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# Montana Statutes

## TITLE 39. LABOR

## CHAPTER 71. WORKERS' COMPENSATION

**Part 1. General Provisions**

**39-71-101. Short title.** This chapter may be cited as the "Workers' Compensation Act".

**History:** En. Sec. 1, Ch. 96, L. 1915; re-en. Sec. 2816, R.C.M. 1921; re-en. Sec. 2816, R.C.M. 1935; amd. Sec. 29, Ch. 341, L. 1969; amd. Sec. 86, Ch. 23, L. 1975; R.C.M. 1947, 92-101(part); amd. Sec. 51, Ch. 397, L. 1979.

**39-71-102. Reference to plans.** Whenever compensation plan No. 1, 2, or 3 is referred to, such reference also includes all other sections which are applicable to the subject matter of such reference.

**History:** En. Sec. 1, Ch. 96, L. 1915; re-en. Sec. 2817, R.C.M. 1921; re-en. Sec. 2817, R.C.M. 1935; R.C.M. 1947, 92-102; amd. Sec. 52, Ch. 397, L. 1979.

**39-71-103. Compensation provisions.** The compensation provisions of this chapter, whenever referred to, shall be held to include the provisions of compensation plan No. 1, 2, or 3 and all other sections of this chapter applicable to the same or any part thereof.

**History:** En. Sec. 1, Ch. 96, L. 1915; re-en. Sec. 2818, R.C.M. 1921; re-en. Sec. 2818, R.C.M. 1935; R.C.M. 1947, 92-103.

**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 provide assistance to a worker at a reasonable cost to the employer. Within that limitation, the wage-loss benefit should bear a reasonable relationship to actual wages lost as a result of a work-related injury or disease.

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

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

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

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

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

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

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

**History:** En. Sec. 1, Ch. 464, L. 1987; amd. Sec. 1, Ch. 630, L. 1993; amd. Sec. 1, Ch. 103, L. 2005; amd. Sec. 9, Ch. 416, L. 2005; amd. Sec. 7, Ch. 448, L. 2005; amd. Sec. 1, Ch. 167, L. 2011.

**39-71-106. No liability for reporting violation.** A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of this chapter.

**History:** En. Sec. 17, Ch. 619, L. 1993; amd. Sec. 10, Ch. 416, L. 2005.

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

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

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

(4) (a) An insurer that uses a third-party agent to provide the insurer with claim examination services shall notify the department in writing of a change of a third-party agent at least 14 days in advance of the change.

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

(5) (a) Except for those medical benefits provided by a managed care organization or a preferred provider organization in Title 39, chapter 71, part 11, or paid pursuant to 39-71-704(4), an insurer that uses a third-party agent to review medical bills shall, when first using the agent's services and annually in subsequent years, obtain written certification from the agent that, for each bill the agent reviews, the agent agrees to calculate the payment due based on the Montana workers' compensation medical fee schedules, provided for under 39-71-704, that were in effect on the date the service was provided.

(b) Except for those medical benefits provided by a managed care organization or a preferred provider organization in Title 39, chapter 71, part 11, or paid pursuant to 39-71-

704(4), an insurer whose agent neglects or fails to use the proper fee schedule may be assessed a penalty of not less than $200 or more than $1,000 for each bill that its agent reviews under a fee schedule other than the proper Montana fee schedule.

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

(6) An insurer shall provide to the claimant:

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

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

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

(7) An insurer shall:

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

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

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

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

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

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

**History:** En. Sec. 4, Ch. 243, L. 1995; amd. Sec. 3, Ch. 214, L. 2001; amd. Sec. 2, Ch. 103, L. 2005; amd. Sec. 2, Ch. 140, L. 2005; amd. Sec. 11, Ch. 416, L. 2005; amd. Sec. 1, Ch. 117, L. 2007; amd. Sec. 5, Ch. 112, L. 2009; amd. Sec. 1, Ch. 150, L. 2011.

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

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

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

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

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

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

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

(4) "Beneficiary" means:

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

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

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

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

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

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

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

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

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

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

(i) determine liability;

(ii) apply the requirements of this title;

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

(iv) determine survivor benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average

monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if average payrolls are not available. This estimate must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

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

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

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

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

(28) "Permanent total disability" means a physical condition resulting from injury as defined in this chapter, after a worker reaches maximum medical healing, in which a worker does not have a reasonable prospect of physically performing regular employment. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

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

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

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

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

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

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

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

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

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

ownership of a business enterprise.

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

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

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

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

(c) suffers a partial wage loss.

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

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

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

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

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

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

(c) a physician assistant licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection (41)(a), in the area where the physician assistant is located;

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

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

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

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

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

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

**History:** Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2853, R.C.M. 1921; re-en. Sec. 2853, R.C.M. 1935; Sec. 92-401, R.C.M. 1947; (1)En. 92-423.2 by Sec. 1, Ch. 445, L. 1973; Sec. 92-423.2, R.C.M. 1947; (2)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2865, R.C.M. 1921; amd. Sec. 4, Ch. 121, L. 1925; re-en. Sec. 2865, R.C.M. 1935; amd. Sec. 1, Ch. 92, L. 1969; amd. Sec. 1, Ch. 331, L. 1973; amd. Sec. 1, Ch. 269, L. 1974; amd. Sec. 1, Ch. 46, L. 1975; Sec. 92-413, R.C.M. 1947; (3)Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2888, R.C.M. 1921; re-en. Sec. 2888, R.C.M. 1935; Sec. 92-436, R.C.M. 1947; Ap. p. Sec. 12, Ch. 235, L. 1947; Sec. 92-1121.1, R.C.M. 1947; (4)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2869, R.C.M. 1921; re-en. Sec. 2869, R.C.M. 1935; amd. Sec. 2, Ch. 92, L. 1969; Sec. 92-417, R.C.M. 1947; (5)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2878, R.C.M. 1921; re-en. Sec. 2878, R.C.M. 1935; amd. Sec. 7, Ch. 23, L. 1975; Sec. 92-426, R.C.M. 1947; (6), (22)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2885, R.C.M. 1921; re-en. Sec. 2885, R.C.M. 1935; Sec. 92-433, R.C.M. 1947; (7)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2877, R.C.M. 1921; re-en. Sec. 2877, R.C.M. 1935; amd. Sec. 1, Ch. 33, L. 1974; Sec. 92-425, R.C.M. 1947; (8)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2887, R.C.M. 1921; re-en. Sec. 2887, R.C.M. 1935; amd. Sec. 7, Ch. 550, L. 1977; Sec. 92-435, R.C.M. 1947; (9)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2868, R.C.M. 1921; re-en. Sec. 2868, R.C.M. 1935; Sec. 92-416, R.C.M. 1947; (10)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2881, R.C.M. 1921; re-en. Sec. 2881, R.C.M. 1935; amd. Sec. 8, Ch. 23, L. 1975; Sec. 92-429, R.C.M. 1947; (11)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2884, R.C.M. 1921; re-en. Sec. 2884, R.C.M. 1935; amd. Sec. 9, Ch. 23, L. 1975; Sec. 92-432, R.C.M. 1947; (12)En. 92-440 by Sec. 1, Ch. 108, L. 1973; Sec. 92-440, R.C.M. 1947; (13)En. 92-441 by Sec. 1, Ch. 109, L. 1973; Sec. 92-441, R.C.M. 1947; (14)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2873, R.C.M. 1921; re-en. Sec. 2873, R.C.M. 1935; Sec. 92-421, R.C.M. 1947; (15)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2889, R.C.M. 1921; re-en. Sec. 2889, R.C.M. 1935; Sec. 92-437, R.C.M. 1947; (16)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2886, R.C.M. 1921; re-en. Sec. 2886, R.C.M,. 1935; Sec. 92-434, R.C.M. 1947; (17)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2860, R.C.M. 1921; re-en. Sec. 2860, R.C.M. 1935; Sec. 92-408, R.C.M. 1947; (18)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2861, R.C.M. 1921; re-en. Sec. 2861, R.C.M. 1935; Sec. 92-409, R.C.M. 1947; (19)En. 92-439 by Sec. 1, Ch. 107, L. 1973; Sec. 92-439, R.C.M. 1947; (20)En. 92-423.1 by Sec. 1, Ch. 444, L. 1973; Sec. 92-423.1, R.C.M. 1947; (21)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2876, R.C.M. 1921; re-en. Sec. 2876, R.C.M. 1935; Sec. 92-424, R.C.M. 1947; R.C.M. 1947, 92-401, 92-408, 92-409, 92-413, 92-416, 92-417, 92-421, 92-423.1, 92-423.2, 92-424, 92-425, 92-426, 92-429, 92-432, 92-433, 92-434, 92-435, 92-436, 92-437, 92-439, 92-440, 92-441, 92-1121.1(part); amd. Sec. 53, Ch. 397, L. 1979; amd. Sec. 1, Ch. 47, L. 1981; amd. Sec. 1, Ch. 349, L. 1981; amd. Sec. 1, Ch. 374, L. 1985; amd. Sec. 2, Ch. 464, L. 1987; amd. Sec. 7, Ch. 333, L. 1989; amd. Sec. 13, Ch. 613, L. 1989; amd. Sec. 6, Ch. 4, Sp. L. May 1990; amd. Sec. 1, Ch. 323, L. 1991; amd. Sec. 2, Ch. 480, L. 1991; amd. Sec. 1, Ch. 574, L. 1991; amd. Sec. 1, Ch. 555, L. 1993; amd. Sec. 1, Ch. 619, L. 1993; amd. Sec. 2, Ch. 628, L. 1993; amd. Sec. 1, Ch. 234, L. 1995; amd. Sec. 5, Ch. 243, L. 1995; amd. Sec. 1, Ch. 516, L. 1995; amd. Sec. 6, Ch. 276, L. 1997; amd. Sec. 1, Ch. 404, L. 1997; amd. Sec. 1, Ch. 500, L. 1997; amd. Sec. 72, Ch. 51, L. 1999; amd. Sec. 30, Ch. 224, L. 2003; amd. Sec. 5, Ch. 26, L. 2005; amd. Sec. 3, Ch. 140, L. 2005; amd. Secs. 12, 41, Ch. 416, L. 2005; amd. Sec. 20, Ch. 519, L. 2005; amd. Sec. 1, Ch. 359, L. 2007; amd. Sec. 2, Ch. 167, L. 2011.

**39-71-117. Employer defined.** (1) "Employer" means:

(a) the state and each county, city and county, city school district, and irrigation district; all other districts established by law; all public corporations and quasi-public corporations and public agencies; each person; each prime contractor; each firm, voluntary association, limited liability company, limited liability partnership, and private corporation, including any public service corporation and including an independent contractor who has a person in service under an appointment or contract of hire, expressed or implied, oral or written; and the legal representative of any deceased employer or the receiver or trustee of the deceased employer;

(b) any association, corporation, limited liability company, limited liability partnership, or organization that seeks permission and meets the requirements set by the department by rule for a group of individual employers to operate as self-insured under plan No. 1 of this chapter;

(c) any nonprofit association, limited liability company, limited liability partnership, or corporation or other entity funded in whole or in part by federal, state, or local government funds that places community service participants, as described in 39-71-118(1)(e), with nonprofit organizations or associations or federal, state, or local government entities; and

(d) a religious corporation, religious organization, or religious trust receiving remuneration from nonmembers for agricultural production, manufacturing, or a construction project conducted by its members on or off the property of the religious corporation, religious organization, or religious trust.

(2) A temporary service contractor is the employer of a temporary worker for premium and loss experience purposes.

(3) Except as provided in chapter 8 of this title, an employer defined in subsection (1) who uses the services of a worker furnished by another person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, is presumed to be the employer for workers' compensation premium and loss experience purposes for work performed by the worker. The presumption may be rebutted by substantial credible evidence of the following:

(a) the person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, furnishing the services of a worker to another retains control over all aspects of the work performed by the worker, both at the inception of employment and during all phases of the work; and

(b) the person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, furnishing the services of a worker to another has obtained workers' compensation insurance for the worker in Montana both at the inception of employment and during all phases of the work performed.

(4) An interstate or intrastate common or contract motor carrier that maintains a place of business in this state and uses an employee or worker in this state is considered the employer of that employee, is liable for workers' compensation premiums, and is subject to loss experience rating in this state unless:

(a) the worker in this state is certified as an independent contractor as provided in 39-71-417; or

(b) the person, association, contractor, firm, limited liability company, limited liability

partnership, or corporation furnishing employees or workers in this state to a motor carrier has obtained Montana workers' compensation insurance on the employees or workers in Montana both at the inception of employment and during all phases of the work performed.

**History:** En. 92-410.1 by Sec. 1, Ch. 154, L. 1973; R.C.M. 1947, 92-410.1(part); amd. Sec. 1, Ch. 480, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 2, Ch. 323, L. 1991; amd. Sec. 1, Ch. 813, L. 1991; amd. Sec. 1, Ch. 458, L. 1993; amd. Sec. 29, Ch. 308, L. 1995; amd. Sec. 18, Ch. 344, L. 1995; amd. Sec. 2, Ch. 516, L. 1995; amd. Sec. 1, Ch. 172, L. 1997; amd. Sec. 4, Ch. 214, L. 2001; amd. Sec. 8, Ch. 448, L. 2005; amd. Sec. 6, Ch. 112, L. 2009.

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

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

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

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

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

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

(i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an

impairment award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part 4, for a full-time employee at the time of the injury; and

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

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

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

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

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

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

(a) 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;

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

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

(d) performing temporary agricultural work for an employer if the person performing the work is otherwise exempt from the requirement to obtain workers' compensation coverage under 39-71-401(2)(r) with respect to a company that primarily performs agricultural work at a fixed business location or under 39-71-401(2)(d) and is not required to obtain an independent contractor's exemption certificate under 39-71-417 because the person does not regularly

perform agricultural work away from the person's own fixed business location. For the purposes of this subsection, the term "agricultural" has the meaning provided in 15-1-101(1)(a).

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter a volunteer as defined in subsection (2)(b), a volunteer emergency medical technician as defined in subsection (10), or a volunteer firefighter as defined in 7-33-4510. An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee under the provisions of this chapter a volunteer emergency medical technician.

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

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the partners, sole proprietor, or members to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (4)(d). A partner, sole proprietor, or member is not considered an employee within this chapter until notice has been given.

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

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (4)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $900 a month and not more than 1 1/2 times the state's average weekly wage.

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

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

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

(d) For the purposes of an election under this subsection (5), all weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $200 a week and not more than 1 1/2 times the state's average weekly wage.

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

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

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

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

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

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

(d) a nonresident of Montana who does not meet the requirements of subsection (8)(b) and whose employer elects coverage with an insurer that allows an election for an employer whose:

(i) nonresident employees are hired in Montana;

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

(iii) nonresident employees are supervised in Montana; and

(iv) business records are maintained in Montana.

