

## HOUSE BILL NO. 334

INTRODUCED BY S. REICHNER

1  
2  
3  
4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION LAWS;  
5 PROVIDING FOR CLOSURE OF CLAIMS; PROVIDING A PROCESS TO REOPEN MEDICAL CLAIMS;  
6 ESTABLISHING A MEDICAL DIRECTOR AND MEDICAL REVIEW PANEL; REVISING PERMANENT PARTIAL  
7 DISABILITY DEFINITION AND BENEFITS; CLARIFYING WHAT CONSTITUTES COURSE AND SCOPE OF  
8 EMPLOYMENT; ALLOWING RETROACTIVE BENEFIT PAYMENTS TO CERTAIN WORKERS; PROVIDING  
9 FOR SETTLEMENTS OF MEDICAL CLAIMS; PROVIDING FOR INSURER DESIGNATION OF TREATING  
10 PHYSICIANS; PROVIDING PAY SCALES FOR TREATING PHYSICIANS AND HEALTH CARE PROVIDERS;  
11 PROVIDING CERTAIN LIMITATIONS ON MEDICAL PAY SCHEDULES FOR THE BIENNIUM; AMENDING  
12 SECTIONS 39-71-105, 39-71-116, 39-71-118, 39-71-225, 39-71-315, 39-71-320, 39-71-407, 39-71-703,  
13 39-71-704, 39-71-711, 39-71-721, 39-71-736, 39-71-741, 39-71-1011, 39-71-1101, 39-71-1102, AND  
14 39-71-1106, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND APPLICABILITY DATES."

15

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

17

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

19 **"39-71-105. Declaration of public policy.** For the purposes of interpreting and applying this chapter,  
20 the following is the public policy of this state:

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

26 (2) It is the intent of the legislature to assert that a conclusive presumption exists that recognizes that  
27 a holder of a current, valid independent contractor exemption certificate issued by the department is an  
28 independent contractor if the person is working under the independent contractor exemption certificate. The  
29 holder of an independent contractor exemption certificate waives the rights, benefits, and obligations of this  
30 chapter unless the person has elected to be bound personally and individually by the provisions of compensation

1 plan No. 1, 2, or 3.

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

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

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

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

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

20 (b) for occupational disease claims, because of the nature of exposure, workers should not be required  
21 to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims  
22 reflect consideration of when the worker knew or should have known that the worker's condition resulted from  
23 an occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by  
24 events occurring on more than a single day or work shift and that it is within the legislature's authority to define  
25 an occupational disease and establish the causal connection to the workplace."

26

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

28 **"39-71-116. Definitions.** Unless the context otherwise requires, in this chapter, the following definitions  
29 apply:

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

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

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

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

5 (b) payment of benefits;

6 (c) setting of reserves;

7 (d) furnishing of services and facilities; and

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

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

11 (4) "Beneficiary" means:

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

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

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

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

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

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

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

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

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

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

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

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

5 ~~(9)(8)~~ (a) "Claims examiner" means an individual who, as a paid employee of the department, of a plan  
 6 No. 1, 2, or 3 insurer, or of an administrator licensed under Title 33, chapter 17, examines claims under chapter  
 7 71 to:

- 8 (i) determine liability;
- 9 (ii) apply the requirements of this title;
- 10 (iii) settle workers' compensation or occupational disease claims; or
- 11 (iv) determine survivor benefits.

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

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

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

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

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

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

23 ~~(12)(13)~~ "Fiscal year" means the period of time between July 1 and the succeeding June 30.

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

26 (15) "High degree of medical certainty" means greater than a 75% level of certainty.

27 ~~(13)(16)~~ (a) "Household or domestic employment" means employment of persons other than members  
 28 of the household for the purpose of tending to the aid and comfort of the employer or members of the employer's  
 29 family, including but not limited to housecleaning and yard work.

30 (b) The term does not include employment beyond the scope of normal household or domestic duties,

1 such as home health care or domiciliary care.

2 ~~(14)~~(17) "Insurer" means an employer bound by compensation plan No. 1, an insurance company  
3 transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3.

4 ~~(15)~~(18) "Invalid" means one who is physically or mentally incapacitated.

5 ~~(16)~~(19) "Limited liability company" has the meaning provided in 35-8-102.

6 ~~(17)~~(20) "Maintenance care" means treatment designed to provide the optimum state of health ~~while~~  
7 ~~minimizing recurrence of the clinical status or treatment after the initial attainment of maximum medical healing.~~

8 ~~(18)~~(21) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical  
9 healing" means a point in the initial healing process when further material functional improvement as established  
10 by objective medical findings would not be reasonably expected from primary medical ~~treatment~~ services. A  
11 subsequent waxing or waning of symptoms does not affect the status of maximum medical improvement.

12 ~~(19)~~(22) "Objective medical findings" means medical evidence, including range of motion, atrophy, muscle  
13 strength, muscle spasm, or other diagnostic evidence, substantiated by clinical findings.

14 ~~(20)~~(23) (a) "Occupational disease" means harm, damage, or death arising out of or contracted in the  
15 course and scope of employment caused by events occurring on more than a single day or work shift.

