LClmac

**** Bill No. ****

Introduced By **********

By Request of the *********

NOTE: The following bill draft truncates some statutes for the sake of trimming the number of pages. What is left out is unchanged. (Some of the language may be slightly different – based on pat's edits)

A Bill for an Act entitled: "An Act revising workers' compensation laws to implement recommendations of the labor management advisory council; revising vocational rehabilitation services and terms to assist an employee in staying at or returning to work; providing conditions for retraining benefits; allowing exchange of information among interested parties; creating a stay at work/return to work assistance fund and assessments for the fund; providing rulemaking authority; providing a process for closing workers' compensation claims; outlining conditions for reopening and mediating a claim; revising public policy to remove reference to actual wage loss; providing exceptions to the course and scope of employment; reducing the time for insurers to accept or deny a claim; revising conditions for temporary total disability benefits; revising the process for providing costs and attorney fees for disputed medical benefits awarded by court; revising certain conditions and benefits for permanent total disabilities; providing specific guidance for impairment ratings and allowing department to change guidance by rule; allowing retroactive benefit payment to certain workers; revising medical claim settlements and lump-sum payments; amending sections 39-71-105, 39-71-116, 39-71-118, 39-71-407, 39-71-606, 39-71-609, 39-71-611, 39-71-612, 39-71-614, 39-71-701, 39-71-702, 39-71-703, 39-71-704, 39-71-711, 39-71-721, 39-71-723, 39-71-736, 39-71-741, and 39-71-1025, MCA; repealing sections 39-71-1006, 39-71-1011, and 39-71-1014, MCA; and providing applicability dates, a retroactive applicability date, and effective dates."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Definitions.** As used in this part, the following definitions apply:

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

(2) "Disabled worker" means a worker who because of a medically determined condition resulting from a work-related injury or occupational disease is precluded temporarily or permanently from returning to the job held at the time of injury.

(3) "Fund" means the stay at work/return to work assistance fund provided by [section 7].

(4) "Rehabilitation provider" means a rehabilitation counselor certified by the commission on rehabilitation counselor certification.

(5) "Stay at work/return to work assistance" means a program of evaluation, planning, implementation, and services provided by a rehabilitation provider that are designed to facilitate a disabled worker's return to work as safely and promptly as is feasible following the worker's injury.

(6) "Stay at work/return to work plan" means a written individualized plan that identifies the services, including their costs and timing, to assist a disabled worker in returning to work through job placement, on-the-job training, specialized job modification, education, or retraining."

NEW SECTION. Section 2. Request for and delivery of stay at work/return to work assistance. (1) A disabled worker, employer, or medical provider may ask that the department designate a rehabilitation provider to furnish stay at work/return to work assistance. The department shall initiate the services by designating a rehabilitation provider or coordinating the assistance with the insurer.

(2) A disabled worker may ask the insurer to provide stay at work/return to work assistance. The insurer shall furnish to the disabled worker a list of local rehabilitation providers that provide stay at work/return to work assistance. The disabled worker may select a rehabilitation provider only from the list.

(3) An insurer may provide stay at work/return to work assistance in the absence of a request by a disabled worker by designating a rehabilitation provider.

(4) An insurer shall notify the department when a rehabilitation provider has been selected or designated.

NEW SECTION. **Section 3. Stay at work/return to work assistance -- when required -- when provided by insurer.** (1) Stay at work/return to work assistance is required when:

(a) a worker claims to be permanently totally disabled as a result of a work-related injury or occupational disease;

(b) has not returned to work; and

(c) has not received a written offer of employment:

(i) for which the worker is qualified;

(ii) is within the physical abilities of the worker; and

(iii) pays wages equal to or greater than the time of injury position.

(2) Stay at work/return to work assistance may be initiated by:

(a) an insurer by designating a rehabilitation provider; or

(b) a disabled worker through a request to the department. The department shall then require the insurer to provide the worker with a list of local rehabilitation providers, and the worker may select a rehabilitation provider from that list.

(4) Stay at work/return to work assistance provided under this section must be delivered through a rehabilitation provider.

(5) Stay at work/return to work assistance is not required once the claim has been closed or indemnity benefits have been settled.