(9) An insurer may require coverage for all nonresident employees of a Montana employer who do not meet the requirements of subsection (8)(b) or (8)(d) as a condition of approving the election under subsection (8)(d).

(10) (a) With the approval of the insurer, an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee within the provisions of this chapter a volunteer emergency medical technician who serves public safety through the ambulance service not otherwise covered by subsection (1)(g) or the paid or volunteer nontransporting medical unit.

(b) In the event of an election under subsection (10)(a), the employer shall report payroll for all volunteer emergency medical technicians for premium and weekly benefit purposes based on the number of volunteer hours of each emergency medical technician, but no more than 60 hours, times the state's average weekly wage divided by 40 hours.

(c) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, may make a separate election to provide benefits as described in this subsection (10) to a member who is either a self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer emergency medical technician pursuant to subsection (10)(a). When injured in the course and scope of employment as a volunteer emergency medical technician, a member

may instead of the benefits described in subsection (10)(b) be eligible for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080 hours a year. If the separate election is made as provided in this subsection (10), payroll information for those self-employed sole proprietors or partners must be reported and premiums must be assessed on the assumed weekly wage.

(d) A volunteer emergency medical technician who receives workers' compensation coverage under this section may not receive disability benefits under Title 19, chapter 17, if the individual is also eligible as a volunteer firefighter.

(e) (i) The term "volunteer emergency medical technician" means a person who has received a certificate issued by the board of medical examiners as provided in Title 50, chapter 6, part 2, and who serves the public through an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county.

(ii) The term does not include a volunteer emergency medical technician who serves an employer as defined in 7-33-4510.

(f) The term "volunteer hours" means the time spent by a volunteer emergency medical technician in the service of an employer or as a volunteer for a town, city, or county, including but not limited to training time, response time, and time spent at the employer's premises.

**History:** En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2863, R.C.M. 1921; amd. Sec. 3, Ch. 121, L. 1925; amd. Sec. 1, Ch. 139, L. 1931; re-en. Sec. 2863, R.C.M. 1935; amd. Sec. 3, Ch. 88, L. 1945; amd. Sec. 1, Ch. 153, L. 1963; amd. Sec. 1, Ch. 308, L. 1971; amd. Sec. 1, Ch. 44, L. 1975; amd. Sec. 1, Ch. 281, L. 1977; R.C.M. 1947, 92-411; amd. Sec. 1, Ch. 21, L. 1981; amd. Sec. 2, Ch. 336, L. 1985; amd. Sec. 20, Ch. 670, L. 1985; amd. Sec. 96, Ch. 370, L. 1987; amd. Sec. 67, Ch. 464, L. 1987; amd. Sec. 25, Ch. 658, L. 1987; amd. Sec. 11, Ch. 333, L. 1989; amd. Sec. 1, Ch. 129, L. 1991; amd. Sec. 3, Ch. 323, L. 1991; amd. Sec. 2, Ch. 813, L. 1991; amd. Sec. 1, Ch. 154, L. 1993; amd. Sec. 8, Ch. 279, L. 1993; amd. Sec. 2, Ch. 458, L. 1993; amd. Sec. 1, Ch. 471, L. 1993; amd. Sec. 6, Ch. 561, L. 1993; amd. Sec. 1, Ch. 131, L. 1995; amd. Sec. 30, Ch. 308, L. 1995; amd. Sec. 19, Ch. 344, L. 1995; amd. Sec. 1, Ch. 424, L. 1995; amd. Sec. 3, Ch. 516, L. 1995; amd. Sec. 2, Ch. 172, L. 1997; amd. Sec. 2, Ch. 500, L. 1997; amd. Sec. 2, Ch. 515, L. 1997; amd. Sec. 1, Ch. 124, L. 1999; amd. Sec. 1, Ch. 238, L. 2001; amd. Sec. 3, Ch. 465, L. 2001; amd. Sec. 6, Ch. 26, L. 2005; amd. Sec. 7, Ch. 449, L. 2007; amd. Sec. 7, Ch. 112, L. 2009; amd. Sec. 1, Ch. 312, L. 2009; amd. Sec. 3, Ch. 167, L. 2011; amd. Sec. 8, Ch. 255, L. 2011; amd. Sec. 1, Ch. 262, L. 2011; amd. Sec. 3, Ch. 412, L. 2013.

**39-71-119. Injury and accident defined.** (1) "Injury" or "injured" means:

(a) internal or external physical harm to the body that is established by objective medical findings;

(b) damage to prosthetic devices or appliances, except for damage to eyeglasses, contact lenses, dentures, or hearing aids; or

(c) death.

(2) An injury is caused by an accident. An accident is:

(a) an unexpected traumatic incident or unusual strain;

(b) identifiable by time and place of occurrence;

(c) identifiable by member or part of the body affected; and

(d) caused by a specific event on a single day or during a single work shift.

(3) "Injury" or "injured" does not mean a physical or mental condition arising from:

(a) emotional or mental stress; or

(b) a nonphysical stimulus or activity.

(4) "Injury" or "injured" does not include a disease that is not caused by an accident.

(5) (a) A cardiovascular, pulmonary, respiratory, or other disease, cerebrovascular accident, or myocardial infarction suffered by a worker is an injury only if the accident is the primary cause of the physical condition in relation to other factors contributing to the physical condition.

(b) "Primary cause", as used in subsection (5)(a), means a cause that, with a reasonable degree of medical certainty, is responsible for more than 50% of the physical condition.

**History:** Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2870, R.C.M. 1921; re-en. Sec. 2870, R.C.M. 1935; amd. Sec. 6, Ch. 162, L. 1961; amd. Sec. 6, Ch. 149, L. 1965; amd. Sec. 1, Ch. 270, L. 1967; amd. Sec. 1, Ch. 488, L. 1973; Sec. 92-418, R.C.M. 1947; Ap. p. Sec. 2, Ch. 488, L. 1973; Sec. 92-418.1, R.C.M. 1947; (3)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2864, R.C.M. 1921; re-en. Sec. 2864, R.C.M. 1935; Sec. 92-412, R.C.M. 1947; R.C.M. 1947, 92-412, 92-418, 92-418.1; amd. Sec. 3, Ch. 464, L. 1987; amd. Sec. 6, Ch. 243, L. 1995.

**39-71-123. Wages defined.** (1) "Wages" means all remuneration paid for services performed by an employee for an employer, or income provided for in subsection (1)(d). Wages include the cash value of all remuneration paid in any medium other than cash. The term includes but is not limited to:

(a) commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and periods of sickness;

(b) backpay or any similar pay made for or in regard to previous service by the employee for the employer, other than retirement or pension benefits from a qualified plan;

(c) tips or other gratuities received by the employee, to the extent that tips or gratuities are documented by the employee to the employer for tax purposes;

(d) income or payment in the form of a draw, wage, net profit, or substitute for money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration;

(e) board, lodging, rent, or housing if it constitutes a part of the employee's remuneration and is based on its actual value; and

(f) payments made to an employee on any basis other than time worked, including but not

limited to piecework, an incentive plan, or profit-sharing arrangement.

(2) The term "wages" does not include any of the following:

(a) employee expense reimbursements or allowances for meals, lodging, travel, subsistence, and other expenses, as set forth in department rules;

(b) the amount of the payment made by the employer for employees, if the payment was made for:

(i) retirement or pension pursuant to a qualified plan as defined under the provisions of the Internal Revenue Code;

(ii) sickness or accident disability under a workers' compensation policy;

(iii) medical or hospitalization expenses in connection with sickness or accident disability, including health insurance for the employee or the employee's immediate family;

(iv) death, including life insurance for the employee or the employee's immediate family;

(c) vacation or sick leave benefits accrued but not paid;

(d) special rewards for individual invention or discovery; or

(e) monetary and other benefits paid to a person as part of public assistance, as defined in 53-4-201.

(3) (a) Except as provided in subsection (3)(b), for compensation benefit purposes, the average actual earnings for the four pay periods immediately preceding the injury are the employee's wages, except that if the term of employment for the same employer is less than four pay periods, the employee's wages are the hourly rate times the number of hours in a week for which the employee was hired to work.

(b) For good cause shown, if the use of the last four pay periods does not accurately reflect the claimant's employment history with the employer, the wage may be calculated by dividing the total earnings for an additional period of time, not to exceed 1 year prior to the date of injury, by the number of weeks in that period, including periods of idleness or seasonal fluctuations.

(4) (a) For the purpose of calculating compensation benefits for an employee working concurrent employments, the average actual wages must be calculated as provided in subsection (3). As used in this subsection, "concurrent employment" means employment in which the employee was actually employed at the time of the injury and would have continued to be employed without a break in the term of employment if not for the injury.

(b) Except as provided in 39-71-118(10)(c), the compensation benefits for a covered volunteer must be based on the average actual wages in the volunteer's regular employment, except self-employment as a sole proprietor or partner who elected not to be covered, from which the volunteer is disabled by the injury incurred.

(c) The compensation benefits for an employee working at two or more concurrent remunerated employments must be based on the aggregate of average actual wages of all employments, except for the wages earned by individuals while engaged in the employments outlined in 39-71-401(3)(a) who elected not to be covered, from which the employee is disabled by the injury incurred.

(5) For the purposes of calculating compensation benefits for an employee working for an employer, as provided in 39-71-117(1)(d), and for calculating premiums to be paid by that employer, the wages must be based upon all hours worked multiplied by the mean hourly wage by area, as published by the department in the edition of Montana Informational Wage Rates

by Occupation, adopted annually by the department, that is in effect as of the date of injury or for the period in which the premium is due.

**History:** En. Sec. 4, Ch. 464, L. 1987; amd. Sec. 12, Ch. 333, L. 1989; amd. Sec. 2, Ch. 129, L. 1991; amd. Sec. 2, Ch. 261, L. 1991; amd. Sec. 2, Ch. 154, L. 1993; amd. Sec. 23, Ch. 619, L. 1993; amd. Sec. 2, Ch. 131, L. 1995; amd. Sec. 7, Ch. 243, L. 1995; amd. Sec. 29, Ch. 491, L. 1997; amd. Sec. 2, Ch. 124, L. 1999; amd. Sec. 2, Ch. 377, L. 1999; amd. Sec. 2, Ch. 238, L. 2001; amd. Sec. 4, Ch. 465, L. 2001; amd. Sec. 8, Ch. 112, L. 2009; amd. Sec. 9, Ch. 255, L. 2011; amd. Sec. 4, Ch. 412, L. 2013.

**39-71-124. Applicability of Workers' Compensation Act -- exceptions.** Except as provided in 39-71-407, 39-71-601, and 39-71-603, this chapter applies to injuries and occupational diseases.

**History:** En. Sec. 1, Ch. 416, L. 2005.

**Part 2. Administrative Provisions**

**39-71-201. Administration fund.** (1) A workers' compensation administration fund is established out of which are to be paid upon lawful appropriation all costs of administering the Workers' Compensation Act and the statutory occupational safety and health acts that the department is required to administer, with the exception of the certification of independent contractors provided for in Title 39, chapter 71, part 4, the subsequent injury fund provided for in 39-71-907, and the uninsured employers' fund provided for in 39-71-503. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:

(a) all fees and penalties provided in 39-71-107, 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337;

(b) all penalties assessed under 50-71-119; and

(c) all fees paid by an assessment on paid losses, plus administrative fines and interest provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act without regard to the application of any deductible whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses pursuant to subsection (2).

(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay its proportionate share determined by the paid losses in the preceding calendar year of all costs of administering and regulating the Workers' Compensation Act and the statutory occupational safety acts that the department is required to administer, with the exception of the certification of independent contractors provided for in Title 39, chapter 71, part 4, the subsequent injury fund provided for in 39-71-907, and the uninsured employers' fund provided for in 39-71-503. In addition, compensation plan No. 3, the state fund, shall pay a proportionate share of these costs based upon paid losses for claims arising before July 1, 1990.

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) An employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

(c) By April 30 of each year, the department shall notify employers described in subsections (5)(a) and (5)(b) of the percentage of the assessment that comprises the compensation plan No. 1 proportionate share of administrative and regulatory costs. Payment of the assessment provided for by this subsection (5) must be paid by the employer in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(6) (a) Compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment may be up to 3% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) Payment of the assessment must be paid in:

(i) one installment due on July 1; or

(ii) two equal installments due on July 1 and December 31 of each year.

(c) If the state fund fails to timely pay to the department the assessment under this section, the department may impose on the state fund an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments 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 a separate cost imposed upon insured employers.

(b) The amount to be funded by the premium surcharge may be up to 3% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and may be up to 3% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

(c) On or before April 30 of each year, the department, in consultation with the advisory organization designated pursuant to 33-16-1023, shall notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge percentage to be effective for policies written or renewed annually on and after July 1 of that year.

(d) The premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

(e) If an employer fails to remit to an insurer the total amount due for the premium and premium surcharge, the amount received by the insurer must be applied to the premium surcharge first and the remaining amount applied to the premium due.

(f) The amount actually collected as a premium surcharge in a given year must be compared to the assessment on the paid losses paid in the preceding year. Any excess amount collected must be deducted from the amount to be collected as a premium surcharge in the following

year. The amount collected that is less than the assessed amount must be added to the amount to be collected as a premium surcharge in the following year.

(8) By July 1, an insurer under compensation plan No. 2 that pays benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment of up to 3% of paid losses paid in the preceding calendar year. The department shall determine and notify the insurer by April 30 of each year of the amount that is due by July 1.

(9) An employer that makes a first-time application for permission to enroll under compensation plan No. 1 shall pay an assessment of $500 within 15 days of being granted permission by the department to enroll under compensation plan No. 1.

(10) The department shall deposit all funds received pursuant to this section in the state treasury, as provided in this section.

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

(12) Disbursements from the administration fund must be made after being approved by the department upon claim for disbursement.

(13) The department may assess and collect the workers' compensation regulatory assessment surcharge from uninsured employers, as defined in 39-71-501, that fail to properly comply with the coverage requirements of the Workers' Compensation Act. Any amounts collected by the department pursuant to this subsection must be deposited in the workers' compensation administration fund.

**History:** En. 92-116.1 by Sec. 1, Ch. 253, L. 1973; amd. Sec. 1, Ch. 318, L. 1975; amd. Sec. 28, Ch. 453, L. 1977; R.C.M. 1947, 92-116.1; amd. Sec. 18, Ch. 104, L. 1979; amd. Sec. 28, Ch. 557, L. 1987; amd. Sec. 14, Ch. 613, L. 1989; amd. Sec. 2, Ch. 558, L. 1991; amd. Sec. 2, Ch. 555, L. 1993; amd. Sec. 2, Ch. 514, L. 1995; amd. Secs. 1, 2, Ch. 385, L. 1997; amd. Secs. 3, 4, Ch. 377, L. 1999; amd. Sec. 51, Ch. 7, L. 2001; amd. Sec. 5, Ch. 214, L. 2001; amd. Sec. 3, Ch. 103, L. 2005; amd. Sec. 3, Ch. 133, L. 2005; amd. Sec. 13, Ch. 416, L. 2005; amd. Sec. 2, Ch. 117, L. 2007; amd. Sec. 15, Ch. 27, L. 2009; amd. Sec. 9, Ch. 112, L. 2009.