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

18 ~~(21)~~(24) "Order" means any decision, rule, direction, requirement, or standard of the department or any  
19 other determination arrived at by the department.

20 ~~(22)~~(25) "Palliative care" means treatment designed to reduce or ease symptoms without curing the  
21 underlying cause of the symptoms.

22 ~~(23)~~(26) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual  
23 payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any  
24 length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an  
25 estimate may be made by the department for any employer starting in business if average payrolls are not  
26 available. This estimate must be adjusted by additional payment by the employer or refund by the department,  
27 as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by  
28 calculating all wages, as defined in 39-71-123, that are paid by an employer.

29 ~~(24)~~(27) "Permanent partial disability" means a physical condition in which a worker, after reaching  
30 maximum medical healing:

1 (a) has a Class 2 or greater class of permanent impairment, as determined by the sixth edition of the  
 2 American medical association's Guides to the Evaluation of Permanent Impairment, that is established by  
 3 objective medical findings for the ratable condition. The ratable condition must be a direct result of the  
 4 compensable injury or occupational disease and may not be based exclusively on complaints of pain.

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

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

8 ~~(25)~~(28) "Permanent total disability" means a physical condition resulting from injury as defined in this  
 9 chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable  
 10 prospect of physically performing regular employment. ~~Regular employment means work on a recurring basis~~  
 11 ~~performed for remuneration in a trade, business, profession, or other occupation in this state.~~ Lack of immediate  
 12 job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

13 ~~(26)~~(29) "Primary medical services" means treatment prescribed by a the treating physician, for conditions  
 14 resulting from the injury, necessary for ~~achieving~~ the initial achievement of medical stability.

15 ~~(27)~~(30) "Public corporation" means the state or a county, municipal corporation, school district, city, city  
 16 under a commission form of government or special charter, town, or village.

17 ~~(28)~~(31) "Reasonably safe place to work" means that the place of employment has been made as free  
 18 from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

19 ~~(29)~~(32) "Reasonably safe tools or appliances" are tools and appliances that are adapted to and that are  
 20 reasonably safe for use for the particular purpose for which they are furnished.

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

23 ~~(30)~~(34) (a) "Secondary medical services" means those medical services or appliances that are  
 24 considered not medically necessary for medical stability. The services and appliances include but are not limited  
 25 to spas or hot tubs, work hardening, physical restoration programs and other restoration programs designed to  
 26 address disability and not impairment, or equipment offered by individuals, clinics, groups, hospitals, or  
 27 rehabilitation facilities.

28 (b) (i) As used in this subsection ~~(30)~~ (34), "disability" means a condition in which a worker's ability to  
 29 engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The  
 30 restrictions may be combined with factors, such as the worker's age, education, work history, and other factors

1 that affect the worker's ability to engage in gainful employment.

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

3 ~~(34)~~(35) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of  
4 a business enterprise.

5 ~~(32)~~(36) "State's average weekly wage" means the mean weekly earnings of all employees under  
6 covered employment, as defined and established annually by the department before July 1 and rounded to the  
7 nearest whole dollar number.

8 ~~(33)~~(37) "Temporary partial disability" means a physical condition resulting from an injury, as defined in  
9 39-71-119, in which a worker, prior to maximum healing:

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

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

13 (c) suffers a partial wage loss.

14 ~~(34)~~(38) "Temporary service contractor" means a person, firm, association, partnership, limited liability  
15 company, or corporation conducting business that hires its own employees and assigns them to clients to fill a  
16 work assignment with a finite ending date to support or supplement the client's workforce in situations resulting  
17 from employee absences, skill shortages, seasonal workloads, and special assignments and projects.

18 ~~(35)~~(39) "Temporary total disability" means a physical condition resulting from an injury, as defined in this  
19 chapter, that results in total loss of wages and exists until the injured worker reaches maximum medical healing.

20 ~~(36)~~(40) "Temporary worker" means a worker whose services are furnished to another on a part-time or  
21 temporary basis to fill a work assignment with a finite ending date to support or supplement a workforce in  
22 situations resulting from employee absences, skill shortages, seasonal workloads, and special assignments and  
23 projects.

24 ~~(37)~~(41) "Treating physician" means a the person who is designated by the insurer to be primarily  
25 responsible for delivery and coordination of the worker's medical services for the treatment of a worker's  
26 compensable injury or occupational disease and is:

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

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

30 (c) a physician assistant licensed by the state of Montana under Title 37, chapter 20, if there is not a

1 treating physician, as provided for in subsection ~~(37)(a)~~ (41)(a), in the area where the physician assistant is  
2 located;

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

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

5 (f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in  
6 subsections ~~(37)(a)~~ (41)(a) through ~~(37)(e)~~ (41)(e) who is licensed or certified in another state; or

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

8 ~~(38)(42)~~ "Work-based learning activities" means job training and work experience conducted on the  
9 premises of a business partner as a component of school-based learning activities authorized by an elementary,  
10 secondary, or postsecondary educational institution.