NEW SECTION. **Section 4. Stay at work/return to work goals and options -- agreement between disabled worker and insurer.** (1) The goal of stay at work/return to work assistance is to minimize avoidable disruption caused by a work-related injury or occupational disease by assisting the disabled worker in the worker's return to work, with a minimum of retraining, as soon as possible after an injury occurs or an occupational disease is discovered.

(2) Stay at work/return to work must provide services so that the disabled worker can return to work using the first appropriate option of the following prioritized outcomes:

(a) return to the same position with the same employer;

(b) return to a modified position with the same employer;

(c) return to a like or modified position with another employer;

(d) return to an alternative position suited to the worker's education and

marketable skills with any employer;

(e) on-the-job training; or

(f) retraining.

(3) A disabled worker and an insurer may mutually agree to a particular option as the worker's goal, even if an option with a higher priority might otherwise be appropriate.

NEW SECTION. **Section 5. Rehabilitation provider -- evaluation.** (1) If a disabled worker is capable of working, the rehabilitation provider shall evaluate and determine the stay at work/return to work capabilities of the disabled worker pursuant to the stay at work/return to work options listed in [section 4].

(2) If the rehabilitation provider has determined that all appropriate services have been provided to the disabled worker and the worker has returned to work, the rehabilitation provider shall document that determination to the insurer and the department.

(3) If the worker has not returned to work as provided in subsection (2), the rehabilitation provider shall document the services provided and itemize the barriers to a successful return to work with any recommendations on how these barriers may be overcome to maximize return to work options. Such documentation must be provided to the insurer, the treating physician, and the department.

(4) If the worker is claiming permanent total disability benefits and the rehabilitation provider certifies that the worker has reasonable vocational goals and reasonable reemployment opportunity through retraining and none of the options in [section 4(2)(a) through (e)] are appropriate, the rehabilitation provider shall prepare a stay at work/return to work plan that involves

retraining. The plan must take into consideration the workers' age, education, training, work history, residual physical capacities, vocational interests, and the jobs available in the local labor market for the new occupation. The plan must specify a beginning date and a completion date. The plan must specify the costs of tuition, fees, books, other reasonable and necessary retraining expenses, and the timeframes required to complete the plan.

NEW SECTION. **Section 6. Retraining benefits.** (1) A worker is eligible for retraining benefits if:

(a) the worker is no longer entitled to temporary total disability benefits;

(b) the worker has requested permanent total disability benefits;

(c) the worker has not returned to work in regular employment;

(d) the worker has not been offered, in writing, a job by the time of injury employer:

(i) for which the worker is qualified; and

(ii) that is within the physical abilities of the worker;

(e) none of the options provided in [section 4(2)(a) through (e)] is appropriate; and

(f) a stay at work/return to work plan involving retraining is agreed upon by the worker and the insurer and a written copy of the plan is provided to the worker.

(2) A stay at work/return to work plan involving retraining must take into consideration the worker's age, education, training, work history, residual physical capacities, vocational interests, and the jobs available in the local labor market for the new occupation. The plan must specify a beginning date and

a completion date. The plan must specify the cost of tuition, fees, books, other reasonable and necessary retraining expenses and timeframes required to complete the plan.

(3) To be entitled to benefits under this section, a worker is required to begin any retraining recommended in the stay at work/return to work plan within 78 weeks after a request for permanent total disability benefits has been made.

(4) A worker entitled to receive biweekly retraining benefits must be paid at the worker's temporary total disability rate. The benefits must be paid for the period specified in the plan, not to exceed 104 weeks. The plan must be completed within 26 weeks of the completion date specified in the plan. Retraining benefits must be paid biweekly while the worker is satisfactorily progressing in the agreed-upon retraining plan. Retraining benefits payable pursuant to a stay at work/return to work plan involving retraining under this section are not payable in a lump sum.

(5) In addition to retraining benefits payable under subsection (4), a worker is entitled to receive payment for tuition, fees, books, and other reasonable and necessary retraining expenses, excluding travel and living expenses paid pursuant to the provisions of [section 7], as set forth in department rules and as specified in the stay at work/return to work plan. Expenses must be paid directly by the insurer.