**39-71-202. Office of department.** The department shall keep its principal office in the capital of the state. It may rent or lease quarters for the conduct of its administrative duties.

**History:** En. Sec. 2, Ch. 96, L. 1915; re-en. Sec. 2826, R.C.M. 1921; re-en. Sec. 2826, R.C.M. 1935; amd. Sec. 1, Ch. 234, L. 1969; amd. Sec. 1, Ch. 23, L. 1975; R.C.M. 1947, 92-111; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-203. Powers of department -- rules.** (1) The department is hereby vested with full power, authority, and jurisdiction to do and perform any and all things that are necessary or convenient in the exercise of any power, authority, or jurisdiction conferred upon it under this chapter.

(2) The department may adopt rules to carry out the provisions of this chapter.

**History:** En. Sec. 18, Ch. 96, L. 1915; re-en. Sec. 2940, R.C.M. 1921; re-en. Sec. 2940, R.C.M. 1935; amd. Sec. 26, Ch. 23, L. 1975; R.C.M. 1947, 92-814; amd. Sec. 5, Ch. 464, L. 1987; amd. Sec. 1, Ch. 525, L. 1987; amd. Sec. 15, Ch. 613, L. 1989.

**39-71-204. Hearings -- rules of evidence -- appeal, rescission, alteration, or amendment by department of its orders, decisions, or awards -- effect -- appeal.** (1) The statutory and common-law rules of evidence do not apply to a hearing before the department under this chapter. A petition for a hearing before the department must be filed within 2 years after benefits are denied.

(2) A hearing under this chapter may be conducted by telephone or by videoconference.

(3) The department has continuing jurisdiction over all its orders, decisions, and awards and may, at any time, upon notice, and after opportunity to be heard is given to the parties in interest, rescind, alter, or amend any order, decision, or award made by it upon good cause.

(4) Any order, decision, or award rescinding, altering, or amending a prior order, decision, or award has the same effect as original orders or awards.

(5) If a party is aggrieved by a department order, the party may appeal the dispute to the workers' compensation judge.

**History:** En. Sec. 20, Ch. 96, L. 1915; re-en. Sec. 2952, R.C.M. 1921; amd. Sec. 9, Ch. 177, L. 1929; re-en. Sec. 2952, R.C.M. 1935; amd. Sec. 1, Ch. 67, L. 1937; amd. Sec. 40, Ch. 23, L. 1975; R.C.M. 1947, 92-826; amd. Sec. 1, Ch. 63, L. 1979; amd. Sec. 6, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 4, Ch. 103, L. 2005.

**39-71-205. Department authorized to charge certain fees -- disposition of.** (1) The department shall have power and authority to charge and collect a fee for copies of papers and records, including certified copies of documents and orders filed in its office, sufficient to

recover the cost of the material and the time expended, as fixed by the department.

(2) The department shall have power and authority to fix and collect reasonable charges for publications issued under its authority.

(3) The fees charged and collected under this section shall be paid monthly into the treasury of the state to the credit of the state special revenue fund and shall be accompanied by detailed statement thereof.

**History:** En. Sec. 2, Ch. 96, L. 1915; re-en. Sec. 2834, R.C.M. 1921; re-en. Sec. 2834, R.C.M. 1935; amd. Sec. 165, Ch. 147, L. 1963; amd. Sec. 4, Ch. 23, L. 1975; R.C.M. 1947, 92-119; amd. Sec. 2, Ch. 21, L. 1981; amd. Sec. 1, Ch. 277, L. 1983; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-206. Legal advisers of department and state fund -- investigative and prosecution services.** (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of this chapter.

**History:** En. Sec. 2, Ch. 96, L. 1915; re-en. Sec. 2835, R.C.M. 1921; re-en. Sec. 2835, R.C.M. 1935; amd. Sec. 1, Ch. 162, L. 1937; amd. Sec. 174, Ch. 147, L. 1963; amd. Sec. 5, Ch. 23, L. 1975; R.C.M. 1947, 92-120; amd. Sec. 1, Ch. 283, L. 1983; amd. Sec. 16, Ch. 613, L. 1989; amd. Sec. 2, Ch. 296, L. 1993; amd. Sec. 14, Ch. 416, L. 2005.

**39-71-208. Blank forms, minutes, and records.** The department shall cause to be printed such blank forms as it considers necessary to facilitate or promote the efficient administration of this chapter. It shall provide a record of all awards made by the department and such other books or records as it considers necessary for the purpose and efficient administration of this chapter. All such records are to be kept in the office of the department.

**History:** En. Sec. 2, Ch. 96, L. 1915; re-en. Sec. 2832, R.C.M. 1921; re-en. Sec. 2832, R.C.M. 1935; amd. Sec. 2, Ch. 23, L. 1975; R.C.M. 1947, 92-117; amd. Sec. 1, Ch. 103, L. 1979; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-209. Publication of reports and bulletins authorized.** The department shall have the power and authority to publish and distribute at its discretion from time to time such further reports and bulletins covering its operations, proceedings, and matters relative to its work as it may deem advisable.

**History:** En. Sec. 2, Ch. 96, L. 1915; re-en. Sec. 2833, R.C.M. 1921; re-en. Sec. 2833, R.C.M. 1935; amd. Sec. 41, Ch. 93, L. 1969; amd. Sec. 3, Ch. 23, L. 1975; R.C.M. 1947, 92-118; amd. Sec. 12, Ch. 125, L. 1983; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-211. Fraud detection and prevention unit -- expenditure accounting.** (1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under this chapter that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended.

**History:** En. Sec. 3, Ch. 296, L. 1993; amd. Sec. 15, Ch. 416, L. 2005.

**39-71-223. Certified copies of public records -- fees.** (1) The department shall, on demand, furnish a certified copy of any public record to a person who has a right to inspect it, if the record is of a nature permitting such copying, or shall furnish reasonable opportunity to inspect or copy.

(2) The department may establish fees reasonably calculated to reimburse the department for its actual cost in making such records available.

**History:** En. 92-846 by Sec. 3, Ch. 25, L. 1975; R.C.M. 1947, 92-846; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-224. Records exempt from disclosure -- separation of exempt material from nonexempt.** (1) In assuring that the right of individual privacy so essential to the well-being of a free society shall not be infringed without the showing of a compelling state interest, the following public records of the department are exempt from disclosure:

(a) information of a personal nature such as personal, medical, or similar information if the public disclosure thereof would constitute an unreasonable invasion of privacy, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy.

(b) any public records or information, the disclosure of which is prohibited by federal law or regulations.

(2) If any public record of the department contains material which is not exempt under subsection (1) of this section, as well as material which is exempt from disclosure, the department shall separate the exempt and nonexempt and make the nonexempt material available for examination.

**History:** En. 92-847 by Sec. 4, Ch. 25, L. 1975; R.C.M. 1947, 92-847; amd. Sec. 64, Ch. 613, L. 1989.

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

(2) Data collected must be used to provide:

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

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

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

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

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

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

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

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

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

(a) avoidance of duplication and inconsistency;

(b) reasonable availability of data elements;

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

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

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

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

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

(h) compatibility with electronic data reporting;

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

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

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

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

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

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

**History:** En. Sec. 1, Ch. 512, L. 1993; amd. Sec. 3, Ch. 310, L. 1997; amd. Sec. 5, Ch. 377, L. 1999; amd. Sec. 4, Ch. 140, L. 2005; amd. Sec. 3, Ch. 48, L. 2007; amd. Sec. 4, Ch. 167, L. 2011.

**Part 3. Miscellaneous Provisions**

**39-71-301. Certificates and certified copies as evidence.** (1) Copies of official documents and orders filed or deposited according to law in the office of the department, certified to by a member of the department or by the secretary under the official seal of the department to be true copies of the original, shall be evidence in like manner as the originals.

(2) In any court proceeding wherein the question as to whether or not an employer or employee has complied with and is operating under or bound by the provisions of the Workers' Compensation Act of the state of Montana is a question for determination, a certificate by a member of the department, or by the secretary under the official seal of the department, certifying that such employer or employee has or has not complied with and is or is not operating under and is or is not bound by the provisions of the Workers' Compensation Act of the state of Montana shall be prima facie evidence thereof.

**History:** En. Sec. 18, Ch. 96, L. 1915; re-en. Sec. 2944, R.C.M. 1921; amd. Sec. 8, Ch. 177, L. 1929; re-en. Sec. 2944, R.C.M. 1935; amd. Sec. 31, Ch. 23, L. 1975; R.C.M. 1947, 92-818; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-304. Books, records, and payrolls to be open to inspection -- penalty for refusal -- subpoenas.** (1) The books, records, and payrolls of an employer pertinent to the administration of this chapter must always be open to inspection by the department or any authorized employee of the department for the purpose of ascertaining the correctness of the payroll, the number of workers employed, and other information that may be necessary for the department and its management under this chapter. Refusal on the part of an employer to submit the books, records, and payrolls for inspection will subject the offending employer to a penalty not exceeding $500 for each offense, to be collected through a civil action in the name of the state and paid into the state treasury.

(2) In addition to the remedy provided in subsection (1), the department may issue subpoenas and compel testimony for the production of evidence, including books, records, papers, documents, and other objects that may be necessary and proper in regard to any investigation or proceeding under this chapter. In the case of disobedience of a subpoena issued and served or the refusal of a witness to testify as to any matter for which the witness may be interrogated in a proceeding before the department, the department may apply to a district court for an order to compel compliance with the subpoena or testimony. Disobedience of the court's order constitutes contempt of court.

**History:** En. Sec. 19, Ch. 96, L. 1915; re-en. Sec. 2946, R.C.M. 1921; re-en. Sec. 2946, R.C.M. 1935; amd. Sec. 166, Ch. 147, L. 1963; amd. Sec. 33, Ch. 23, L. 1975; R.C.M. 1947, 92-820; amd.

Sec. 3, Ch. 103, L. 1979; amd. Sec. 55, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 3, Ch. 555, L. 1993; amd. Sec. 10, Ch. 442, L. 1999; amd. Sec. 6, Ch. 214, L. 2001.

**39-71-306. Insurers to file summary reports of benefits paid for injuries and miscellaneous expenses and statements of medical expenditures.** (1) Each insurer shall, on or before the 15th day after each state government fiscal quarter ends, file with the department:

(a) summary reports of benefits for all compensation payments made during the previous state fiscal quarter to injured workers or their beneficiaries or dependents;

(b) statements showing the amounts expended during the previous state fiscal quarter for all medical services for injured workers; and

(c) statements showing all miscellaneous amounts, other than compensation and medical expenditures, paid during the previous state fiscal quarter to or on behalf of injured workers or their beneficiaries or dependents and not otherwise reported as an expenditure for the workers' compensation administration assessment provided for in 39-71-201.

(2) An insurer that fails to file the summary report required by this section or the annual paid losses report required in 39-71-201 within 5 days after the date on which either report is due may be assessed a penalty in an amount of not less than $250 or more than $1,000 to be deposited in the workers' compensation administration fund.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2932, R.C.M. 1921; re-en. Sec. 2932, R.C.M. 1935; amd. Sec. 21, Ch. 23, L. 1975; R.C.M. 1947, 92-806; amd. Sec. 56, Ch. 397, L. 1979; amd. Sec. 17, Ch. 613, L. 1989; amd. Sec. 3, Ch. 558, L. 1991; amd. Sec. 7, Ch. 214, L. 2001; amd. Sec. 2, Ch. 69, L. 2005.

**39-71-307. Employers and insurers to file reports -- penalty.** (1) Every employer insured by a plan No. 2 or a plan No. 3 insurer is required to file with the employer's insurer, under rules adopted by the department, a full and complete report of every accident, injury, or occupational disease to an employee arising out of or in the course of employment.

(2) Every insurer transacting business under this chapter shall, under rules adopted by the department, make and file with the department the reports of every injury or occupational disease.

(3) An employer or insurer who refuses or neglects to submit the reports necessary for the proper filing and review of a claim, as provided in subsection (1) or (2), shall be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. An employer or insurer may contest a penalty assessment in a hearing conducted according to department rules.

**History:** (1)En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2934, R.C.M. 1921; re-en. Sec. 2934, R.C.M. 1935; amd. Sec. 22, Ch. 23, L. 1975; Sec. 92-808, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2987, R.C.M. 1921; re-en. Sec. 2987, R.C.M. 1935; amd. Sec. 64, Ch. 23, L. 1975; Sec. 92-1010, R.C.M. 1947; R.C.M. 1947, 92-808, 92-1010; amd. Sec. 14, Ch. 333, L. 1989; amd. Secs. 18, 64, Ch. 613, L. 1989; amd. Sec. 2, Ch. 619, L. 1993; amd. Sec. 5, Ch. 103, L. 2005; amd. Sec. 5, Ch. 140, L. 2005; amd. Sec. 10, Ch. 112, L. 2009.

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

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

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

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

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

**History:** En. Sec. 16, Ch. 619, L. 1993; amd. Sec. 4, Ch. 516, L. 1995; amd. Sec. 11, Ch. 442, L. 1999; amd. Sec. 3, Ch. 69, L. 2005; amd. Sec. 16, Ch. 416, L. 2005; amd. Sec. 5, Ch. 167, L. 2011.

**39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means.** (1) A person filing a claim under this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

(2) (a) A person who obtains or assists in obtaining benefits to which the person is not entitled or who obtains or assists another person in obtaining benefits to which the other person is not entitled under this chapter is guilty of theft and may be prosecuted under 45-6-301. A county attorney or the attorney general may initiate criminal proceedings against the person. This subsection includes but is not limited to a person who is receiving temporary total

disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

(b) As used in subsection (2)(a), "person" includes but is not limited to an employee, employer, insurer, or medical service provider.

(3) (a) The department may require a person convicted of theft under 45-6-301(5) to pay to the department an amount equal to 10 times the amount paid by an insurer on the false claim, provided that the amount does not exceed $50,000. If upon demand of the department the person refuses to pay the fine, the department may petition the workers' compensation court to collect the money owed.

(b) The department shall:

(i) use the money collected pursuant to subsection (3)(a) to administer and enforce the provisions of this section; and

(ii) forward any surplus money to the department of justice. The forwarded money must be used exclusively for the staffing and operation of the workers' compensation fraud investigation and prosecution office established in 2-15-2015.

(c) This section does not limit an insurer's civil remedies to collect for money paid to a person convicted under 45-6-301(5).

(4) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of this chapter.

**History:** En. Sec. 7, Ch. 464, L. 1987; amd. Sec. 4, Ch. 296, L. 1993; amd. Sec. 1, Ch. 618, L. 1993; amd. Sec. 9, Ch. 619, L. 1993; amd. Sec. 12, Ch. 442, L. 1999; amd. Sec. 17, Ch. 416, L. 2005.

