical stability;

(b) must have a physician's determination of the claimant's physical restrictions resulting from the industrial injury;

(c) must have a physician's determination, based on the physician's knowledge of the claimant's

job analysis prepared by a rehabilitation provider, that the claimant can return to work, with or without restrictions, on the job on which the claimant was injured or on another job for which the claimant is suited by age, education, work experience, and physical condition;

(d) shall give notice to the claimant of the insurer's receipt of the report of the physician's determinations required pursuant to subsections (2)(a) through (2)(c). The notice must be attached to a copy of the report.

(3) This section does not apply to a claimant who has received a full duty release."

Section 9. Section 39-71-610, MCA, is amended to read:

"**39-71-610. Termination of benefits by insurer -- department order to pay disputed benefits prior to hearing or mediation -- limitation on order -- right of reimbursement.** (1) If an insurer terminates biweekly compensation benefits and the termination of compensation benefits is disputed by the claimant, the department may, upon written request, order an insurer to pay additional biweekly compensation benefits prior to a hearing before the workers' compensation court or prior to mediation, but the biweekly compensation benefits may not be ordered to be paid under this section for a period exceeding 49 days or for any period subsequent to the date of the hearing or mediation. A party may appeal this order to the workers' compensation court. A proceeding in the workers' compensation court brought pursuant to this section is a new proceeding and is not subject to mediation. If after a hearing before the workers' compensation court it is held that the insurer was not liable for the compensation payments ordered by the department, the insurer has the right to be reimbursed for the payments by the claimant.

(2) Benefits may be ordered only on the claimant demonstrating, on a more probable than not basis, that the claimant will prevail.

(3) This section does not apply to disputes regarding:

(a) The insurer's selection of a treating physician;

(b) the refusal to cooperate with medical care;

(c) unaccepted body parts;

(d) the refusal to cooperate with the nurse case manager; or

(e) the refusal to cooperate with an independent medical examination.

(4) Compensation benefits awarded under this section are stayed on appeal."

Section 10. Section 39-71-613, MCA, is amended to read:

"**39-71-613. Regulation of attorney fees -- forfeiture of fee for noncompliance -- return of fee when claimant received benefits through fraud or deception.** (1) When an attorney represents or acts on behalf of a claimant or any other party on any workers' compensation claim, the attorney shall submit to the department a contract of employment, on a form provided by the department, stating specifically the terms of the fee arrangement between the attorney and the claimant.

(2) The department may regulate the amount of the attorney fees in any workers' compensation case. In regulating the amount of the fees, the department shall consider:

(a) the benefits the claimant gained due to the efforts of the attorney;

(b) the time the attorney was required to spend on the case;

(c) the complexity of the case; and

(d) any other relevant matter the department may consider appropriate.

(3) An attorney who violates a provision of this section, a rule adopted under this section, or an order fixing attorney fees under this section forfeits the right to any fees that the attorney collected or was entitled to collect.

(4) Attorney fees may not be awarded under the common fund doctrine or any other action or doctrine in law or equity.

~~(4)~~(5) If, after an attorney receives attorney fees and costs assessed against an insurer, the claimant is convicted of having obtained benefits through fraud or deception, the attorney fees and costs for obtaining the benefits must be returned to the insurer by the attorney.

~~(5)~~(6) (a) A dispute concerning the forfeiture or return of attorney fees is considered a dispute for which the workers' compensation court has original jurisdiction and is not subject to mediation or a contested case hearing.

(b) The parties to a dispute referred to in subsection ~~(5)(a)~~ (6)(a) may voluntarily request a mediator appointed by the department and proceed to nonbinding mediation."

Section 11. Section 39-71-615, MCA, is amended to read:

"**39-71-615. Payment of medical claims without acceptance of liability.** (1) An insurer may pay a medical claim that is based upon the report of a nonwage loss injury or occupational disease without the payments being construed as an acceptance of liability for the claim.

(2) An insurer shall, within 10 days of making payment under subsection (1), notify the worker of the payment of the medical claim without acceptance of liability.

(3) Upon written request by a worker for the payment of indemnity benefits or for a determination of liability, the insurer shall investigate the claim to determine liability for the injury or occupational disease under 39-71-606 or 39-71-608.

(4) An insurer may not be required to pay compensation benefits under this section."

Section 12. 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 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

(iii) is more than zero.

(2) 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 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 high school 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 payments for benefits not accrued may be reduced to present value at the rate established by the department pursuant to 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 13. 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 that are a direct result of the compensable injury or occupational disease, for those periods specified in this section.

(b) 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 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 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 or injuries that ~~occurs~~ occur 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) The benefits provided for in this section terminate 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 39-71-717.

(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 this 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) The fee schedule rates established in subsection (2)(b), when adopted, must be based on the following standards as adopted by the centers for medicare and medicaid services, regardless of where services are provided:

(i) the American medical association current procedural terminology codes, as those codes exist on January 1 of each year;

(ii) the healthcare common procedure coding system, as those codes and their relative weights exist on January 1 of each year;

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

(iv) the ambulatory payment classifications, as those codes and their relative weights exist on January 1 of each year;

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

(vi) the national correct coding initiative edits, as those codes exist on January 1 of each year; and

(vii) the relative value units in the published resource-based relative value scale, as those codes exist on January 1 of each year.

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

(3) (a) The department 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 establish compensable medical treatment for an injured worker.

(b) (i) The department may adopt a drug formulary as part of its utilization and treatment guidelines. To implement this section, the department may annually adopt by rule an evidence-based commercial or other evidence-based drug formulary as part of its utilization and treatment guidelines.

(ii) If the department adopts a commercial drug formulary, the formulary automatically includes all of the changes and updates furnished by the commercial vendor that are made during the year. This process is independent of the provisions of 2-4-307.

(iii) If the department adopts a drug formulary, the department shall, by rule, provide for:

(A) an appropriate transition of treatment, if the treatment began prior to the adoption of a drug formulary, to treatment that is consistent with the application of the formulary; and

(B) a timely and responsive dispute resolution process for disputes related to use of the formulary.

(c) 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.

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

(5) 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.

(6) (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 (6) 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.

(7) Once a determination has been made regarding the correct reimbursement amount, any overpayment made to a 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.

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

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

(10) After mediation pursuant to department rules, an unresolved dispute between an insurer and a health care provider regarding the amount of a fee for medical services may be brought before the workers' compensation court.

(11) (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 (11), 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 (11)(a) if the visit is for treatment requested by an insurer."

Section 14. 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 health care providers, the insurer, or an agent of the insurer;

(4) to comply with the insurer's selection of the treating physician; or

(5) to cooperate with the nurse case manager or obstructs the nurse case manager's ability to communicate with health care providers."

NEW SECTION. **Section 15. Repealer.** The following sections of the Montana Code Annotated are repealed:

39-71-611. Costs and attorney fees payable on denial of claim or termination of benefits later found compensable -- barring of attorney fees under common fund and other doctrines.

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

39-71-614. Calculation of attorney fees -- limitation.

39-71-2907. Increase in award for unreasonable delay or refusal to pay.

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