(6) A worker may not receive permanent partial disability benefits and the benefits under subsection (4) during the same period of time. The payment of permanent partial disability benefits otherwise due to the worker must be deferred while the worker is receiving retraining benefits and resumed after retraining benefits have terminated.

(7) A rehabilitation provider authorized by the insurer shall continue to assist the injured worker until the stay at work/return to work plan is:

(a) fulfilled; or

(b) discontinued by:

(i) agreement of the worker and the insurer; or

(ii) an order of the workers' compensation court.

(8) A worker may not receive both wages and retraining benefits without the written consent of the insurer. A worker who receives both wages and retraining benefits without written consent of the insurer commits the offense of theft and may be prosecuted under 45-6-301.

NEW SECTION. **Section 7. Auxiliary stay at work/return to work benefits.** In addition to benefits otherwise provided in this chapter, separate benefits not exceeding a total of $4,000 may be paid by the insurer for specialized job modification or reasonable travel and relocation expenses used to:

(1) search for new employment;

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

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

(4) attend an on-the-job training program."

NEW SECTION. **Section 8. Exchange of information.** (1) The worker, employer, medical providers, department, insurer, and the rehabilitation provider shall provide to one another case information as provided in this section.

(2) In order to protect the privacy rights of an injured worker, health care information related to a workplace injury or occupational disease may not

be released to the worker's employer without an authorization for the release of the information, signed by the worker. Either of the following documents constitutes an authorization for release of information:

(a) a first report of injury or occupational disease form signed by the worker; or

(b) a written authorization for release of stay at work/return to work information, signed by the worker, allowing that information to be provided to the rehabilitation provider, the employer, the department, the insurer, and to other health care providers. A written authorization as provided in this subsection (2)(b) may be executed without the need for either the worker or the employer to have already completed a first report of injury or occupational disease.

(3) After satisfying the release of information requirements provided in subsection (2), only the following information, which may constitute health care information, may be released to the workers' employer:

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

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

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

(d) the date or anticipated date of maximum medical healing.

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

NEW SECTION. **Section 9. Payments for stay at work/return to work assistance services made by fund – insurer involvement - procedure.** (1) There is created the stay at work/return to work assistance fund in the proprietary category.

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

(3) Upon receipt of a request pursuant to [section 2] for stay at work/return to work assistance, the department shall promptly attempt to determine which insurer is on the risk for the injury or occupational disease. If the department determines which insurer is at risk for the claim, the department shall promptly contact that insurer and advise the insurer of the request for stay at work/return to work assistance.

(a) If an insurer has accepted liability for the claim, the insurer shall provide stay at work/return to work assistance in accordance with [section 2]. The insurer is liable for directly paying the rehabilitation provider for the stay at work/return to work assistance services furnished.

(b) If liability for the claim has not been accepted by an insurer:

(i) an insurer may take immediate action and initiate stay at work/return to work assistance in accordance with [section 2]. In such instances, the insurer is responsible for directly paying the rehabilitation provider for stay at work/return to work assistance.

(ii) If the insurer does not take action within 12 business hours of being contacted by the department to initiate stay at work/return to work assistance in accordance with [section 2], the department shall obtain stay at work/return to work assistance for the injured worker. The department shall be billed for stay at work/return to work assistance by the rehabilitation provider, and pay

for the stay at work/return to work assistance services out of the fund.

(iii) If the department is unable to promptly determine which insurer is on the risk, the department shall obtain stay at work/return to work assistance by the rehabilitation provider, and pay for the assistance services out of the fund.

(4) The department may establish by rule the amounts and types of services to be provided, and the maximum hourly rate that can be charged for department-obtained stay at work/return to work assistance which is paid for by the fund. The rules do not apply where the insurer has taken over direct responsibility for providing for assistance. In the absence of rules on the subject, a rehabilitation provider who is being paid by the fund for a given claim may provide not more than 25 hours of stay at work/return to work assistance on the claim at a rate of not more than $80 an hour.

(6) Services may be terminated if the insurer or the department determines that the worker has not suffered a compensable injury or occupational disease.