**39-71-317. Employer not to terminate worker for filing claim -- preference -- jurisdiction over dispute.** (1) An employer may not use as grounds for terminating a worker the filing of a claim under this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

(2) When an injured worker is capable of returning to work within 2 years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

(3) This preference applies only to employment with the employer for whom the employee was working at the time the injury occurred.

(4) The workers' compensation court has exclusive jurisdiction to administer or resolve a dispute concerning the reemployment preference under this section. A dispute concerning the reemployment preference is not subject to mediation or a contested case hearing.

**History:** En. Sec. 20, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 13, Ch. 442, L. 1999; amd. Sec. 18, Ch. 416, L. 2005.

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

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

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

(b) requiring continuing education for certified claims examiners;

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

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

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

(a) minimum qualifications;

(b) examination;

(c) 2-year certification and renewal;

(d) continuing education requirements; and

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

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

(5) The department shall maintain:

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

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

(i) documentation of current and historical certifications;

(ii) beginning and ending dates of certifications; and

(iii) continuing education records.

(6) The training curriculum and continuing education used by insurers, self-insured employers, and third-party administrators for claims examiners must relate to the state

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

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

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

(a) initial certification, including examination;

(b) certification renewal;

(c) approval of training curricula, including continuing education courses, course content, instructors, materials, instructional format, and sponsoring organizations; and

(d) specialized training offered by the department.

**History:** En. Sec. 2, Ch. 125, L. 2009; amd. Sec. 6, Ch. 167, L. 2011.

**39-71-325. Claim summary and actuarial documentation for impaired insurer.** (1) An insurer becomes impaired if the insurer:

(a) becomes insolvent;

(b) is placed in receivership or administration;

(c) declares bankruptcy; or

(d) seeks protection from its creditors.

(2) An impaired insurer shall, within 30 days of the insurer becoming impaired, furnish the department with a claim summary and actuary information relevant to each claim for which the insurer may have future liability.

**History:** En. Sec. 14, Ch. 117, L. 2007.

**Part 4. Coverage, Liability, and Subrogation**

**39-71-401. Employments covered and exemptions -- elections -- notice.** (1) Except as provided in subsection (2), the Workers' Compensation Act applies to all employers and to all employees. An employer who has any employee in service under any appointment or contract of hire, expressed or implied, oral or written, shall elect to be bound by the provisions of compensation plan No. 1, 2, or 3. Each employee whose employer is bound by the Workers' Compensation Act is subject to and bound by the compensation plan that has been elected by the employer.

(2) Unless the employer elects coverage for these employments under this chapter and an insurer allows an election, the Workers' Compensation Act does not apply to any of the following:

(a) household or domestic employment;

(b) casual employment;

(c) employment of a dependent member of an employer's family for whom an exemption may be claimed by the employer under the federal Internal Revenue Code;

(d) employment of sole proprietors, working members of a partnership, working members of a limited liability partnership, or working members of a member-managed limited liability company, except as provided in subsection (3);

(e) employment of a real estate, securities, or insurance salesperson paid solely by commission and without a guarantee of minimum earnings;

(f) employment as a direct seller as defined by 26 U.S.C. 3508;

(g) employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States;

(h) employment of a person performing services in return for aid or sustenance only, except employment of a volunteer under 67-2-105;

(i) employment with a railroad engaged in interstate commerce, except that railroad construction work is included in and subject to the provisions of this chapter;

(j) employment as an official, including a timer, referee, umpire, or judge, at an amateur athletic event;

(k) employment of a person performing services as a newspaper carrier or freelance correspondent if the person performing the services or a parent or guardian of the person performing the services in the case of a minor has acknowledged in writing that the person performing the services and the services are not covered. As used in this subsection (2)(k):

(i) "freelance correspondent" means a person who submits articles or photographs for publication and is paid by the article or by the photograph; and

(ii) "newspaper carrier":

(A) means a person who provides a newspaper with the service of delivering newspapers singly or in bundles; and

(B) does not include an employee of the paper who, incidentally to the employee's main duties, carries or delivers papers.

(l) cosmetologist's services and barber's services as referred to in 39-51-204(1)(e);

(m) a person who is employed by an enrolled tribal member or an association, business, corporation, or other entity that is at least 51% owned by an enrolled tribal member or members, whose business is conducted solely within the exterior boundaries of an Indian reservation;

(n) employment of a jockey who is performing under a license issued by the board of horseracing from the time that the jockey reports to the scale room prior to a race through the time that the jockey is weighed out after a race if the jockey has acknowledged in writing, as a condition of licensing by the board of horseracing, that the jockey is not covered under the Workers' Compensation Act while performing services as a jockey;

(o) employment of a trainer, assistant trainer, exercise person, or pony person who is performing services under a license issued by the board of horseracing while on the grounds of a licensed race meet;

(p) employment of an employer's spouse for whom an exemption based on marital status may be claimed by the employer under 26 U.S.C. 7703;

(q) a person who performs services as a petroleum land professional. As used in this subsection, a "petroleum land professional" is a person who:

(i) is engaged primarily in negotiating for the acquisition or divestiture of mineral rights or in negotiating a business agreement for the exploration or development of minerals;

(ii) is paid for services that are directly related to the completion of a contracted specific task rather than on an hourly wage basis; and

(iii) performs all services as an independent contractor pursuant to a written contract.

(r) an officer of a quasi-public or a private corporation or, except as provided in subsection (3), a manager of a manager-managed limited liability company who qualifies under one or more of the following provisions:

(i) the officer or manager is not engaged in the ordinary duties of a worker for the corporation or the limited liability company and does not receive any pay from the corporation or the limited liability company for performance of the duties;

(ii) the officer or manager is engaged primarily in household employment for the corporation or the limited liability company;

(iii) the officer or manager either:

(A) owns 20% or more of the number of shares of stock in the corporation or owns 20% or more of the limited liability company; or

(B) owns less than 20% of the number of shares of stock in the corporation or limited liability company if the officer's or manager's shares when aggregated with the shares owned by a person or persons listed in subsection (2)(r)(iv) total 20% or more of the number of shares in the corporation or limited liability company; or

(iv) the officer or manager is the spouse, child, adopted child, stepchild, mother, father, son-in-law, daughter-in-law, nephew, niece, brother, or sister of a corporate officer who meets the requirements of subsection (2)(r)(iii)(A) or (2)(r)(iii)(B);

(s) a person who is an officer or a manager of a ditch company as defined in 27-1-731;

(t) service performed by an ordained, commissioned, or licensed minister of a church in the exercise of the church's ministry or by a member of a religious order in the exercise of duties required by the order;

(u) service performed to provide companionship services, as defined in 29 CFR 552.6, or respite care for individuals who, because of age or infirmity, are unable to care for themselves when the person providing the service is employed directly by a family member or an individual who is a legal guardian;

(v) employment of a person performing the services of an intrastate or interstate common or contract motor carrier when hired by an individual or entity who meets the definition of a broker or freight forwarder, as provided in 49 U.S.C. 13102;

(w) employment of a person who is not an employee or worker in this state as defined in 39-71-118(8);

(x) employment of a person who is working under an independent contractor exemption certificate;

(y) employment of an athlete by or on a team or sports club engaged in a contact sport. As used in this subsection, "contact sport" means a sport that includes significant physical contact between the athletes involved. Contact sports include but are not limited to football, hockey, roller derby, rugby, lacrosse, wrestling, and boxing.

(z) a musician performing under a written contract.

(3) (a) (i) A person who regularly and customarily performs services at locations other than the person's own fixed business location shall elect to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3 unless the person has waived the rights and benefits of the Workers' Compensation Act by obtaining an independent contractor exemption certificate from the department pursuant to 39-71-417.

(ii) Application fees or renewal fees for independent contractor exemption certificates must be deposited in the state special revenue account established in 39-9-206 and must be used to offset the certification administration costs.

(b) A person who holds an independent contractor exemption certificate may purchase a workers' compensation insurance policy and with the insurer's permission elect coverage for the certificate holder.

(c) For the purposes of this subsection (3), "person" means:

(i) a sole proprietor;

(ii) a working member of a partnership;

(iii) a working member of a limited liability partnership;

(iv) a working member of a member-managed limited liability company; or

(v) a manager of a manager-managed limited liability company that is engaged in the work of the construction industry as defined in 39-71-116.

(4) (a) A corporation or a manager-managed limited liability company shall provide coverage for its employees under the provisions of compensation plan No. 1, 2, or 3. A quasi-public corporation, a private corporation, or a manager-managed limited liability company may elect coverage for its corporate officers or managers, who are otherwise exempt under subsection (2), by giving a written notice in the following manner:

(i) if the employer has elected to be bound by the provisions of compensation plan No. 1, by delivering the notice to the board of directors of the corporation or to the management organization of the manager-managed limited liability company; or

(ii) if the employer has elected to be bound by the provisions of compensation plan No. 2 or 3, by delivering the notice to the board of directors of the corporation or to the management

organization of the manager-managed limited liability company and to the insurer.

(b) If the employer changes plans or insurers, the employer's previous election is not effective and the employer shall again serve notice to its insurer and to its board of directors or the management organization of the manager-managed limited liability company if the employer elects to be bound.

(5) The appointment or election of an employee as an officer of a corporation, a partner in a partnership, a partner in a limited liability partnership, or a member in or a manager of a limited liability company for the purpose of exempting the employee from coverage under this chapter does not entitle the officer, partner, member, or manager to exemption from coverage.

(6) Each employer shall post a sign in the workplace at the locations where notices to employees are normally posted, informing employees about the employer's current provision of workers' compensation insurance. A workplace is any location where an employee performs any work-related act in the course of employment, regardless of whether the location is temporary or permanent, and includes the place of business or property of a third person while the employer has access to or control over the place of business or property for the purpose of carrying on the employer's usual trade, business, or occupation. The sign must be provided by the department, distributed through insurers or directly by the department, and posted by employers in accordance with rules adopted by the department. An employer who purposely or knowingly fails to post a sign as provided in this subsection is subject to a $50 fine for each citation.

**History:** (1), (2)(a) thru (f)En. 92-202.1 by Sec. 1, Ch. 492, L. 1973; amd. Sec. 1, Ch. 550, L. 1977; Sec. 92-202.1, R.C.M. 1947; (2)(g)En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2931, R.C.M. 1921; re-en. Sec. 2931, R.C.M. 1935; Sec. 92-805, R.C.M. 1947; R.C.M. 1947, 92-202.1, 92-805; amd. Sec. 58, Ch. 397, L. 1979; amd. Sec. 1, Ch. 470, L. 1983; amd. Sec. 1, Ch. 94, L. 1985; amd. Sec. 1, Ch. 100, L. 1985; amd. Sec. 3, Ch. 336, L. 1985; amd. Sec. 1, Ch. 148, L. 1987; amd. Sec. 1, Ch. 290, L. 1987; amd. Sec. 6, Ch. 314, L. 1987; amd. Sec. 10, Ch. 464, L. 1987; amd. Sec. 2, Ch. 526, L. 1987; amd. Sec. 1, Ch. 33, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 39, Ch. 16, L. 1991; amd. Sec. 2, Ch. 573, L. 1991; amd. Sec. 4, Ch. 555, L. 1993; amd. Sec. 3, Ch. 48, L. 1995; amd. Sec. 2, Ch. 95, L. 1995; amd. Sec. 1, Ch. 112, L. 1995; amd. Sec. 1, Ch. 142, L. 1995; amd. Sec. 6, Ch. 516, L. 1995; amd. Sec. 4, Ch. 172, L. 1997; amd. Sec. 4, Ch. 310, L. 1997; amd. Sec. 1, Ch. 386, L. 1997; amd. Sec. 30, Ch. 491, L. 1997; amd. Sec. 12, Ch. 548, L. 1997; amd. Sec. 14, Ch. 442, L. 1999; amd. Sec. 1, Ch. 14, L. 2001; amd. Sec. 1, Ch. 43, L. 2001; amd. Sec. 2, Ch. 339, L. 2001; amd. Sec. 3, Ch. 83, L. 2003; amd. Sec. 1, Ch. 193, L. 2003; amd. Sec. 7, Ch. 26, L. 2005; amd. Sec. 4, Ch. 133, L. 2005; amd. Sec. 9, Ch. 448, L. 2005; amd. Sec. 1, Ch. 179, L. 2007; amd. Sec. 1, Ch. 288, L. 2007; amd. Sec. 1, Ch. 234, L. 2009; amd. Sec. 1, Ch. 450, L. 2009; amd. Sec. 1, Ch. 200, L. 2011; amd. Sec. 5, Ch. 412, L. 2013.

**39-71-402. Extraterritorial applicability and reciprocity of coverage -- agreements with other states -- rulemaking.** (1) (a) In the absence of an agreement under subsection (2), if a worker employed in this state who is subject to the provisions of this chapter temporarily leaves this state incidental to that employment and receives an injury arising out of and in the course of employment, the provisions of this chapter apply to the worker as though the worker were injured within this state.

(b) Except as provided in subsection (1)(c) and in the absence of an agreement under subsection (2), if a worker from another state and the worker's employer from another state are temporarily engaged in work within this state, this chapter does not apply to them:

(i) if the employer and employee are bound by the provisions of the workers' compensation law or similar law of the other state that applies to them while they are temporarily engaged in work in the state of Montana; and

(ii) if the Workers' Compensation Act of this state is recognized and given effect as the exclusive remedy for workers employed in this state who are injured while temporarily engaged in work in the other state.

(c) Unless specifically addressed in an agreement as provided in subsection (2)(d), employers from another state that are engaged in the construction industry, as defined in 39-71-116, and that employ workers from another state shall obtain coverage for those workers under the provisions of this chapter.

(2) (a) The department, with the approval of the governor, may enter into a reciprocal agreement with an authorized officer of the workers' compensation department or similar agency of another state to allow an employer from one state and its employees from that state to work in the other state without obtaining workers' compensation coverage from both states.

(b) The reciprocal agreement must contain, at a minimum, the following provisions:

(i) the employer and employee must be bound by the provisions of the workers' compensation law or similar law of the other state that applies to them while they are engaged in work in the state of Montana; and

(ii) the Workers' Compensation Act of this state must be recognized and given effect as the exclusive remedy for workers employed in this state who are injured while engaged in work in the other state.

(c) The agreement may contain other provisions, including but not limited to provisions regarding how long the work may continue and whether limitations or exclusions apply to the types of work covered by the agreement.

(d) Unless the agreement specifically provides that the agreement is applicable to employers engaged in the construction industry, as defined in 39-71-116, an employer from another state engaged in the construction industry in Montana does not qualify for extraterritorial coverage that might otherwise be provided by this section.

(e) The agreement may be canceled, renewed, or modified from time to time as provided in the agreement.