11 ~~(39)(43)~~ "Year", unless otherwise specified, means calendar year."  
12

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

14 **"39-71-118. Employee, worker, volunteer, and volunteer firefighter defined.** (1) As used in this  
15 chapter, the term "employee" or "worker" means:

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

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

27 (c) a person who is receiving on-the-job vocational rehabilitation training or other on-the-job training  
28 under a state or federal vocational training program, whether or not under an appointment or contract of hire with  
29 an employer, as defined in 39-71-117, and, except as provided in subsection (9), whether or not receiving  
30 payment from a third party. However, this subsection (1)(c) does not apply to students enrolled in vocational

1 training programs, as outlined in this subsection, while they are on the premises of a public school or community  
2 college.

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

4 (e) a person, other than a juvenile as described in subsection (1)(b), who is performing community  
5 service for a nonprofit organization or association or for a federal, state, or local government entity under a court  
6 order, or an order from a hearings officer as a result of a probation or parole violation, whether or not under  
7 appointment or contract of hire with an employer, as defined in 39-71-117, and whether or not receiving payment  
8 from a third party. For a person covered by the definition in this subsection (1)(e):

9 (i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an impairment  
10 award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part  
11 4, for a full-time employee at the time of the injury; and

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

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

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

18 (h) a person placed at a public or private entity's worksite pursuant to 53-4-704. The person is  
19 considered an employee for workers' compensation purposes only. The department of public health and human  
20 services shall provide workers' compensation coverage for recipients of financial assistance, as defined in  
21 53-4-201, or for participants in the food stamp program, as defined in 53-2-902, who are placed at public or  
22 private worksites through an endorsement to the department of public health and human services' workers'  
23 compensation policy naming the public or private worksite entities as named insureds under the policy. The  
24 endorsement may cover only the entity's public assistance participants and may be only for the duration of each  
25 participant's training while receiving financial assistance or while participating in the food stamp program under  
26 a written agreement between the department of public health and human services and each public or private  
27 entity. The department of public health and human services may not provide workers' compensation coverage  
28 for individuals who are covered for workers' compensation purposes by another state or federal employment  
29 training program. Premiums and benefits must be based upon the wage that a probationary employee is paid for  
30 work of a similar nature at the assigned worksite.

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

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

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

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

9 ~~(c)(b)~~ performing services as a volunteer, except for a person who is otherwise entitled to coverage  
10 under the laws of this state. As used in this subsection ~~(2)(c)~~ (2)(b), "volunteer" means a person who performs  
11 services on behalf of an employer, as defined in 39-71-117, but who does not receive wages as defined in  
12 39-71-123.

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

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

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

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

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

29 (b) In the event of an election, the employer shall serve upon the employer's insurer written notice  
30 naming the partners, sole proprietor, or members to be covered and stating the level of compensation coverage

1 desired by electing the amount of wages to be reported, subject to the limitations in subsection (5)(d). A partner,  
2 sole proprietor, or member is not considered an employee within this chapter until notice has been given.

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

5 (d) All weekly compensation benefits must be based on the amount of elected wages, subject to the  
6 minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination  
7 of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than  
8 \$900 a month and not more than 1 1/2 times the state's average weekly wage.

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

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

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

18 (d) All weekly compensation benefits must be based on the amount of elected wages, subject to the  
19 minimum and maximum limitations of this subsection (6)(d). For premium ratemaking and for the determination  
20 of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than  
21 \$200 a week and not more than 1 1/2 times the state's average weekly wage.

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

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

29 (c) A self-employed sole proprietor or partner who has elected not to be covered under this chapter, but  
30 who is covered as a volunteer firefighter pursuant to subsection (7)(a) and when injured in the course and scope

1 of employment as a volunteer firefighter, may in addition to the benefits described in subsection (7)(b) be eligible  
2 for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080  
3 hours a year. The trustees of a rural fire district, a county governing body providing rural fire protection, or the  
4 county commissioners or trustees for a fire service area may make an election for benefits. If an election is made,  
5 payrolls must be reported and premiums must be assessed on the assumed wage.

6 (8) Except as provided in chapter 8 of this title, an employee or worker in this state whose services are  
7 furnished by a person, association, contractor, firm, limited liability company, limited liability partnership, or  
8 corporation, other than a temporary service contractor, to an employer, as defined in 39-71-117, is presumed to  
9 be under the control and employment of the employer. This presumption may be rebutted as provided in  
10 39-71-117(3).

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

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

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

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

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

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

25 (i) nonresident employees are hired in Montana;

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

27 (iii) nonresident employees are supervised in Montana; and

28 (iv) business records are maintained in Montana.

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

1 (10)(d)."

2

3 **Section 4.** Section 39-71-225, MCA, is amended to read:

4 **"39-71-225. Workers' compensation database system.** (1) The department shall develop a workers'  
5 compensation database system to generate management information about Montana's workers' compensation  
6 system. The database system must be used to collect and compile information from insurers, employers, ~~medical~~  
7 health care providers, claimants, claims examiners, rehabilitation providers, and the legal profession.