NEW SECTION. **Section 10. Assessment for stay at work/return to work assistance fund -- definition.** (1) As used in this section, "money expended" means expenditures for stay at work/return to work assistance from the stay at work/return to work assistance fund provided in [section 9]

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount paid by the fund in the preceding fiscal year less other realized income that is deposited in the fund. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, and plan No. 3 employers, based on

a proportionate share of moneys expended for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

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

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

(5) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 insurers in the previous calendar year. The numerator for the calculation must be adjusted as provided in subsection (8).

(5) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (5). When collected, the assessment

premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation stay at work/return to work assistance fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(7) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state

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

(8) The amount of the assessment premium surcharge actually collected pursuant to subsection (6) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (5)for the following year's assessment premium surcharge.

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

NEW SECTION. **Section 11. Rulemaking authority.** The department may adopt rules to implement this part.

NEW SECTION. **Section 12. Claim closure -- reopening -- procedure.** (1) When a worker has submitted a claim for an injury or occupational disease under this chapter and an insurer has accepted liability or made payments pursuant to 39-71-608 or 39-71-615 on that claim, the claim is eligible for closure 3 years after the latest of:

(a) the date of the injury;

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

(c) the date of the last furnishing of medical benefits.

(2) The 3-year period for closure of a claim provided for in subsection (1) begins when the insurer gives written notice to the claimant and the department that the claim is eligible to be closed pursuant to this section. Notice must be given at the time the insurer, based on its records, believes the 3-year period will begin.

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

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

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

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

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

judicial decision regarding the dispute, whichever is later. If the parties otherwise resolve the dispute, the tolling of the period ceases.

(7) This section does not apply to a claim for which all indemnity and medical benefits have been settled pursuant to 39-71-741.

Section 13. Section 39-71-105 , MCA, is amended to read:

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

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

… NO OTHER CHANGES TO THIS SECTION

Section 14. Section 39-71-116 , MCA, is amended to read:

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

~~(1) "Actual wage loss" means that the wages that a worker earns or is qualified to earn after the worker reaches maximum healing are less than the actual wages the worker received at the time of the injury.~~

ONLY NUMBERING CHANGES UNTIL:

(13) (a) "Indemnity benefits" means any payment made directly to the worker

or the worker's beneficiaries, other than a medical benefit. The term includes payments made pursuant to a reservation of rights.

(b) The term does not include expense reimbursements for items such as meals, travel, or lodging.

NO CHANGES UNTIL:

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

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

(b) ~~is able to return to work in some capacity but the permanent impairment impairs the worker's ability to work~~ has not been offered, in writing, a job by the time of injury employer:

(i) for which the claimant is qualified;

(ii) is within the physical abilities of the worker; and

(iii) pays wages equal to or greater than the time of injury position; and

(c) has not returned to work within **[14 or 21]** days of reaching maximum medical healing~~; and~~

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

NO CHANGES UNTIL:

(30) "Retraining benefits" means the biweekly payments specified in [section 5] that are paid to the worker during the period specified in the stay at work/return to work plan.

ONLY NUMBERING CHANGES FOR REST OF 39-71-116

Section 15. Section 39-71-118 , MCA, is amended to read:

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

(a) each person in this state, …

NO CHANGES IN SUBSECTION (1)

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

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

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

NO OTHER CHANGES TO 39-71-118

Section 16. Section 39-71-407 , MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) For workers' compensation injuries, each insurer is liable for the payment of compensation, in the manner and to the extent provided in this section, to an employee of an employer covered under plan No. 1, plan No. 2, and the state fund under plan No. 3 that it insures who receives an injury arising out of and in the course

of employment or, in the case of death from the injury, to the employee's beneficiaries, if any.

(2) (a) Regarding breaks or activities as described in this subsection (2), an injury does not arise out of and in the course of employment when the employee is:

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

(ii) engaged in a social or recreational activity, regardless of whether the employer pays for any portion of the cost of the activity.

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

ONLY NUMBERING CHANGES AFTER THIS in 39-71-407

Section 17. Section 39-71-606 , MCA, is amended to read:

"39-71-606. Insurer to accept or deny claim within ~~thirty~~ fourteen days of receipt -- notice of benefits and entitlements to claimants -- notice of denial -- notice of reopening -- notice to employer. (1) Each insurer under any plan for the payment of workers' compensation benefits shall, within ~~30~~ 14 days of receipt of a claim for compensation signed by the claimant or the claimant's representative, either accept or deny the claim and, if denied, shall inform

the claimant and the department in writing of the denial.