(f) After an agreement has been entered into pursuant to this subsection (2), a certificate from an authorized officer of the workers' compensation department or similar agency of another state certifying that an employer of the other state is bound by the Workers' Compensation Act of the state and that its act will be applied to employees of the employer

while engaged in work in the state of Montana is prima facie evidence that:

(i) the workers' compensation law of the certifying state applies to the employer and its employees while engaged in work in Montana; and

(ii) the employer is properly insured for workers' compensation purposes in the certifying state as of the date of the certification.

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

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2911, R.C.M. 1921; re-en. Sec. 2911, R.C.M. 1935; amd. Sec. 1, Ch. 70, L. 1967; amd. Sec. 17, Ch. 23, L. 1975; amd. Sec. 8, Ch. 550, L. 1977; R.C.M. 1947, 92-614(2) thru (5); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 4, Ch. 480, L. 1991; amd. Sec. 3, Ch. 458, L. 1993; amd. Sec. 1, Ch. 74, L. 2013.

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

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

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

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

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

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

(3) (a) A public corporation, other than a state agency, that elects plan No. 1 may establish a fund sufficient to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably incurred during the fiscal year for which the election is effective. Proceeds from the fund must be used only to pay claims covered by this chapter and for actual and necessary expenses required for the efficient administration of the fund, including debt service on any bonds and notes issued pursuant to subsection (3)(b).

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

(ii) The bonds and notes:

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

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

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

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

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

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

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

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

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

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

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

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

bureaus, and offices;

(B) the judicial branch; and

(C) the legislative branch.

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

**History:** En. Sec. 3, Ch. 96, L. 1915; amd. Sec. 1, Ch. 100, L. 1919; amd. Sec. 1, Ch. 196, L. 1921; re-en. Sec. 2840, R.C.M. 1921; re-en. Sec. 2840, R.C.M. 1935; amd. Sec. 1, Ch. 410, L. 1971; amd. Sec. 6, Ch. 23, L. 1975; R.C.M. 1947, 92-206(part); amd. Sec. 1, Ch. 155, L. 1979; (2) thru (4)En. Sec. 2, Ch. 155, L. 1979; amd. Sec. 4, Ch. 21, L. 1981; amd. Sec. 97, Ch. 370, L. 1987; amd. Sec. 20, Ch. 613, L. 1989; amd. Sec. 1, Ch. 665, L. 1989; amd. Sec. 1, Ch. 560, L. 1999; amd. Sec. 31, Ch. 29, L. 2001; amd. Sec. 145, Ch. 574, L. 2001; amd. Sec. 19, Ch. 416, L. 2005; amd. Sec. 1, Ch. 17, L. 2009; amd. Sec. 7, Ch. 167, L. 2011.

**39-71-405. Liability of employer who contracts work out.** (1) An employer who contracts with an independent contractor to have work performed of a kind which is a regular or a recurrent part of the work of the trade, business, occupation, or profession of such employer is liable for the payment of benefits under this chapter to the employees of the contractor if the contractor has not properly complied with the coverage requirements of the Worker's Compensation Act. Any insurer who becomes liable for payment of benefits may recover the amount of benefits paid and to be paid and necessary expenses from the contractor primarily liable therein.

(2) Where an employer contracts to have any work to be done by a contractor other than an independent contractor, and the work so contracted to be done is a part or process in the trade or business of the employer, then the employer is liable to pay all benefits under this chapter to the same extent as if the work were done without the intervention of the contractor, and the work so contracted to be done shall not be construed to be casual employment. Where an employer contracts work to be done as specified in this subsection, the contractor and the contractor's employees shall come under that plan of compensation adopted by the employer.

(3) Where an employer contracts any work to be done, wholly or in part for the employer, by an independent contractor, where the work so contracted to be done is casual employment as to such employer, then the contractor shall become the employer for the purposes of this chapter.

**History:** (1)En. 92-410.1 by Sec. 1, Ch. 154, L. 1973; Sec. 92-410.1, R.C.M. 1947; (2), (3)En. Sec. 11, Ch. 96, L. 1915; re-en. Secs. 2901, 2902, 2903, R.C.M. 1921; re-en. Secs. 2901, 2902, 2903, R.C.M. 1935; Secs. 92-604, 92-605, 92-606, R.C.M. 1947; R.C.M. 1947, 92-410.1(part), 92-604, 92-605, 92-606; amd. Sec. 4, Ch. 103, L. 1979.

**39-71-406. Deduction from wages of any part of premium a misdemeanor.** It is unlawful for the employer to deduct or obtain any part of any premium required to be paid by this chapter from the wages or earnings of the employer's workers, and the making or attempt to make any premium deduction is a misdemeanor.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2937, R.C.M. 1921; re-en. Sec. 2937, R.C.M. 1935; R.C.M. 1947, 92-811; amd. Sec. 59, Ch. 397, L. 1979; amd. Sec. 6, Ch. 101, L. 1985; amd. Sec. 8, Ch. 637, L. 1993; amd. Sec. 8, Ch. 276, L. 1997.

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

(2) An injury does not arise out of and in the course of employment when the employee is:

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

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

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

(i) a claimed injury has occurred; or

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

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

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

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

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

(b) A payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is

not wages but is designated as an incentive to work at a particular jobsite is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(5) Except as provided in subsection (6), an employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the major contributing cause of the accident.

(6) (a) An employee who has received written certification, as defined in 50-46-302, from a physician for the use of marijuana for a debilitating medical condition and who is otherwise eligible for benefits payable under this chapter is subject to the limitations of subsections (6)(b) through (6)(d).

(b) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of marijuana for a debilitating medical condition, as defined in 50-46-302, is the major contributing cause of the injury or occupational disease.

(c) Nothing in this chapter may be construed to require an insurer to reimburse any person for costs associated with the use of marijuana for a debilitating medical condition, as defined in 50-46-302.

(d) In an accepted liability claim, the benefits payable under this chapter may not be increased or enhanced due to a worker's use of marijuana for a debilitating medical condition, as defined in 50-46-302. An insurer remains liable for those benefits that the worker would qualify for absent the worker's use of marijuana for a debilitating medical condition.

(7) The provisions of subsection (5) do not apply if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs not prescribed by a physician. This subsection (7) does not apply to the use of marijuana for a debilitating medical condition because marijuana is not a prescribed drug.

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

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

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

(11) For occupational diseases, every employer enrolled under plan No. 1, every insurer under plan No. 2, or the state fund under plan No. 3 is liable for the payment of compensation, in the manner and to the extent provided in this chapter, to an employee of an employer covered under plan No. 1, plan No. 2, or the state fund under plan No. 3 if the employee is diagnosed with a compensable occupational disease.

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

(a) is established by objective medical findings; and

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

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

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

(a) the time that the occupational disease was first diagnosed by a health care provider; or

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

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

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

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2911, R.C.M. 1921; re-en. Sec. 2911, R.C.M. 1935; amd. Sec. 1, Ch. 70, L. 1967; amd. Sec. 17, Ch. 23, L. 1975; amd. Sec. 8, Ch. 550, L. 1977; R.C.M. 1947, 92-614(1); amd. Sec. 11, Ch. 464, L. 1987; amd. Sec. 1, Ch. 184, L. 1989; amd. Sec. 26, Ch. 619, L. 1993; amd. Sec. 8, Ch. 243, L. 1995; amd. Sec. 1, Ch. 435, L. 2003; amd. Sec. 6, Ch. 103, L. 2005; amd. Sec. 20, Ch. 416, L. 2005; amd. Sec. 8, Ch. 167, L. 2011; amd. Sec. 4, Ch. 315, L. 2011.

**39-71-408. Liability as first lien in case of bankruptcy or failure.** In case of bankruptcy, insolvency, liquidation, or the failure of an employer or insurer to meet any obligations imposed by this chapter, every liability which may be due under this chapter shall constitute a first lien upon any deposit made by such employer or insurer, and if such deposit shall not be sufficient to secure the payment of such liability in the manner and at the times provided for in this chapter, the deficiency shall be a lien upon all the property of such employer or insurer within this state and shall be prorated with other lienable claims and shall have preference over the claim of any creditor or creditors of such employer or insurer except the claims of other lienors.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2928, R.C.M. 1921; re-en. Sec. 2928, R.C.M. 1935; R.C.M. 1947, 92-802.

**39-71-409. Waivers by employee invalid.** (1) An agreement by an employee to waive any rights under this chapter is not valid.

(2) (a) A person who possesses and is working under a current independent contractor exemption certificate issued by the department waives all rights and benefits of the Workers' Compensation Act unless the person elects coverage pursuant to 39-71-401(3)(b).

(b) A waiver by reason of an independent contractor exemption certificate is an exception to the general prohibition of waiving the advantage of a statute enacted for a public reason as provided for in 1-3-204.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2929, R.C.M. 1921; re-en. Sec. 2929, R.C.M. 1935; R.C.M. 1947, 92-803; amd. Sec. 10, Ch. 448, L. 2005.

**39-71-411. Provisions of chapter exclusive remedy -- nonliability of insured employer.** For all employments covered under the Workers' Compensation Act or for which an election has been made for coverage under this chapter, the provisions of this chapter are exclusive. Except as provided in part 5 of this chapter for uninsured employers and except as otherwise provided in the Workers' Compensation Act, an employer is not subject to any liability whatever for the death of or personal injury to an employee covered by the Workers' Compensation Act or for any claims for contribution or indemnity asserted by a third person from whom damages are sought on account of the injuries or death. The Workers' Compensation Act binds the employee and, in case of death, binds the employee's personal representative and all persons having any right or claim to compensation for the employee's injury or death, as well as the employer and the servants and employees of the employer and those conducting the employer's business during liquidation, bankruptcy, or insolvency.

**History:** En. 92-204.1 by Sec. 1, Ch. 493, L. 1973; amd. Sec. 2, Ch. 550, L. 1977; R.C.M. 1947, 92-204.1(part); amd. Sec. 1, Ch. 329, L. 1979; amd. Sec. 61, Ch. 397, L. 1979; amd. Sec. 1543, Ch. 56, L. 2009.

**39-71-412. Liability of third party other than employer or fellow employee -- additional cause of action.** The right to compensation and medical benefits as provided by this chapter is not affected by the fact that the injury, occupational disease, or death is caused by the negligence of a third party other than the employer or the servants or employees of the employer. Whenever injury, occupational disease, or death occurs to an employee while performing the duties of employment and the event is caused by the act or omission of some persons or corporations other than the employee's employer or the servants or employees of the employee's employer, the employee or in case of death the employee's heirs or personal representative, in addition to the right to receive compensation under this chapter, has a right to prosecute any cause of action that the employee or heirs may have for damages against the persons or corporations.

**History:** En. 92-204.1 by Sec. 1, Ch. 493, L. 1973; amd. Sec. 2, Ch. 550, L. 1977; R.C.M. 1947, 92-204.1(part); amd. Sec. 1544, Ch. 56, L. 2009.

**39-71-413. Liability of employer or fellow employee for intentional and deliberate acts -- additional cause of action -- intentional injury defined.** (1) (a) If an employee is intentionally injured by an intentional and deliberate act of the employee's employer or by the intentional and deliberate act of a fellow employee while performing the duties of employment, the employee or in case of death the employee's heirs or personal representatives, in addition to the right to receive compensation under the Workers' Compensation Act, have a cause of action for damages against the person whose intentional and deliberate act caused the intentional injury.

(b) For the purposes of this section, the standard of proof for an act to be determined to be intentional and deliberate is clear and convincing evidence.

(2) An employer is not vicariously liable under this section for the intentional and deliberate acts of an employee.

(3) As used in this section, "intentional injury" means an injury caused by an intentional and deliberate act that is specifically and actually intended to cause injury to the employee injured and there is actual knowledge that an injury is certain to occur.

**History:** En. 92-204.1 by Sec. 1, Ch. 493, L. 1973; amd. Sec. 2, Ch. 550, L. 1977; R.C.M. 1947, 92-204.1(part); amd. Sec. 1, Ch. 229, L. 2001; amd. Sec. 1, Ch. 148, L. 2013.

**39-71-414. Subrogation.** (1) If an action is prosecuted as provided for in 39-71-412 or 39-71-413 and except as otherwise provided in this section, the insurer is entitled to subrogation for

all compensation and benefits paid or to be paid under the Workers' Compensation Act. The insurer's right of subrogation is a first lien on the claim, judgment, or recovery.

(2) (a) If the injured employee intends to institute the third-party action, the employee shall give the insurer reasonable notice of the intention to institute the action.

(b) The injured employee may request that the insurer pay a proportionate share of the reasonable cost of the action, including attorney fees.

(c) The insurer may elect not to participate in the cost of the action. If this election is made, the insurer waives 50% of its subrogation rights granted by this section.

(d) If the injured employee or the employee's personal representative institutes the action, the employee is entitled to at least one-third of the amount recovered by judgment or settlement less a proportionate share of reasonable costs, including attorney fees, if the amount of recovery is insufficient to provide the employee with that amount after payment of subrogation.

(3) If an injured employee refuses or fails to institute the third-party action within 1 year from the date of injury, the insurer may institute the action in the name of the employee and for the employee's benefit or that of the employee's personal representative. If the insurer institutes the action, it shall pay to the employee any amount received by judgment or settlement that is in excess of the amounts paid or to be paid under the Workers' Compensation Act after the insurer's reasonable costs, including attorney fees for prosecuting the action, have been deducted from the recovery.

(4) An insurer may enter into compromise agreements in settlement of subrogation rights.

(5) Regardless of whether the amount of compensation and other benefits payable under the Workers' Compensation Act have been fully determined, the insurer and the claimant's heirs or personal representative may stipulate the proportion of the third-party settlement to be allocated under subrogation. Upon review and approval by the department, the agreement constitutes a compromise settlement of the issue of subrogation. A dispute between the insurer and claimant concerning subrogation is a dispute subject to the mediation requirements of 39-71-2401.

(6) (a) The insurer is entitled to full subrogation rights under this section, unless the claimant is able to demonstrate damages in excess of the workers' compensation benefits and the third-party recovery combined. If the insurer is entitled to subrogation under this section, the insurer may subrogate against the entire settlement or award of a third-party claim brought by the claimant or the claimant's personal representative without regard to the nature of the damages.

(b) If a survival action does not exist and the parties reach a settlement of a wrongful death claim without apportionment of damages by a court or jury, the insurer may subrogate against the entire settlement amount, without regard to the parties' apportionment of the damages, unless the insurer is a party to the settlement agreement.

(7) Regardless of whether the amount of compensation and other benefits payable have been fully determined, the insurer and the claimant may stipulate the proportion of the third-party settlement to be allocated under subrogation. Upon review and approval by the department, the agreement constitutes a compromise settlement of the issue of subrogation. A dispute between the insurer and claimant concerning subrogation is a dispute subject to the mediation requirements of 39-71-2401.