8 (2) Data collected must be used to provide:

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

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

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

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

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

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

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

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

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

5 (a) avoidance of duplication and inconsistency;

6 (b) reasonable availability of data elements;

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

8 (d) uniformity to permit efficiency of collection and to allow interstate comparisons;

9 (e) a workable mechanism to ensure the accuracy of the data collected and to protect the confidentiality  
10 of collected data;

11 (f) reasonable availability of the data at a fair cost to the user;

12 (g) a broad application to plan No. 1, plan No. 2, and plan No. 3 insurers;

13 (h) compatibility with electronic data reporting;

14 (i) reporting procedures that can be handled through private data collection systems that adhere to the  
15 provisions of subsections (4)(a) through (4)(h);

16 (j) implementation of reporting requirements that allow reasonable lead time for compliance.

17 (5) The department shall publish an annual report on the information compiled.

18 (6) Users of information obtained from the workers' compensation database under this section are liable  
19 for damages arising from misuse or unlawful dissemination of database information.

20 (7) An insurer or a third-party administrator who submitted 50 or more "first reports of injury" to the  
21 department in the preceding calendar year shall electronically submit the reports and any other reports related  
22 to the reported claims in a nationally recognized format specified by department rule.

23 (8) The department may adopt rules to implement this section."  
24

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

26 **"39-71-315. Prohibited actions -- penalty.** (1) The following actions by a ~~medical~~ health care provider  
27 constitute violations and are subject to the penalty in subsection (2):

28 (a) failing to certify the provision of the services or treatment for which compensation is claimed under  
29 this chapter; or

30 (b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under this

1 chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the  
2 ownership interest and provides the name and address of alternate facilities, if any exist.

3 (2) A person who violates this section may be assessed a penalty of not less than \$200 or more than  
4 \$500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this  
5 section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions  
6 brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant  
7 to this section are not subject to mediation.

8 (3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating  
9 physician with an ownership interest in a managed care organization that has been certified by the department."  
10

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

12 **"39-71-320. Voluntary certification program for claims examiners -- purpose -- rulemaking --**  
13 **advisory committee -- continuing education.** (1) Pursuant to the public policy stated in 39-71-105, accurate  
14 and prompt claims handling practices are necessary to provide appropriate service to injured workers, employers,  
15 and ~~medical~~ health care providers. In order to further that public policy, the purpose of this section is to authorize  
16 the department to establish a voluntary certification program for claims examiners. The department shall  
17 administer the voluntary certification program.

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

20 (a) establishing minimum qualifications and procedures for certifying claims examiners;

21 (b) requiring continuing education for certified claims examiners;

22 (c) better educating certified claims examiners about changes in the law; and

23 (d) providing standards for the qualifications of instructors, courses, and materials.

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

26 (a) minimum qualifications;

27 (b) examination;

28 (c) 2-year certification and renewal;

29 (d) continuing education requirements; and

30 (e) a waiver of the examination requirement for an individual requesting certification as a claims examiner

1 within the first 12 months after the department has adopted the initial rules under this subsection (3). The waiver  
2 is available only to an individual who has been actively engaged in the work of a claims examiner in this state,  
3 working on workers' compensation claims for 5 of the 7 years immediately preceding the individual's application  
4 for certification under this section.

5 (4) The department may appoint an advisory committee composed of injured workers, insurers,  
6 self-insured employers, third-party administrators, claims examiners, and members of the public to advise the  
7 department on setting standards for certification and continuing education.

8 (5) The department shall maintain:

9 (a) a list of all certified claims examiners; and

10 (b) the following records related to certified claims examiners:

11 (i) documentation of current and historical certifications;

12 (ii) beginning and ending dates of certifications; and

13 (iii) continuing education records.

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

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

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

30 (a) initial certification, including examination;

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

5

6 **Section 7.** Section 39-71-407, MCA, is amended to read:

7 **"39-71-407. Liability of insurers -- limitations.** (1) For workers' compensation injuries, each insurer

8 is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee

9 of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who

10 receives an injury arising out of and in the course of employment or, in the case of death from the injury, to the

11 employee's beneficiaries, if any.

12 (2) (a) Injuries that do not arise out of and in the course of employment include but are not limited to the

13 following:

14 (i) an injury that occurs off any worksite of an employer while an employee is on break, whether paid or

15 unpaid, and the employee is not engaged in duties for the employer; or

16 (ii) except as provided in subsection (2)(b), an injury that occurs while the employee is voluntarily

17 participating in a recreational or social activity, including but not limited to athletic events, parties, and picnics,

18 even though the employer pays for some or all of the cost of the activity and the employee is not engaged in

19 duties assigned by the employer.

20 (b) The provisions of subsection (2)(a)(ii) do not apply if the employee is either in a paid work status while

21 participating in the recreational or social activity or is required by the employer to participate in the recreational

22 or social activity.

23 ~~(2)~~(3) (a) An insurer is liable for an injury, as defined in 39-71-119, only if the injury is established by

24 objective medical findings and if the claimant establishes that it is more probable than not that:

25 (i) a claimed injury has occurred; or

26 (ii) a claimed injury has occurred and aggravated a preexisting condition.

27 (b) An insurer is liable for a diagnosed condition that is a direct result of a compensable injury only if the

28 condition is diagnosed within 2 years of the date of the injury.

29 ~~(b)~~(c) Proof that it was medically possible that a claimed injury occurred or that the claimed injury

30 aggravated a preexisting condition is not sufficient to establish liability.