NO OTHER CHANGES TO 39-71-606

Section 18. Section 39-71-609 , MCA, is amended to read:

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

(2) Temporary total disability benefits may be terminated subject to 39-71-701(4) if:

(a) the claimant has actually returned to work; or

(b)(i) the claimant has reached maximum healing; and

(ii) the insurer has:

(A) been advised by the treating physician that the claimant has no permanent impairment as a result of the injury or occupation disease; or

(B) received an impairment rating for the claimant from a physician.

(3) Permanent partial disability benefits begin on the day following the

day the claimant is no longer entitled to receive temporary total disability or temporary partial disability benefits. ~~on the date that the worker has been released to return to work in some capacity. Unless the claimant is found, at maximum healing, to be without a permanent physical impairment from the injury, the insurer, prior to converting temporary total disability benefits or temporary partial disability benefits to permanent partial disability benefits:~~

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

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

~~(c) must have a physician's determination, based on the physician's knowledge of the claimant's job analysis prepared by a rehabilitation provider, that the claimant can return to work, with or without restrictions, on the job on which the claimant was injured or on another job for which the claimant is suited by age, education, work experience, and physical condition;~~

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

{*Internal References to 39-71-609: None.*}

Section 19. Section 39-71-611 , MCA, is amended to read:

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

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

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

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

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

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

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

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

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

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

{*Internal References to 39-71-611:*

39-71-614 a *39-71-614a*}

Section 20. Section 39-71-612 , MCA, is amended to read:

"39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge -- barring of attorney fees under common fund or other doctrines. (1) If an insurer pays or submits a written offer of payment of compensation under this chapter but controversy relates to the amount of compensation due, the case is brought before the workers' compensation judge for adjudication of the controversy, and the award granted by the judge is greater than the amount paid or offered by the insurer, reasonable attorney fees and costs as established by the workers' compensation judge if the case has gone to a hearing may be awarded by the judge in addition to the amount of compensation.

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

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

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

(i) the insurer pays or submits a written offer of payment of medical benefits under Title 39, chapter 71, but there is controversy related to the amount of benefits due. A written offer of payment made 30 days or more before

the date of hearing must be considered a valid offer of payment for the purposes of this section.

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

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

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

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

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

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

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

{*Internal References to 39-71-612:*

39-71-614 a *39-71-614a*}

Section 21. Section 39-71-614 , MCA, is amended to read:

"39-71-614. Calculation of attorney fees -- limitation. (1) The amount of an attorney's fee assessed against an insurer under 39-71-611 or 39-71-612 when the actions of the insurer were unreasonable must be based exclusively on

the time spent by the attorney in representing the claimant on the issues brought to hearing. The attorney must document the time spent, but the judge is not bound by the documentation submitted. The hourly rate applied to the time spent must be based on the attorney's customary and current hourly rate for legal work performed in this state, subject to a maximum established by the department.

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

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

{*Internal References to 39-71-614: None.*}

Section 22. Section 39-71-701 , MCA, is amended to read:

"39-71-701. Compensation for temporary total disability -- exception. (1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:

(a) when the worker suffers a total loss of wages as a result of an injury

~~and~~ or occupational disease;

(b) until the worker reaches maximum healing; ~~or~~

~~(b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements~~ and

(c) the insurer has:

(i) been advised by the treating physician that the worker has no permanent impairment as a result of the injury or occupational disease; or

(ii received an impairment rating for the worker from a physician.

(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.

(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in ~~39-71-702(5)~~ 39-71-702(6). NO OTHER CHANGES EXCEPT FOR NUMBERING TO THIS SECTION

Section 23. Section 39-71-702 , MCA, is amended to read:

"39-71-702. Compensation for permanent total disability. (1) If a worker ~~is no longer temporarily totally disabled and is permanently totally disabled,~~ has a permanent partial disability and has not returned to work, the worker may request permanent total disability benefits. The request for permanent total disability benefits must be made not later than 2 years after the worker receives the worker's final permanent partial disability benefit payment.