**History:** En. 92-204.2 by Sec. 3, Ch. 550, L. 1977; R.C.M. 1947, 92-204.2; amd. Sec. 12, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 4, Ch. 323, L. 1991; amd. Sec. 2, Ch. 574, L. 1991; amd. Sec. 1, Ch. 459, L. 1993; amd. Sec. 5, Ch. 172, L. 1997.

**39-71-415. Procedure for resolving disputes regarding independent contractor status.**

(1) If a claimant and insurer have a dispute over benefits and the dispute involves an issue of whether the claimant is an independent contractor or employee, either party may, after mediation pursuant to department rules, petition the workers' compensation judge for resolution of the dispute in accordance with 39-71-2905.

(2) (a) A dispute involving an employer, a worker, or the department and involving the issue of whether a worker is an independent contractor or an employee, but not involving workers' compensation benefits, must be brought before the independent contractor central unit of the department for resolution.

(b) (i) A decision of the independent contractor central unit is final unless a party dissatisfied with the decision requests mediation pursuant to department rules within 15 days of the mailing of the decision by the independent contractor central unit.

(ii) At the conclusion of the mediation process, the mediator shall issue a report summarizing the status of the proceeding and shall mail a copy of the report to the parties.

(c) If after mediation the parties have not resolved their dispute concerning a worker's status as an independent contractor or an employee, a party may appeal the decision of the independent contractor central unit by filing a petition with the workers' compensation court within 30 days of the mailing of the mediator's report.

(d) An appeal from the independent contractor central unit to the workers' compensation court brought pursuant to this subsection (2) is a new proceeding.

**History:** En. Sec. 7, Ch. 314, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 15, Ch. 442, L. 1999; amd. Sec. 8, Ch. 214, L. 2001; amd. Sec. 11, Ch. 448, L. 2005; amd. Sec. 3, Ch. 117, L. 2007.

**39-71-417. Independent contractor certification.** (1) (a) (i) Except as provided in subsection (1)(a)(ii), a person who regularly and customarily performs services at a location other than the person's own fixed business location shall apply to the department for an independent contractor exemption certificate unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3.

(ii) An officer or manager who is exempt under 39-71-401(2)(r)(iii) or (2)(r)(iv) may apply, but is not required to apply, to the department for an independent contractor exemption

certificate.

(b) A person who meets the requirements of this section and receives an independent contractor exemption certificate is not required to obtain a personal workers' compensation insurance policy.

(c) For the purposes of this section, "person" means:

(i) a sole proprietor;

(ii) a working member of a partnership;

(iii) a working member of a limited liability partnership;

(iv) a working member of a member-managed limited liability company; or

(v) a manager of a manager-managed limited liability company that is engaged in the work of the construction industry as defined in 39-71-116.

(2) The department shall adopt rules relating to an original application for or renewal of an independent contractor exemption certificate. The department shall adopt by rule the amount of the fee for an application or certificate renewal. The application or renewal must be accompanied by the fee.

(3) The department shall deposit the application or renewal fee in an account in the state special revenue fund to pay the costs of administering the program.

(4) (a) To obtain an independent contractor exemption certificate, the applicant shall swear to and acknowledge the following:

(i) that the applicant has been and will continue to be free from control or direction over the performance of the person's own services, both under contract and in fact; and

(ii) that the applicant is engaged in an independently established trade, occupation, profession, or business and will provide sufficient documentation of that fact to the department.

(b) For the purposes of subsection (4)(a)(i), an endorsement required for licensure, as provided in 37-47-303, does not imply or constitute control.

(5) (a) An applicant for an independent contractor exemption certificate shall submit an application under oath on a form prescribed by the department and containing the following:

(i) the applicant's name and address;

(ii) the applicant's social security number;

(iii) each occupation for which the applicant is seeking independent contractor certification; and

(iv) other documentation as provided by department rule to assist in determining if the applicant has an independently established business.

(b) The department shall adopt a retention schedule that maintains copies of documents submitted in support of an initial application or renewal application for an independent contractor exemption certificate for a minimum of 3 years after an application has been received by the department. The department shall, to the extent feasible, produce renewal applications that reduce the burden on renewal applicants to supply information that has been previously provided to the department as part of the application process.

(c) An applicant who applies on or after July 1, 2011, to renew an independent contractor exemption certificate is not required to submit documents that have been previously submitted to the department if:

(i) the applicant certifies under oath that the previously submitted documents are still valid

and current; and

(ii) the department, if it considers it necessary, independently verifies a specific document or decides that a document has not expired pursuant to the document's own terms and is therefore still valid and current.

(6) The department shall issue an independent contractor exemption certificate to an applicant if the department determines that an applicant meets the requirements of this section.

(7) (a) When the department approves an application for an independent contractor exemption certificate and the person is working under the independent contractor exemption certificate, the person's status is conclusively presumed to be that of an independent contractor.

(b) A person working under an approved independent contractor exemption certificate has waived all rights and benefits under the Workers' Compensation Act and is precluded from obtaining benefits unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3.

(c) For the purposes of the Workers' Compensation Act, a person is working under an independent contractor exemption certificate if:

(i) the person is performing work in the trade, business, occupation, or profession listed on the person's independent contractor exemption certificate; and

(ii) the hiring agent and the person holding the independent contractor exemption certificate do not have a written or an oral agreement that the independent contractor exemption certificate holder's status with respect to that hiring agent is that of an employee.

(8) Once issued, an independent contractor exemption certificate remains in effect for 2 years unless:

(a) suspended or revoked pursuant to 39-71-418; or

(b) canceled by the independent contractor.

(9) If the department's independent contractor central unit denies an application for an independent contractor exemption certificate, the applicant may contest that decision as provided in 39-71-415(2).

**History:** En. Sec. 1, Ch. 448, L. 2005; amd. Sec. 4, Ch. 117, L. 2007; amd. Sec. 2, Ch. 340, L. 2007; amd. Sec. 1, Ch. 120, L. 2009; amd. Sec. 2, Ch. 200, L. 2011.

**39-71-418. Suspension or revocation of independent contractor exemption certificate.** (1) The department may suspend an independent contractor exemption certificate for a specific business relationship if the department determines that the employing unit exerts or retains a right of control to a degree that causes a certificate holder to violate the provisions of 39-71-417(4).

(2) The department may revoke an independent contractor exemption certificate after determining that the certificate holder:

(a) made misrepresentations in the application affidavit or certificate renewal form;

(b) altered or amended the application form, the renewal application form, other supporting documentation required by the department, or the independent contractor exemption certificate;

(c) failed to cooperate with the department in providing information relevant to the continued validity of the holder's certificate; or

(d) does not have an independently established business as required by 39-71-417(4).

(3) A decision by the department to suspend or revoke an independent contractor exemption certificate takes effect upon issuance of the decision. Suspension or revocation of the independent contractor exemption certificate does not invalidate the certificate holder's waiver of the rights and benefits of the Workers' Compensation Act for the period prior to notice to the hiring agent by the department of the department's decision to suspend or revoke the independent contractor exemption certificate.

(4) A decision by the department's independent contractor central unit to suspend or revoke an independent contractor exemption certificate may be contested in the same manner as provided in 39-71-415(2).

**History:** En. Sec. 2, Ch. 448, L. 2005; amd. Sec. 5, Ch. 117, L. 2007; amd. Sec. 2, Ch. 150, L. 2011.

**39-71-419. Independent contractor violations -- penalty.** (1) A person may not:

(a) perform work as an independent contractor without first:

(i) obtaining from the department an independent contractor exemption certificate unless the individual is not required to obtain an independent contractor exemption certificate pursuant to 39-71-417(1)(a); or

(ii) electing to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3;

(b) perform work as an independent contractor when the department has revoked or denied the independent contractor's exemption certificate;

(c) transfer to another person or allow another person to use an independent contractor exemption certificate that was not issued to that person;

(d) alter or falsify an independent contractor exemption certificate; or

(e) misrepresent the person's status as an independent contractor.

(2) An employer may not:

(a) require an employee through coercion, misrepresentation, or fraudulent means to adopt independent contractor status to avoid the employer's obligations to provide workers' compensation coverage; or

(b) exert control to a degree that causes the independent contractor to violate the provisions of 39-71-417(4).

(3) In addition to any other penalty or sanction provided in this chapter, a person or

employer who violates a provision of this section is subject to a fine to be assessed by the department of up to $1,000 for each violation. The department shall deposit the fines in the uninsured employers' fund. The lien provisions of 39-71-506 apply to any assessed fines.

(4) A person or employer who disputes a fine assessed by the department pursuant to this section may file an appeal with the department within 30 days of the date on which the fine was assessed. If, after mediation, the issue is not resolved, the issue must be transferred to the workers' compensation court for resolution.

**History:** En. Sec. 3, Ch. 448, L. 2005.

**39-71-421. Financial incentives to institute safety programs.** Insurers may provide financial incentives to an employer who implements a formal safety program. An insurer may provide to an employer a premium discount that reflects the degree of risk diminished by the implemented safety program.

**History:** En. Sec. 9, Ch. 464, L. 1987; amd. Sec. 21, Ch. 613, L. 1989.

**39-71-432. Definitions.** As used in 39-71-433, the following definitions apply:

(1) "Business entity" means a business enterprise owned by a single person, corporation, organization, business trust, trust, partnership, limited liability company, limited liability partnership, joint venture, association, or other business entity.

(2) "Group" means two or more business entities that join together to purchase individual workers' compensation insurance policies covering each business entity that is part of a group.

**History:** En. Sec. 20, Ch. 619, L. 1993; amd. Sec. 7, Ch. 516, L. 1995; amd. Sec. 6, Ch. 172, L. 1997; amd. Sec. 6, Ch. 377, L. 1999.

**39-71-433. Group purchase of workers' compensation insurance.** (1) Two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(2) A group formed under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write

workers' compensation insurance in this state, except that the state fund, as defined in 39-71-2312, has the right to refuse coverage of a group and its plan of operation but may not refuse coverage to an individual employer. Under an individual policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(3) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

(4) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, the eligibility requirements to join the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management.

**History:** En. Sec. 21, Ch. 619, L. 1993; amd. Sec. 8, Ch. 516, L. 1995; amd. Sec. 5, Ch. 310, L. 1997.

**39-71-434. Deductible insurance policy provision for medical benefits.** (1) In order to lower the amount an employer is required to pay to obtain workers' compensation insurance coverage under this chapter, a workers' compensation policy issued by the state compensation insurance fund under plan No. 3 or by a private insurer under plan No. 2 must offer a deductible for the medical, hospital, and related services allowed under 39-71-704. The medical deductible must be offered in amounts of at least $500.

(2) If the insured employer chooses to accept a medical deductible, the insured employer is liable for the amount of the deductible for the medical benefits paid for each otherwise compensable claim of work injury suffered by an employee.

(3) The insured employer shall contract with the insurer to have the insurer pay the entire cost of the covered medical benefits directly to the provider of medical or related services and then seek reimbursement from the insured employer for the deductible amount. The insurer is entitled to reimbursement only for medical, hospital, and related services allowed under 39-71-704, up to the amount of the deductible.

(4) If an insured employer who has contracted with an insurer for a medical deductible does not pay the medical deductible amount to the insurer through reimbursement, the amount paid by the insurer on the claim may be included as benefits paid in a determination of the insured employer's rate.

(5) If an insured employer chooses to accept a medical deductible, then for purposes of computing rates and rating plans, all medical losses incurred must be reported to the insurer without regard to the application of any medical deductible regardless of whether the employer or the insurer pays the losses.

**History:** En. Sec. 1, Ch. 641, L. 1989; amd. Sec. 1, Ch. 666, L. 1991; amd. Sec. 1, Ch. 248, L. 1993.

**39-71-435. Workers' compensation and employers' liability insurance -- optional deductibles.** (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) The advisory organization designated under 33-16-1023 may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.

(h) Losses subject to the deductible must be reported and recorded as losses for purposes of calculating rates for a policyholder on the same basis as losses under policies providing first dollar coverage.

(4) The state compensation insurance fund, plan No. 3, may adopt the plan filed by the designated advisory organization or adopt an optional deductible plan that meets the requirements of this section.

(5) For purposes of 39-71-201 and 39-71-915, liability for assessments must be ascertained without regard to application of any deductible, whether the employer or the insurer pays the losses. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible.

**History:** En. Sec. 8, Ch. 619, L. 1993; amd. Sec. 24, Ch. 186, L. 1995; amd. Sec. 9, Ch. 214, L. 2001.

**39-71-441. Tribal employment coverage.** The department may, as provided in Title 18, chapter 11, enter into an agreement with a tribal government to recognize, with the same effect as the exclusive remedy and benefits under plans No. 1, 2, and 3, tribal workers' compensation plans or self-insured plans that the department determines provide adequate coverage to persons who are:

(1) employed by an enrolled tribal member or by an association, business, corporation, or other entity at least 51% of which is owned by one or more enrolled tribal members; and

(2) working outside the exterior boundaries of an Indian reservation.

**History:** En. Sec. 1, Ch. 112, L. 2009.

**Part 5. Uninsured Employers**

**39-71-501. Definition of uninsured employer.** For the purposes of 39-71-501, 39-71-503 through 39-71-511, 39-71-515 through 39-71-520, and 39-71-541, "uninsured employer" means an employer who has not properly complied with the provisions of 39-71-401.

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(part); amd. Sec. 62, Ch. 397, L. 1979; amd. Sec. 179, Ch. 42, L. 1997; amd. Sec. 7, Ch. 377, L. 1999; amd. Sec. 11, Ch. 112, L. 2009.

**39-71-503. Uninsured employers' fund -- purpose and administration of fund -- maintaining balance for administrative costs -- appropriation.** (1) There is created an uninsured employers' fund in the state special revenue account to pay:

(a) to an injured employee of an uninsured employer the same benefits the employee would

have received if the employer had been properly enrolled under compensation plan No. 1, 2, or 3, except as provided in subsection (3);

(b) the costs of investigating and prosecuting workers' compensation fraud under 2-15-2015; and

(c) the expenses incurred by the department in administering the uninsured employers' fund.

(2) The department may refer to the workers' compensation fraud office, established in 2-15-2015, cases involving:

(a) false or fraudulent claims for benefits; and

(b) criminal violations of 45-7-501.

(3) (a) Except as provided in subsection (3)(b), surpluses and reserves may not be kept for the fund. The department shall make payments that it considers appropriate as funds become available from time to time. The payment of weekly disability benefits takes precedence over the payment of medical benefits. Lump-sum payments of future projected benefits, including impairment awards, may not be made from the fund. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(b) The department shall maintain at least a 3-month balance based on projected budget costs for administration of the fund. The balance for administrative costs may be used by the department only in administering the fund.

(c) The maximum aggregate medical benefits expenditure that may be made from the fund may not exceed $100,000 for any single claim regardless of whether the claim arises from an injury or an occupational disease.

(4) The amounts necessary for the payment of benefits from the fund are statutorily appropriated, as provided in 17-7-502, from the fund.