1           ~~(3)~~(4) (a) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

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

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

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

10          ~~(4)~~(5) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use  
11 of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident. However, if the  
12 employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection  
13 does not apply.

14          ~~(5)~~(6) If there is no dispute that an insurer is liable for an injury but there is a liability dispute between  
15 two or more insurers, the insurer for the most recently filed claim shall pay benefits until that insurer proves that  
16 another insurer is responsible for paying benefits or until another insurer agrees to pay benefits. If it is later  
17 proven that the insurer for the most recently filed claim is not responsible for paying benefits, that insurer must  
18 receive reimbursement for benefits paid to the claimant from the insurer proven to be responsible.

19          ~~(6)~~(7) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to  
20 the same part of the body, the workers' compensation insurer is not liable for any compensation or medical  
21 benefits caused by the subsequent nonwork-related injury.

22          ~~(7)~~(8) An employee is not eligible for benefits payable under this chapter unless the entitlement to  
23 benefits is established by objective medical findings that contain sufficient factual and historical information  
24 concerning the relationship of the worker's condition to the original injury.

25          ~~(8)~~(9) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan  
26 No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the  
27 extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state  
28 fund under plan No. 3 if the employee is diagnosed with an a compensable occupational disease ~~that arises out~~  
29 ~~of or is contracted in the course and scope of employment.~~

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

1 scope of employment if:

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

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

4 ~~(b)(ii)~~ arises out of or is contracted in the course and scope of employment. An occupational disease is  
 5 considered to arise out of or be contracted in the course and scope of employment if the events occurring on  
 6 more than a single day or work shift are the major contributing cause of the occupational disease in relation to  
 7 other factors contributing to the occupational disease.

8 (b) An insurer is liable for conditions that are a direct result of a compensable occupational disease only  
 9 if the condition is diagnosed within 2 years of the date of the diagnosis of the compensable occupational disease.

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

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

15 (a) the time that the occupational disease was first diagnosed by a ~~treating physician or medical panel~~  
 16 health care provider; or

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

19 ~~(12)(13)~~ In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state  
 20 or substantially all of the assets of a mine from a person who was an operator of the mine on or after December  
 21 30, 1969, is liable for and shall secure the payment of all benefits that would have been payable by that person  
 22 with respect to miners previously employed in the mine if acquisition had not occurred and that person had  
 23 continued to operate the mine, and the prior operator of the mine is not relieved of any liability under this section.

24 ~~(13)(14)~~ As used in this section, "major contributing cause" means a cause that is the leading cause  
 25 contributing to the result when compared to all other contributing causes."

26

27 **Section 8.** Section 39-71-703, MCA, is amended to read:

28 **"39-71-703. Compensation for permanent partial disability.** (1) If an injured worker suffers a  
 29 permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the  
 30 worker is entitled to a permanent partial disability award if that worker:

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

2 (b) has a Class 2 or greater class of permanent impairment rating as determined by the sixth edition of  
 3 the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition.

4 The ratable condition must be a direct result of the compensable injury or occupational disease that:

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

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

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

9 (2) ~~When a worker receives an impairment rating as the result of a compensable injury and has no actual~~  
 10 ~~wage loss as a result of the injury, the A worker is eligible to receive payment for an impairment award only if the~~  
 11 ~~worker meets the criteria in subsection (1).~~

12 (3) The permanent partial disability award must be arrived at by multiplying the percentage arrived at  
 13 through the calculation provided in subsection (5) by ~~375~~ 400 weeks.

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

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

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

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

22 (c) if a worker has no actual wage loss as a result of the industrial injury, 0%; if a worker has an actual  
 23 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  
 24 more than \$2 an hour as a result of the industrial injury, 20%. Wage loss benefits must be based on the difference  
 25 between the actual wages received at the time of injury and the wages that the worker earns or is qualified to earn  
 26 after the worker reaches maximum healing.

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

1 labor activity, 2%.

2 (6) The weekly benefit rate for permanent partial disability is 66 2/3% of the wages received at the time  
3 of injury, but the rate may not exceed one-half the state's average weekly wage. The weekly benefit amount  
4 established for an injured worker may not be changed by a subsequent adjustment in the state's average weekly  
5 wage for future fiscal years.

6 (7) An undisputed impairment award may be paid biweekly or in a lump sum at the discretion of the  
7 worker. Lump sums paid for impairments are not subject to the requirements of 39-71-741, except that lump-sum  
8 ~~conversions~~ payments for benefits not accrued may be reduced to present value at the rate established by the  
9 department pursuant to ~~39-71-741(3)~~ 39-71-741(5).

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

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

15 (10) As used in this section:

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

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

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

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

24

25 **Section 9.** Section 39-71-704, MCA, is amended to read:

26 **"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates**  
27 **-- fee limitation.** (1) In addition to the compensation provided under this chapter and as an additional benefit  
28 separate and apart from compensation benefits actually provided, the following must be furnished:

29 (a) After the happening of a compensable injury or occupational disease and subject to other provisions  
30 of this chapter, the insurer shall furnish reasonable primary medical services, including prescription drugs for

1 conditions ~~resulting from~~ that are a direct result of the compensable injury or occupational disease, for those  
2 periods ~~as the nature of the injury or the process of recovery requires~~ specified in this section.