(2) If the worker requests permanent total disability benefits, the insurer is required to designate a certified vocational rehabilitation provider to provider stay at work/return to work assistance as defined in 39-71-1011 for the purposes of assessing the worker's employability, potential for retraining, or eligibility for permanent total disability benefits. If, after receiving stay at work/return to work assistance, the worker is permanently totally disabled as defined in 39-71-116, the worker is eligible for permanent total disability benefits. Permanent total disability benefits must be paid for the duration of the worker's permanent total disability, subject to 39-71-710.

~~(2)~~(3) The determination of permanent total disability must be supported by a preponderance of objective medical findings.

~~(3)~~(4) Weekly compensation benefits for an injury resulting in permanent total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury.

NO OTHER CHANGES TO THIS SECTION EXCEPT NUMBERING

Section 24 Section 39-71-703 , MCA, is amended to read:

"39-71-703. *(Temporary - expires June 30, 2013)* **Compensation for an impairment award and a permanent partial disability award.** (1) If an injured worker ~~suffers~~ receives a permanent ~~partial disability~~ impairment rating and is no longer entitled to temporary total ~~or permanent total~~ ~~disability~~ benefits, the worker is entitled to ~~a permanent partial disability~~ an impairment award if that worker:

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

~~(b)~~ (a) has a permanent impairment rating that:

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

(ii) is established by objective medical findings; and

(iii) is more than zero as determined ~~by the latest edition of the American medical association Guides to the Evaluation of Permanent Impairment~~ using the impairment rating method in 39-71-711.

(2) When a worker receives an impairment rating as the result of a compensable injury or occupational disease and has ~~no actual wage loss as a result of the injury~~ returned to work at wages equal to or greater than the worker's time of injury wage, the worker is eligible for an impairment award only.

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

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

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

(3) The impairment award must be arrived at by multiplying the percentage of the whole body impairment by 375 weeks.

(4) If the worker has suffered a permanent partial disability, the worker is entitled to an impairment award and a permanent partial disability award. The permanent partial disability award is based on the sum of the following percentages, then multiplied by 375 weeks:

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

(b) for a worker who has completed less than 12 years of education, 1%;

for a worker who has completed 12 years or more of education or who has received a graduate equivalency diploma, 0%; plus

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

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

(d) a percentage equal to the impairment rating if:

(i) the worker has not returned to work within **[14 or 21]** days from the date the insurer receives from a physician the worker's impairment rating; and

(ii) the worker has not received a written job offer from the time of injury employer for a job:

(A) for which the worker is qualified;

(B) is within the physical abilities of the worker; and

(C) pays wages equal to or greater than the time of injury position.

(5) The total amount of benefits paid for an impairment award and a permanent partial disability award granted to an injured worker may not exceed

375 weeks.

(6) The weekly benefit rate for an impairment award or a permanent partial disability award is 66 2/3% of the wages received at the time of injury, but the rate may not exceed ~~one half~~ 75% of the state's average weekly wage. The weekly benefit amount established for an injured worker may not be changed by a subsequent adjustment in the state's average weekly wage for future fiscal years.

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

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

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

~~(10)~~(9) As used in this section:

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

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

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

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

(10) If a worker only received an impairment award at medical stability and returned to work with the time of injury employer at wages equal to or greater than the time of injury wages and within six months of the return to work the position is no longer available to the worker for any reason except the worker's incarceration, as provided for in 39-71-744, resignation or termination for disciplinary reasons, the worker qualifies for any additional percentages resulting from the injury.

(11) (a) If a worker is "union attached" or "job attached" to the time of injury employer at the time the worker reaches medical stability and is waiting to be returned to work, the worker is eligible for an impairment award only if the worker returns to work within six months of reaching medical stability.

(b) For purposes of this subsection:

(i) "union attached" means the worker is a member in good standing and on the out-of-work list of a labor union that operates an exclusive hiring hall; and

(ii) "job attached" means the worker has a definite or approximate date of hire or recall to work at which the worker will be regularly scheduled to work."