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(part); amd. Sec. 14, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 5, Ch. 555, L. 1993; amd. Sec. 9, Ch. 516, L. 1995; amd. Sec. 6, Ch. 310, L. 1997; amd. Sec. 35, Ch. 422, L. 1997; amd. Sec. 8, Ch. 377, L. 1999; amd. Sec. 18, Ch. 389, L. 1999; amd. Sec. 2, Ch. 193, L. 2003; amd. Sec. 4, Ch. 48, L. 2007.

**39-71-504. Funding of fund -- option for agreement between department and injured employee.** The fund is funded in the following manner:

(1) (a) The department may require that the uninsured employer pay to the fund a penalty of either up to double the premium amount the employer would have paid on the payroll of the employer's workers in this state if the employer had been enrolled with compensation plan No. 3 or $200, whichever is greater. In determining the premium amount for the calculation of the penalty under this subsection, the department shall make an assessment based on how much premium would have been paid on the employer's past 3-year payroll for periods within the 3 years when the employer was uninsured.

(b) The fund shall collect from an uninsured employer an amount equal to all benefits paid or

to be paid from the fund to or on behalf of an injured employee of the uninsured employer.

(c) In addition to any amounts recovered under subsections (1)(a) and (1)(b), the fund shall collect a penalty of $200 from an employer that fails to obtain Montana workers' compensation insurance within 30 days of notice of the requirement.

(2) (a) An uninsured employer that fails to make timely penalty or claim reimbursement payments required under this part must be assessed a late fee of $50 for each late payment.

(b) Any unpaid balance owed to the fund under this part must accrue interest at 12% a year or 1% a month or fraction of a month. Interest on unpaid balances accrues from the date of the original billing.

(c) Late fees and interest assessed pursuant to this subsection (2) must be deposited into the fund for payment of administrative expenses and benefits.

(3) The department may enter into an agreement with the injured employee or the employee's beneficiaries to assign to the employee or the beneficiaries all or part of the funds collected by the department from the uninsured employer pursuant to subsection (1)(b).

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(2); amd. Sec. 5, Ch. 103, L. 1979; amd. Sec. 1, Ch. 601, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 661, L. 1991; amd. Sec. 10, Ch. 516, L. 1995; amd. Sec. 3, Ch. 284, L. 1997; amd. Sec. 7, Ch. 310, L. 1997; amd. Sec. 3, Ch. 193, L. 2003; amd. Sec. 4, Ch. 69, L. 2005.

**39-71-505. Applicability of other provisions of chapter to fund.** All appropriate provisions in the Workers' Compensation Act apply to the fund in the same manner as they apply to compensation plans No. 1, 2, and 3.

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(5).

**39-71-506. Lien for payment of unpaid penalties, fees, and interest -- levy and execution.** (1) (a) If, upon demand of the department, an uninsured employer refuses to make the payments to the fund that are provided for in 39-71-504(1)(a), (1)(c), and (2), the unpaid penalties, fees, and interest have the effect of a judgment against the employer at the time the payments become due. After issuing an order to the uninsured employer requiring payment of penalties, fees, and interest and after the due process requirements of 39-71-2401(2) and (3) are satisfied, the department may issue a certificate setting forth the amount of payment due and direct the clerk of the district court of any county in the state to enter the certificate as a judgment on the docket pursuant to 25-9-301. From the time the judgment is entered on the docket, it becomes a lien upon all real property of the uninsured employer. The department

may enforce the judgment at any time within 10 years of creation of the lien.

(b) A judgment lien filed pursuant to this section may be renewed for another 10-year period upon motion of the lienholder or by a judgment for that purpose.

(2) The department may settle through compromise with an uninsured employer the amount due the fund under subsection (1).

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(3); amd. Sec. 63, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 6, Ch. 555, L. 1993; amd. Sec. 4, Ch. 193, L. 2003; amd. Sec. 12, Ch. 112, L. 2009.

**39-71-507. Department to order uninsured employer to cease operations -- noncompliance with order a misdemeanor -- coordination of remedies.** (1) When the department discovers an uninsured employer, it shall order the employer to cease operations until the employer has elected to be bound by a compensation plan.

(2) When the department discovers a person, business, or other entity functioning as a prime contractor that has subcontracted for the services of an uninsured employer, it may order the person, business, or other entity functioning as a prime contractor to cause all operations performed by the uninsured employer to cease at worksites controlled by the prime contractor until the uninsured employer has elected to be bound by a compensation plan. If after 3 business days following the order by the department the person, business, or other entity functioning as a prime contractor has not complied with the order, the department may order the prime contractor to cease all operations at the affected worksites.

(3) An employer who does not comply with the department's order to cease operations is guilty of a misdemeanor. Each day of violation is a separate offense. The county attorney may prosecute a criminal action under this subsection in the county in which the violation occurs. Prosecution under this subsection does not bar the department from enforcing its order by a civil action.

(4) A person, business, or other entity functioning as a prime contractor that does not comply with the department's order to cease all operations is guilty of a misdemeanor. Each day of violation is a separate offense. The county attorney may prosecute a criminal action under this subsection in the county in which the violation occurs. Prosecution under this subsection does not bar the department from enforcing its order by a civil action. In addition, the department may assess a penalty against the person, business, or other entity functioning as a prime contractor of not more than $1,000 per day for each day of violation.

(5) The department may institute and maintain in the name of the state, through the attorney general or the county attorney of the county in which the violation occurs, an action for an injunction order or other civil remedy in district court to enforce its order to cease operations.

(6) The remedies provided in 39-71-506 and subsections (3) through (5) of this section are not mutually exclusive and may be pursued concurrently.

**History:** En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(6); amd. Sec. 1, Ch. 586, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 11, Ch. 516, L. 1995.

**39-71-508. Coordination of remedies -- limitation of liability of employee to third-party providers -- rights of third-party providers.** (1) An employee who suffers an injury arising out of and in the course of employment while working for an uninsured employer, as defined in 39-71-501, or an employee's beneficiaries in injuries resulting in death may pursue all remedies concurrently, including but not limited to:

(a) a claim for benefits from the uninsured employers' fund;

(b) a damage action against the employer in accordance with 39-71-509;

(c) an independent action against an employer as provided in 39-71-515; or

(d) any other civil remedy provided by law.

(2) An employee who is entitled to recover under this part is not liable to any third-party provider for services provided to the employee that are not reimbursed by the uninsured employers' fund.

(3) A third-party provider that is not fully reimbursed by the uninsured employers' fund for services provided to an injured employee may bring an action directly against the uninsured employer for the amount of services that were not paid by the uninsured employers' fund.

**History:** En. 92-213 by Sec. 5, Ch. 550, L. 1977; R.C.M. 1947, 92-213(part); amd. Sec. 2, Ch. 601, L. 1985; amd. Sec. 5, Ch. 48, L. 2007.

**39-71-509. Action against uninsured employer -- limitation of employer's defenses.** If an injured employee or the employee's beneficiaries bring an action to recover damages for personal injuries sustained or for death resulting from personal injuries sustained, it is not a defense for the employer that the:

(1) employee was negligent unless the negligence was willful;

(2) injury was caused by the negligence of a fellow employee; or

(3) employee had assumed the risks inherent in, incident to, or arising out of the employee's employment or arising from the failure of the employer to provide and maintain a reasonably safe place to work or reasonably safe tools or appliances.

**History:** En. 92-213 by Sec. 5, Ch. 550, L. 1977; R.C.M. 1947, 92-213(part); amd. Sec. 5, Ch. 601, L. 1985; amd. Sec. 1545, Ch. 56, L. 2009.

**39-71-510. Limitation on benefit entitlement under fund.** (1) Notwithstanding the provisions of 39-71-407, 39-71-503, and subsection (2) of this section, injured employees or an employee's beneficiaries who pursue a claim for benefits from the uninsured employers' fund are not granted an entitlement by this state for full workers' compensation benefits from the fund. Benefits from the fund must be paid in accordance with the money in the fund. If the department determines at any time that the money in the fund is not adequate to fully pay all claims, the department may make appropriate proportionate reductions in benefits to all claimants. The reductions do not entitle claimants to retroactive reimbursements in the future.

(2) The maximum medical benefits entitlement for any single claim against the fund is limited to an aggregate amount of $100,000.

**History:** En. 92-213 by Sec. 5, Ch. 550, L. 1977; R.C.M. 1947, 92-213(2); amd. Sec. 64, Ch. 397, L. 1979; amd. Sec. 4, Ch. 601, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 9, Ch. 377, L. 1999; amd. Sec. 6, Ch. 48, L. 2007.

**39-71-511. Setoffs to claim against fund.** A claim for benefits from the uninsured employers' fund must be discharged, finally or periodically, to the extent that an employee or the employee's beneficiaries receive actual monetary compensation by judgment or settlement from the uninsured employer, a third party who shares liability as defined in 39-71-412, or a fellow employee who shares liability as defined in 39-71-413.

**History:** En. Sec. 3, Ch. 601, L. 1985.

**39-71-515. Independent cause of action.** (1) An injured employee or the employee's beneficiaries have an independent cause of action against an uninsured employer for failure to be enrolled in a compensation plan as required by this chapter.

(2) In an action described in subsection (1), prima facie liability of the uninsured employer exists if the claimant proves, by a preponderance of the evidence, that:

(a) the employer was required by law to be enrolled under compensation plan No. 1, 2, or 3 with respect to the claimant; and

(b) the employer was not enrolled on the date of the injury or death.

(3) It is not a defense to an action that the employee had knowledge of or consented to the employer's failure to carry insurance or that the employee was negligent in permitting the failure to exist.

(4) The amount of recoverable damages in an action is the amount of compensation that the employee would have received had the employer been properly enrolled under compensation plan No. 1, 2, or 3.

(5) A plaintiff who prevails in an action brought under this section is entitled to recover reasonable costs and attorney fees incurred in the action, in addition to damages.

**History:** En. Sec. 6, Ch. 601, L. 1985; amd. Sec. 1546, Ch. 56, L. 2009.

**39-71-516. District court venue and jurisdiction for independent cause of action.** An injured employee or an employee's beneficiaries pursuing an independent cause of action pursuant to 39-71-515 shall bring the action in the district court in the district where the claimant resides or where the alleged violation occurred. The court may grant interim relief that it considers appropriate, including but not limited to injunctive relief, attachment, or receivership. The court may request the workers' compensation judge to determine the amount of recoverable damages due to the employee.

**History:** En. Sec. 7, Ch. 601, L. 1985; amd. Sec. 12, Ch. 516, L. 1995.

**39-71-517. Requirement to serve papers.** In pursuing remedies under 39-71-501, 39-71-503 through 39-71-511, and 39-71-515 through 39-71-520, an injured employee or the employee's beneficiaries shall serve all pleadings and all other litigation papers on the department and the uninsured employer, regardless of whether the department or the uninsured employer is a party to the particular action to which the papers relate.

**History:** En. Sec. 8, Ch. 601, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 180, Ch. 42, L. 1997; amd. Sec. 10, Ch. 377, L. 1999.

**39-71-518. Setoffs against remaining liability.** Any actual monetary compensation received by judgment or settlement by the injured employee or the employee's beneficiaries under 39-71-509 or 39-71-515 may be offset by the uninsured employer against the employer's remaining liability under those sections.

**History:** En. Sec. 9, Ch. 601, L. 1985; amd. Sec. 1547, Ch. 56, L. 2009.

**39-71-519. Settlement.** The department, the uninsured employer, the injured employee or the employee's beneficiaries, a third party who shares liability as defined in 39-71-412, or a fellow employee who shares liability as defined in 39-71-413 may enter into a settlement agreement to finally settle the rights and liabilities under 39-71-501, 39-71-503 through 39-71-511, and 39-71-515 through 39-71-520 of any or all of the parties. The settlement is subject to department approval in accordance with 39-71-741.

**History:** En. Sec. 10, Ch. 601, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 181, Ch. 42, L. 1997; amd. Sec. 11, Ch. 377, L. 1999.

**39-71-520. Time limit to appeal to mediation -- petitioning workers' compensation court -- failure to settle or petition.** (1) A dispute concerning uninsured employers' fund benefits must be appealed to mediation within 90 days from the date of the determination by the department or the determination is considered final.

(2) (a) If the parties fail to reach a settlement through the mediation process, any party who disagrees with the department's determination may file a petition before the workers' compensation court.

(b) A party's petition must be filed within 60 days of the mailing of the mediator's report provided for in 39-71-2411 unless the parties stipulate in writing to a longer time period for filing the petition.

(c) If a settlement is not reached through mediation and a petition is not filed within 60 days of the mailing of the mediator's report, the determination by the department is final.

(d) A mediator's report is not a determination by the department for the purposes of this section. A determination by the department is final if an appeal to mediation described in subsection (1) or a petition described in subsection (2)(a) is not filed within the required time period.

**History:** En. Sec. 19, Ch. 555, L. 1993; amd. Sec. 5, Ch. 193, L. 2003; amd. Sec. 13, Ch. 112, L. 2009.

**39-71-521. Burden of proof -- insurance coverage.** (1) In a proceeding brought by the department or an employer to resolve the issue of the existence of workers' compensation insurance coverage for that employer, the initial burden of proof is on the department to demonstrate that:

(a) the employer is required to have workers' compensation insurance coverage; and

(b) either:

(i) the database of the recognized agent providing proof of coverage indicates that no coverage is reported by an insurer to cover the employer's Montana operations; or

(ii) the department confirms with the insurer that reported coverage for the employer that the policy previously covering the employer's Montana operations has been canceled by that insurer.

(2) The burden then shifts to the employer to demonstrate that the employer is not required either to have workers' compensation insurance coverage or to produce a valid workers' compensation insurance policy covering the employer's Montana operations during the period of time in question. A valid workers' compensation insurance policy is one acknowledged by the insurer to be valid or adjudged to be valid by a court of competent jurisdiction.

**History:** En. Sec. 1, Ch. 214, L. 2001.

**39-71-522. Inspection of construction sites -- public policy -- penalty.** (1) In recognition of the benefit of fair competition among business competitors and the public policy of this state providing for enforcement of workers' compensation insurance coverage requirements, the legislature finds that it is reasonable to allow access by authorized employees of the department onto construction sites for the purpose of determining whether workers are appropriately covered by workers' compensation insurance or a valid exemption from insurance coverage.

(2) In order to determine if proper workers' compensation insurance coverage is in place or if a valid exemption is held by a worker present on a construction site, authorized employees of the department may enter onto any construction site for which a construction permit is required or has been issued.

(3) Upon presentation of proper credentials, department employees must be admitted to a construction site to:

(a) gather information relating to compliance with the coverage requirements of this chapter; and

(b) when appropriate, issue a notice of violation to a person who is in violation of 39-71-419.

(4) This section does not authorize the department's employees to engage in a breach of the peace. The department may request the assistance of appropriate local law enforcement agencies to peaceably enter a construction site.