3 (b) ~~The~~ Subject to the limitations in this chapter, the insurer shall furnish secondary medical services only  
4 upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual  
5 employment.

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

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

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

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

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

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

21 (D) travel for unauthorized treatment or disallowed procedures.

22 (iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel  
23 or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the  
24 travel and treatment were required.

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

1 for a travel companion to accompany the catastrophically injured worker.

2 (f) ~~(i) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the~~  
3 ~~The~~ benefits provided for in this section terminate ~~when they are not used for a period of 60 consecutive 60~~  
4 ~~months from the date of injury or diagnosis of an occupational disease. A worker may request reopening of~~  
5 ~~medical benefits that were terminated under this subsection (1)(f) as provided in [section 20].~~

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

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

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

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

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

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

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

27 (b) (i) The department may not set the rate for medical services at a rate greater than 10% above the  
28 average of the conversion factors used by up to the top five insurers or third-party administrators providing group  
29 health insurance coverage within this state who use the resource-based relative value scale to determine fees  
30 for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy

- 1 at least 1% of the market share for group health insurance policies as reported annually to the state auditor.
- 2 (ii) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their  
3 standard conversion rates to the department.
- 4 (iii) The department may use the conversion rates only for the purpose of determining average conversion  
5 rates under this subsection (2).
- 6 (iv) The department shall maintain the confidentiality of the conversion rates.
- 7 (c) The fee schedule rates established in subsection (2)(b) must be based on the following standards  
8 as adopted by the centers for medicare and medicaid services in effect at the time the services are provided,  
9 regardless of where services are provided:
- 10 (i) the American medical association current procedural terminology codes;  
11 (ii) the healthcare common procedure coding system;  
12 (iii) the medicare severity diagnosis-related groups;  
13 (iv) the ambulatory payment classifications;  
14 (v) the ratio of costs to charges for each hospital;  
15 (vi) the national correct coding initiative edits; and  
16 (vii) the relative value units as adjusted annually using the most recently published resource-based  
17 relative value scale.
- 18 (d) The department may establish additional ~~coding standards~~ codes for use by providers when billing  
19 for medical services under this section.
- 20 (e) The rates in effect through June 30, 2013, may not be less than the rates for medical services in  
21 effect as of January 1, 2011.
- 22 (3) (a) The department ~~may~~ shall establish by rule evidence-based utilization and treatment guidelines  
23 for primary and secondary medical services. There is a rebuttable presumption that the utilization and treatment  
24 guidelines established by the department are ~~correct medical treatment for the injured worker~~ an appropriate  
25 limitation on medical services for which an insurer is liable for payment under this chapter.
- 26 (b) An insurer is not responsible for treatment or services that do not fall within the utilization and  
27 treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer.  
28 If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for  
29 payment of the medical treatment or services.
- 30 (c) The department ~~may establish by rule~~ shall hire a medical director to conduct an independent medical

1 review process for The independent medical review process must be used to assess treatment or services  
2 denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.

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

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

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

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

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

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

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

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

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

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

30 (i) a treating physician;

- 1 (ii) a physical therapist;  
 2 (iii) a psychologist; or  
 3 (iv) hospital outpatient services available in a nonhospital setting.  
 4 (c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (10)(a) if the visit  
 5 is for treatment requested by an insurer."  
 6

- 7 **Section 10.** Section 39-71-711, MCA, is amended to read:  
 8 **"39-71-711. Impairment evaluation -- ratings.** (1) An impairment rating:  
 9 (a) is a purely medical determination and must be determined by an impairment evaluator after a  
 10 claimant has reached maximum healing;  
 11 (b) must be based on the ~~current~~ sixth edition of the American medical association Guides to the  
 12 Evaluation of Permanent Impairment ~~published by the American medical association;~~  
 13 (c) must be expressed as a percentage of the whole person; and  
 14 (d) must be established by objective medical findings and may not be based exclusively on complaints  
 15 of pain.  
 16 (2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator if the injury falls  
 17 within the scope of the evaluator's practice and if the evaluator is one of the following:  
 18 (a) a physician or an osteopath licensed under Title 37, chapter 3, with admitting privileges to practice  
 19 in one or more hospitals, if any, in the area where the physician or osteopath is located;  
 20 (b) a chiropractor licensed under Title 37, chapter 12;  
 21 (c) a physician assistant licensed under Title 37, chapter 20, if there is not a physician as provided for  
 22 in subsection (2)(a) in the area where the physician assistant is located;  
 23 (d) a dentist licensed under Title 37, chapter 4;  
 24 (e) an advanced practice registered nurse licensed under Title 37, chapter 8; or  
 25 (f) for a claimant residing out of state or upon approval of the insurer, an evaluator referred to in  
 26 subsections (2)(a) through (2)(e) who is licensed or certified in another state.  
 27 (3) If the claimant and insurer cannot agree upon the rating, the mediation procedure in Title 39, chapter  
 28 71, part 24, must be followed.  
 29 (4) Disputes over impairment ratings are subject to the provisions of 39-71-605."  
 30

1           **Section 11.** Section 39-71-721, MCA, is amended to read:

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

6           (b) The insurer is entitled to recover any overpayments or compensation paid in a lump sum to a worker  
7 prior to death but not yet recouped. The insurer shall recover the payments from the beneficiary's biweekly  
8 payments as provided in ~~39-71-744(3)~~ 39-71-741(5).