{*Internal References to 39-71-703:*

39-71-118a *39-71-708x* *39-71-712 x* *39-71-741a*}

Section 24. *(Effective July 1, 2013)* Section 39-71-703 , MCA, is amended to read:

"39-71-703. Compensation for an impairment award and a permanent partial disability award. (1) If an injured worker ~~suffers~~ receives a permanent ~~partial~~

~~disability~~ impairment rating and is no longer entitled to temporary total ~~or permanent total~~ disability benefits, the worker is entitled to ~~a permanent partial disability~~ an impairment award if that worker:

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

~~(b)~~ (a) has a permanent impairment rating that:

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

(ii) is established by objective medical findings; and

(iii) is more than zero as determined ~~by the latest edition of the American medical association Guides to the Evaluation of Permanent Impairment~~ using the impairment rating method in 39-71-711.

(2) When a worker receives an impairment rating as the result of a compensable injury or occupational disease and has ~~no actual wage loss as a result of the injury~~ returned to work at wages equal to or greater than the worker's time of injury wage, the worker is eligible for an impairment award only.

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

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

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

(3) The impairment award must be determined by multiplying the percentage of the whole body impairment by 400 weeks.

(4) If the worker has suffered a permanent partial disability, the worker is entitled to an impairment award and a permanent partial disability award.

The permanent partial disability award is based on the sum of the following percentages, then multiplied by 400 weeks:

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

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

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

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

(d) a percentage equal to the impairment rating if:

(i) the worker has not returned to work within **[14 or 21]** days from the date the insurer receives from a physician the worker's impairment rating; and

(ii) the worker has not received a written job offer from the time of injury employer for a job:

(A) for which the worker is qualified;

(B) is within the physical abilities of the worker; and

(C) pays wages equal to or greater than the time of injury position.

(5) The total amount of benefits paid for an impairment award and a permanent partial disability award granted to an injured worker may not exceed 400 weeks.

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

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

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

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

~~(10)~~(9) As used in this section:

(a) "heavy labor activity" means the ability to lift over 50 pounds

occasionally or up to 50 pounds frequently;

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

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

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

(10) If a worker received only an impairment award at medical stability and returned to work with the time of injury employer at wages equal to or greater than the time of injury wages and within six months of the return to work the position is no longer available to the worker for any reason except the worker's incarceration, as provided for in 39-71-744, resignation or termination for disciplinary reasons, the worker qualifies for any additional percentages resulting from the injury.

(11) (a) If a worker is "union attached" or "job attached" to the time of injury employer at the time the worker reaches medical stability and is waiting to be returned to work, the worker is eligible for an impairment award only if the worker returns to work within six months of reaching medical stability.

(b) For purposes of this subsection:

(i) "union attached" means the worker is a member in good standing and on the out-of-work list of a labor union that operates an exclusive hiring hall; and

(ii) "job attached" means the worker has a definite or approximate date of hire or recall to work at which the worker will be regularly scheduled to work."

{*Internal References to 39-71-703:*

39-71-118a 39-71-708x 39-71-712 x 39-71-741a}

Section 26. Section 39-71-704 , MCA, is amended to read:

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

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

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

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

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

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to

the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

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

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

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

(D) travel for unauthorized treatment or disallowed procedures.

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

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

(f) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate ~~when they are not used for a period of 60 consecutive months~~ pursuant to [section 12].

NO CHANGES IN REMAINDER

Section 27. Section 39-71-711 , MCA, is amended to read:

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

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

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

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

(d) must be established by objective medical findings.

INTERMEDIATE SUBSECTION NOT CHANGED

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

{ *Internal References to 39-71-711:*

37-12-201

Section 28. Section 39-71-736 , MCA, is amended to read:

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

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

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

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

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

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

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

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

a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by ~~an injured~~ a worker may not affect the worker's eligibility for temporary total disability benefits."
{*Internal References to 39-71-736:*

39-71-701a}

Section 28. Section 39-71-741 , MCA, is amended to read:

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

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

(a) all benefits if a claimant and an insurer dispute the initial compensability of an injury and there is a reasonable dispute over compensability~~;~~. If the settlement is subject to a Medicare-approved set-aside for payment of future medical expenses, the department may not approve the

settlement unless the settlement language is expressly contingent on Medicare's approval of the set-aside.