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

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

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

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

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

25           (7) Benefits paid under this section may not be adjusted for cost of living as provided in 39-71-702."  
26

27           **Section 12.** Section 39-71-736, MCA, is amended to read:

28           **"39-71-736. Compensation -- from what dates paid.** (1) (a) ~~Compensation~~ Except as provided in  
29 subsection (1)(c), compensation may not be paid for the first 32 hours or 4 days' loss of wages, whichever is less,  
30 that the claimant worker is totally disabled and unable to work because of an injury. A claimant worker is eligible

1 for compensation starting with the 5th day.

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

3 (c) If the worker is totally disabled and unable to work in any capacity for 21 days or longer,  
4 compensation must be paid retroactively to the first day of total wage loss unless the worker waives the payment  
5 as provided in subsection (2)(b)(ii).

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

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

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

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

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

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

18

19 **Section 13.** Section 39-71-741, MCA, is amended to read:

20 **"39-71-741. ~~Compromise settlements~~ Settlements and lump-sum payments -- legislative intent.**

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

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

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

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

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

12 (i) relates to:

13 (A) the necessities of life;

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

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

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

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

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

21 (f) medical benefits on an accepted claim if the claimant has reached maximum medical improvement  
22 and the following applicable conditions are met:

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

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

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

28 ~~(2)(4)~~ Any lump-sum conversion of benefits under this section must be converted to present value using  
29 the rate prescribed under subsection ~~(3)(b)~~ (5)(b).

30 ~~(3)(5)~~ (a) An insurer may recoup any lump-sum ~~payment~~ advance amortized at the rate established by

1 the department, prorated biweekly over the projected duration of the compensation period.

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

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

7 ~~(4)(6)~~ A dispute between a claimant and an insurer regarding the conversion of biweekly payments into  
8 a lump sum is considered a dispute for which a mediator and the workers' compensation court have jurisdiction  
9 to make a determination.

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

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

16

17 **Section 14.** Section 39-71-1011, MCA, is amended to read:

18 **"39-71-1011. Definitions.** As used in this chapter, the following definitions apply:

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

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

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

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

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

1 counselor certification and designated by the insurer.

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

4 (7) "Stay-at-work/return-to-work services" means services provided to facilitate a worker's staying at work  
5 or returning to work with the worker's employer as soon as possible following the insurer's acceptance of liability  
6 for a worker's injury or occupational disease. Services may be for a return to the job performed at the time of  
7 injury or to a modified position. For the purposes of this subsection, the term "employer" is the employer at the  
8 time of injury."

9

10 **Section 15.** Section 39-71-1101, MCA, is amended to read:

11 **"39-71-1101. Choice of physician health care provider by worker -- change insurer designation**  
12 **of treating physician -- receipt of care from or managed care organization -- payment terms -- definition.**

13 (1) Subject to subsection (3), Prior to the insurer's designation of a treating physician as provided in subsection  
14 (2) or a referral to a managed care organization or preferred provider organization as provided in subsection (7),  
15 a worker may choose the a health care provider for initial treating physician within the state of Montana treatment.

16 (2) Upon receipt of a claim for benefits and acceptance of liability by an insurer, the insurer may  
17 designate a treating physician who agrees to assume the responsibilities of the treating physician. The designated  
18 treating physician:

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

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

23 (c) shall conduct or arrange for timely impairment ratings.

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

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

30 (5) A health care provider to whom the worker is referred by the treating physician must be reimbursed

1 at 90% of the department's fee schedule.

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

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

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

9 ~~(3)(8) A medical service~~ After the insurer directs a worker to a managed care organization or preferred  
10 provider organization, a health care provider who otherwise qualifies as a treating physician but who is not a  
11 member of a managed care organization may not provide treatment unless authorized by the insurer, ~~if:~~

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

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

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

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

18 ~~(4)(9)~~ (8) After the date that a worker whose injury is subject to the provisions of subsection ~~(3)~~ (8) receives  
19 individual written notice of a referral to a managed care organization, the worker must, unless otherwise  
20 authorized by the insurer, receive medical services from the managed care organization designated by the  
21 insurer, in accordance with 39-71-1104. The designated treating physician in the managed care organization then  
22 becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except  
23 that a worker may receive immediate emergency medical treatment for a compensable injury from a ~~medical~~  
24 ~~service~~ health care provider who is not a member of a managed care organization.