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

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

(i) relates to:

(A) the necessities of life;

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

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

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

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

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

is subject to a Medicare-approved set-aside for payment of future medical expenses, the department may not approve the settlement unless the settlement language is expressly contingent on Medicare's approval of the set-aside.

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

(i) the insurer and claimant mutually agree to a settlement of all or a portion of medical benefits and a settlement is in the best interest of the parties to the settlement. The parties to the settlement agreement shall set out the amount of the anticipated future medical costs included in the settlement agreement and the rationale that is the basis for those costs. The claimant shall also indicate by a signed acknowledgment an understanding of what medical benefits will terminate because of the settlement.

(ii) If the amount of the settlement agreement attributable to the medical portion is for $25,000 or more and the amount is not subject to a Medicare-approved set-aside, the department may approve the agreement if the agreement is not grossly inadequate.

(iii) If the amount of the settlement agreement attributable to the medical portion is for $25,000 or more and the agreement is subject to a Medicare-approved set-aside for payment of future medical expenses, the department may not approve the settlement unless the settlement language is expressly contingent on Medicare's approval of the set-aside and the agreement is not grossly inadequate.

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

~~(2)~~ (4) Any lump-sum conversion of benefits under this section must be

converted to present value using the rate prescribed under subsection ~~(3)(b)~~ (5)(b).

~~(3)~~(5) (a) An insurer may recoup any lump-sum ~~payment~~ advance amortized at the rate established by the department, prorated biweekly over the projected duration of the compensation period.

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

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

~~(4)~~(6) A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump sum or settlement of medical benefits is considered a dispute for which a mediator and the workers' compensation court have jurisdiction to make a determination. A request for mediation must be filed with the department. Upon any review by a court, the court shall use the standards for approval set by this section.

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

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

{*Internal References to 39-71-741:*

39-71-519 x 39-71-703a 39-71-703 a 39-71-721a}

NEW SECTION. **Section 30. {standard} Repealer.** The following sections of the Montana Code Annotated are repealed:

39-71-1006. Rehabilitation benefits.

39-71-1011 Definitions

39-71-1014. Rehabilitation services -- required and provided by insurers.
{*Internal References to 39-71-1006: 39-71-1011a*

Internal References to 39-71-1014: None.}

NEW SECTION. **Section 31. {standard} Applicability.** (1) [Sections 1 through 18, 22, 23, 26, 27, and 28] apply to injuries and occupational diseases occurring on or after July 1, 2011.

(2) [Sections 19 through 21] apply to disputes arising on or after July 1, 2011.

(3) [section 25] applies to injuries and occupational diseases occurring on or after July 1, 2013.

NEW SECTION. **Section 32. {standard} Retroactive applicability.** Revisions to 39-71-741, [section 29], applies retroactively, within the meaning of 1-2-109, to claims for injuries or occupational diseases for which all benefits have not been settled.

NEW SECTION. **Section 33. Transition for stay at work/return to work assistance fund.** (1) The department of labor and industry shall transfer $100,000 from the administrative fund provided for by 39-71-201 to provide the

initial funding for the stay at work/return to work assistance fund provided by [section 7].

(2) Effective for policies written or renewed in state fiscal year 2012 only, the premium surcharge rate to be levied by insurers on workers' compensation insurance premiums pursuant to section [8] is 0.00082.

NEW SECTION. **Section 35. {standard} Effective dates.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2011.

(2) [Section 25] is effective July 2, 2013.

(3) [Sections 33 and 34] and this section are effective on passage and approval.

NEW SECTION. **Section 36. {standard} Severability -- nonseverability.** (1) Except as provided in subsection (2), if a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

(2) It is the intent of the legislature that [sections 1, 3(1), 6, 13, 14, 18, 22 through 25, 30] are essentially dependent upon each other and that if one or more of these sections are held invalid or unconstitutional, the other sections specified in this subsection (2) also are to be made invalid.

NEW SECTION. **Section 37. {standard} Codification instruction.** (1) [Sections 1 through 11] are intended to be codified as an integral part of Title 39, chapter 71, part 10, and the provisions of Title 39, chapter 71, part 10,

apply to [sections 1 through 11].

(2) [Section 12] is intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [section 12].

- END -