25 ~~(5)(10)~~ Posting of managed care requirements in the workplace on bulletin boards, in personnel policies,  
26 in company manuals, or by other general or broadcast means does not constitute individual written notice. To  
27 constitute individual written notice under this section, information regarding referral to a managed care  
28 organization must be provided to the worker in written form by mail or in person after the date ~~that the~~ of injury  
29 ~~meets the provisions of subsection (3). The notice must advise the worker of the worker's right to choose the~~  
30 ~~initial treating physician under subsection (1).~~

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

6

7 **Section 16.** Section 39-71-1102, MCA, is amended to read:

8 **"39-71-1102. Preferred provider organizations -- establishment -- limitations.** (1) In order to promote  
 9 cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by  
 10 insurers is encouraged. Insurers may establish arrangements with suppliers of soft and durable medical goods  
 11 and ~~medical~~ health care providers in addition to or in conjunction with managed care organizations. Workers'  
 12 compensation insurers may contract with other entities to use the other entities' preferred provider organizations.  
 13 After the date that an injured worker is given an individual written notice by the insurer of a preferred provider,  
 14 the insurer is not liable for charges from nonpreferred providers. ~~This section does not prohibit the worker from~~  
 15 ~~choosing the initial treating physician under 39-71-1101(1).~~

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

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

25

26 **Section 17.** Section 39-71-1106, MCA, is amended to read:

27 **"39-71-1106. Compliance with medical treatment required -- termination of compensation benefits**  
 28 **for noncompliance.** An insurer that provides 14 days' notice to the worker and the department may terminate  
 29 any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that  
 30 the worker is unreasonably refusing:

1 (1) to cooperate with a managed care organization, a preferred provider organization, or the treating  
2 physician;

3 (2) to submit to medical treatment recommended by the treating physician, except for invasive  
4 procedures; or

5 (3) to provide access to health care information to ~~medical~~ health care providers, the insurer, or an agent  
6 of the insurer."

7

8 **NEW SECTION. Section 18. Stay-at-work/return-to-work services.** (1) A worker is eligible to receive  
9 stay-at-work/return-to-work services if the worker has not returned to work following the insurer's acceptance of  
10 liability for the claim. Services may be provided by:

11 (a) a rehabilitation provider designated by the insurer; or

12 (b) the insurer.

13 (2) A worker or the worker's employer may request from the insurer that the worker receive  
14 stay-at-work/return-to-work services as provided in subsection (1). If a worker or the worker's employer requests  
15 stay-at-work/return-to-work services from the department, the department shall require the insurer to provide  
16 those services under this section.

17

18 **NEW SECTION. Section 19. Work ability form.** (1) The department shall create a work ability form  
19 to be provided to a health care provider providing treatment for a compensable injury or occupational disease.

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

21 (a) the worker's first and last names and claim number;

22 (b) the diagnosed condition that is a direct result of the compensable injury or occupational disease;

23 (c) the treatment plan for the worker;

24 (d) identification of any medications prescribed for treatment of the worker;

25 (e) the timeframe during which the treating physician recommends that the worker be completely off  
26 work;

27 (f) the date or anticipated date of the worker's release to modified duty;

28 (g) the date or anticipated date of the worker's release to full duty;

29 (h) any temporary work restrictions applicable to the worker;

30 (i) any permanent work restrictions applicable to the worker;

1 (j) the anticipated date of maximum medical improvement; and

2 (k) the date of the worker's next appointment.

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

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

7

8 **NEW SECTION. Section 20. Reopening of terminated medical benefits -- medical review.** (1) A  
9 petition to reopen medical benefits that terminate under 39-71-704(1)(f) must be reviewed as provided in this  
10 section.

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

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

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

23 (5) A petition for reopening of medical benefits must be filed with the department within 2 years of the  
24 termination of medical benefits pursuant to 39-71-704(1)(f). A petition for reopening must be supported by a  
25 medical opinion by the treating physician documenting the grounds for the requested reopening.

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

29 (7) The proof necessary to support reopening of medical benefits must be to a high degree of medical  
30 certainty.

1 (8) Within 60 days of the submission of a petition to reopen medical benefits, the medical review panel  
2 or the department's medical director shall issue a report. The report must provide the rationale for the decision  
3 reached. A report issued by the medical review panel must be supported by a majority of the panel members.  
4 If the report concludes that medical benefits must be reopened, the report must state the extent to which the  
5 benefits must be reopened consistent with the utilization and treatment guidelines. Benefits reopened pursuant  
6 to this section remain open for a maximum of 2 years or until maximum medical improvement is achieved  
7 following surgery, whichever occurs first.

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

12  
13 **NEW SECTION. Section 21. Codification instruction.** (1) [Sections 18 and 19] are intended to be  
14 codified as an integral part of Title 39, chapter 71, part 10, and the provisions of Title 39, chapter 71, part 10,  
15 apply to [sections 18 and 19].

16 (2) [Section 20] is intended to be codified as an integral part of Title 39, chapter 71, part 7, and the  
17 provisions of Title 39, chapter 71, part 7, apply to [section 20].

18  
19 **NEW SECTION. Section 22. Saving clause.** Except as provided in [section 24], [this act] does not  
20 affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the  
21 effective date of this act].

22  
23 **NEW SECTION. Section 23. Severability.** If a part of [this act] is invalid, all valid parts that are  
24 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,  
25 the part remains in effect in all valid applications that are severable from the invalid applications.

26  
27 **NEW SECTION. Section 24. Effective date.** [This act] is effective on passage and approval.

28  
29 **NEW SECTION. Section 25. Applicability -- retroactive applicability.** (1) Except as provided in  
30 subsections (2) and (3), [this act] applies to injuries and occupational diseases occurring on or after July 1, 2011.