(5) A person who purposely or knowingly restricts the access to a construction site by a credentialed department employee or who obstructs the employee in the performance of the

employee's duties under this section commits the offense of obstruction of a public servant as provided in 45-7-302.

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

(a) "Construction permit" means any permit that can be issued pursuant to Title 50, chapter 60, and includes:

(i) a boiler permit;

(ii) a building permit;

(iii) an electrical permit;

(iv) an elevator permit;

(v) a mechanical permit; or

(vi) a plumbing permit.

(b) "Construction site" means any parcel of real property where work is being performed for which a construction permit is required or has been issued.

**History:** En. Sec. 1, Ch. 48, L. 2007.

**39-71-525. Confidentiality of records -- exception for use by public employees.** Information obtained from any individual under this part is confidential and may not be disclosed, sold, or opened to public inspection except to department employees when necessary to allow them to perform their public duties under this chapter or to provide relevant and necessary information to other public entities or pursuant to a subpoena issued upon a showing of compelling state interest.

**History:** En. Sec. 21, Ch. 377, L. 1999; amd. Sec. 22, Ch. 416, L. 2005.

**39-71-535. Collection of penalties, claim costs, late fees, and interest -- liability for payment of collection costs.** (1) If the department is unable to collect penalties, claim costs, late fees, or interest assessed pursuant to the provisions of this part, the department may assign the debt to a collection service or transfer the debt to the department of revenue pursuant to Title 17, chapter 4, part 1.

(2) (a) The reasonable collection costs of a collection service, if approved by the department, or assistance costs charged the department by the department of revenue pursuant to 17-4-103(3) may be added to the debt for which collection is being sought.

(b) (i) All money collected by the department of revenue is subject to the provisions of 17-4-106.

(ii) All money collected by a collection service must be paid to the department, except that

the collection service may retain those collection costs or, if the total debt is not collected, that portion of collection costs that are approved by the department.

**History:** En. Sec. 6, Ch. 193, L. 2003.

**39-71-541. Uninsured employer as party to benefits disputes -- indemnification by uninsured employer for benefits paid -- lien for payment -- levy and execution.** (1) An uninsured employer or an employer alleged to be uninsured is a party to all disputes concerning any benefits for which the employer may become obligated to indemnify the department pursuant to 39-71-504(1)(b).

(2) (a) After mediation pursuant to department rules, an uninsured employer or an employer alleged to be uninsured is joined as a party when a dispute over benefits is brought before the workers' compensation judge pursuant to 39-71-2905.

(b) The workers' compensation judge may enter a judgment, including a default judgment, requiring an uninsured employer to indemnify the department with respect to any benefits paid or ordered payable by the department in relation to the claim.

(c) If a judgment ordered under subsection (2)(b) includes a specific amount paid or ordered payable, the department may issue to the uninsured employer a certificate listing the amount of payment due and directing the clerk of the district court of any county in the state to enter the certificate as a judgment on the docket pursuant to 25-9-301. The judgment becomes a lien on all real property of the uninsured employer from the time of being entered on the docket.

(3) (a) An uninsured employer is obligated to make claim reimbursements as provided in 39-71-504(1)(b), plus the interest and other charges assessed on the claim reimbursement as provided in 39-71-504(2), when demand for those payments is made to the uninsured employer.

(b) If the uninsured employer does not make the payments and does not dispute the obligation in the manner provided by 39-71-520, the department may issue a certificate listing the amount of payment due and directing the clerk of the district court of any county in the state to enter the certificate as a judgment on the docket pursuant to 25-9-301. The judgment becomes a lien on all real property of the uninsured employer from the time of being entered on the docket.

(4) A judgment lien filed pursuant to this section may be renewed for another 10-year period upon motion of the lienholder or by a judgment for that purpose.

**History:** En. Sec. 3, Ch. 112, L. 2009.

**Part 6. Claims for Benefits**

**39-71-601. Statute of limitation on presentment of claim -- waiver.** (1) Except for a claim for benefits for occupational diseases pursuant to subsections (3) and (4), all claims in the case of personal injury or death must be forever barred unless signed by the claimant or the claimant's representative and presented in writing to the employer, the insurer, or the department within 12 months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on the claimant's behalf.

(2) The insurer may waive the time requirement up to an additional 24 months upon a reasonable showing by the claimant of:

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

(3) When a claimant seeks benefits for an occupational disease, the claimant's claims for benefits must be in writing, signed by the claimant or the claimant's representative, and presented to the employer, the employer's insurer, or the department within 1 year from the date that the claimant knew or should have known that the claimant's condition resulted from an occupational disease. When a beneficiary seeks benefits under this chapter, claims for death benefits must be presented in writing to the employer, the employer's insurer, or the department within 1 year from the date that the beneficiary knew or should have known that the decedent's death was related to an occupational disease.

(4) Any dispute regarding the statute of limitations for filing time is considered a dispute that, after mediation pursuant to department rules, is subject to jurisdiction of the workers' compensation court.

**History:** En. Sec. 10, Ch. 96, L. 1915; amd. Sec. 3, Ch. 100, L. 1919; re-en. Sec. 2899, R.C.M. 1921; amd. Sec. 1, Ch. 34, L. 1935; re-en. Sec. 2899, R.C.M. 1935; amd. Sec. 1, Ch. 264, L. 1973; R.C.M. 1947, 92-601; amd. Sec. 1, Ch. 254, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 24, Ch. 619, L. 1993; amd. Sec. 16, Ch. 442, L. 1999; amd. Sec. 23, Ch. 416, L. 2005; amd. Sec. 14, Ch. 112, L. 2009.

**39-71-602. Statute of limitation not to apply during minority or mental incompetency unless guardian appointed.** No limitation of time as provided in 39-71-601 or in this chapter, known as the Workers' Compensation Act, shall run as against any injured worker who is mentally incompetent and without a guardian or an injured minor under 18 years of age who may be without a parent or guardian. A guardian in either case may be appointed by any court

of competent jurisdiction, in which event the period of limitations as provided for in 39-71-601 shall begin to run on the date of appointment of such guardian or when such minor arrives at 18 years of age, whichever date is earlier.

**History:** En. Sec. 10, Ch. 96, L. 1915; re-en. Sec. 2900, R.C.M. 1921; amd. Sec. 9, Ch. 121, L. 1925; re-en. Sec. 2900, R.C.M. 1935; amd. Sec. 1, Ch. 79, L. 1939; amd. Sec. 5, Ch. 235, L. 1947; R.C.M. 1947, 92-602; amd. Sec. 65, Ch. 397, L. 1979.

**39-71-603. Notice of injuries other than death to be submitted within 30 days -- exception.** (1) A claim to recover benefits under the Workers' Compensation Act for injuries not resulting in death may not be considered compensable unless, within 30 days after the occurrence of the accident that is claimed to have caused the injury, notice of the time and place where the accident occurred and the nature of the injury is given to the employer or the employer's insurer by the injured employee or someone on the employee's behalf. Actual knowledge of the accident and injury on the part of the employer or the employer's managing agent or superintendent in charge of the work in which the injured employee was engaged at the time of the injury is equivalent to notice.

(2) If a sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under this chapter is injured in an accident, the sole proprietor, partner, manager, member, or corporate officer or an appointed designee shall, within 30 days, notify the insurer of the time and location of the accident and the nature of the injury.

(3) This section does not apply to occupational diseases.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2933, R.C.M. 1921; amd. Sec. 7, Ch. 177, L. 1929; re-en. Sec. 2933, R.C.M. 1935; amd. Sec. 9, Ch. 234, L. 1957; R.C.M. 1947, 92-807; amd. Sec. 6, Ch. 103, L. 1979; amd. Sec. 66, Ch. 397, L. 1979; amd. Sec. 1, Ch. 352, L. 1987; amd. Sec. 9, Ch. 243, L. 1995; amd. Sec. 24, Ch. 416, L. 2005.

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

(2) A signed claim for workers' compensation or occupational disease benefits authorizes disclosure to the workers' compensation insurer, as defined in 39-71-116, or to the agent of a workers' compensation insurer by the health care provider. The disclosure authorized by this subsection authorizes the physician or other health care provider to disclose or release only information relevant to the claimant's condition. Health care information relevant to the claimant's condition may include past history of the complaints of or the treatment of a condition that is similar to that presented in the claim, conditions for which benefits are subsequently claimed, other conditions related to the same body part, or conditions that may affect recovery. A release of information related to workers' compensation must be consistent with the provisions of this subsection. Authorization under this section is effective only as long as the claimant is claiming benefits. This subsection may not be construed to restrict the scope of discovery or disclosure of health care information, as allowed under the Montana Rules of Civil Procedure, by the workers' compensation court or as otherwise provided by law.

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

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

**History:** (1)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3006, R.C.M. 1921; re-en. Sec. 3006, R.C.M. 1935; amd. Sec. 6, Ch. 213, L. 1945; amd. Sec. 78, Ch. 23, L. 1975; Sec. 92-1118, R.C.M. 1947; (2)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3008, R.C.M. 1921; re-en. Sec. 3008, R.C.M. 1935; amd. Sec. 80, Ch. 23, L. 1975; Sec. 92-1120, R.C.M. 1947; R.C.M. 1947, 92-1118, 92-1120; amd. Sec. 7, Ch. 103, L. 1979; amd. Sec. 2, Ch. 525, L. 1987; amd. Sec. 22, Ch. 613, L. 1989; amd. Sec. 4, Ch. 558, L. 1991; amd. Sec. 1, Ch. 464, L. 2003.

**39-71-605. Examination of employee by physician -- effect of refusal to submit to examination -- report and testimony of physician -- cost.** (1) (a) Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, the employee shall, upon the written request of the insurer, submit from time to time to examination by a physician, psychologist, or panel that must be provided and paid for by the insurer and shall likewise submit to examination from time to time by any physician, psychologist, or panel

selected by the department or as ordered by the workers' compensation judge.

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

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

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

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

**History:** (1)En. Sec. 13, Ch. 96, L. 1915; re-en. Sec. 2906, R.C.M. 1921; re-en. Sec. 2906, R.C.M. 1935; amd. Sec. 16, Ch. 23, L. 1975; Sec. 92-609, R.C.M. 1947; (2)En. Sec. 10, Ch. 234, L. 1957; amd. Sec. 27, Ch. 23, L. 1975; Sec. 92-814.1, R.C.M. 1947; R.C.M. 1947, 92-609, 92-814.1; amd. Sec. 1, Ch. 422, L. 1985; amd. Sec. 15, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 5, Ch. 558, L. 1991; amd. Sec. 3, Ch. 619, L. 1993; amd. Sec. 10, Ch. 276, L. 1997; amd. Sec. 1, Ch. 218, L. 1999; amd. Sec. 12, Ch. 377, L. 1999; amd. Sec. 1, Ch. 141, L. 2005.

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

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

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

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

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

**History:** En. Sec. 1, Ch. 477, L. 1973; amd. Sec. 1, Ch. 173, L. 1974; R.C.M. 1947, 92-615(part); amd. Sec. 1, Ch. 122, L. 1981; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 22, Ch. 619, L. 1993; amd. Sec. 13, Ch. 630, L. 1993; amd. Sec. 11, Ch. 276, L. 1997.

**39-71-607. Suspension of payments by insurer pending receipt of medical information.** Under rules adopted by the department, an insurer may suspend compensation payments pending the receipt of medical information when an injured worker unreasonably fails to keep scheduled medical appointments. If, after a medical examination, the injured worker is released to return to work, the worker forfeits the right to any suspended benefits.

**History:** En. Sec. 2, Ch. 477, L. 1973; amd. Sec. 2, Ch. 173, L. 1974; R.C.M. 1947, 92-616(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 4, Ch. 619, L. 1993.

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

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

(a) written consent of the claimant; or
(b) approval of the department.

**History:** En. Sec. 1, Ch. 477, L. 1973; amd. Sec. 1, Ch. 173, L. 1974; R.C.M. 1947, 92-615(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 103, L. 2005.

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

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

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

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

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

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

**History:** En. Sec. 1, Ch. 477, L. 1973; amd. Sec. 1, Ch. 173, L. 1974; R.C.M. 1947, 92-615(part); amd. Sec. 8, Ch. 103, L. 1979; amd. Sec. 5, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 243, L. 1995; amd. Sec. 1, Ch. 174, L. 2001.

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

**History:** En. 92-617 by Sec. 1, Ch. 124, L. 1975; R.C.M. 1947, 92-617; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 13, Ch. 377, L. 1999; amd. Sec. 17, Ch. 442, L. 1999; amd. Sec. 10, Ch. 214, L. 2001.

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

**History:** En. Sec. 2, Ch. 477, L. 1973; amd. Sec. 2, Ch. 173, L. 1974; R.C.M. 1947, 92-616(part); amd. Sec. 2, Ch. 63, L. 1979; amd. Sec. 16, Ch. 464, L. 1987; amd. Sec. 2, Ch. 464, L. 2003.

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

**History:** En. 92-618 by Sec. 1, Ch. 187, L. 1975; R.C.M. 1947, 92-618; amd. Sec. 1, Ch. 575, L. 1985; amd. Sec. 17, Ch. 464, L. 1987; amd. Sec. 3, Ch. 464, L. 2003; amd. Sec. 25, Ch. 416, L. 2005.

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

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

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

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

(c) the complexity of the case; and

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

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

(4) If, after an attorney receives attorney fees and costs assessed against an insurer, the claimant is convicted of having obtained benefits through fraud or deception, the attorney fees

and costs for obtaining the benefits must be returned to the insurer by the attorney.

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

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

**History:** En. 92-619 by Sec. 1, Ch. 402, L. 1975; R.C.M. 1947, 92-619; amd. Sec. 18, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 235, L. 1995; amd. Sec. 18, Ch. 442, L. 1999; amd. Sec. 15, Ch. 112, L. 2009.

**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 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.

(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.

(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.

**History:** En. Sec. 2, Ch. 575, L. 1985; amd. Sec. 19, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

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

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

(3) Upon written request by a worker for the payment of indemnity benefits or for a

determination of liability, the insurer shall investigate the claim to determine liability for the injury or occupational disease under 39-71-606 or 39-71-608.

**History:** En. Sec. 3, Ch. 243, L. 1995.

## Part 7. Compensation and Benefits Generally

**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 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.

(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).

(4) If the treating physician releases a worker to return to the same, a modified, or an alternative position that the individual is able and qualified to perform with the same employer at an equivalent or higher wage than the individual received at the time of injury, the worker is no longer eligible for temporary total disability benefits even though the worker has not reached maximum healing. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available to the worker for any reason except for the worker's incarceration as provided for in 39-71-744, resignation, or termination for disciplinary reasons caused by a violation of the employer's policies that provide for termination of employment and if the worker continues to be temporarily totally disabled, as defined in 39-71-116.

(5) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(6) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a

period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

(7) A worker may not receive both wages and temporary total disability benefits without the written consent of the insurer. A worker who receives both wages and temporary total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

**History:** En. 92-701.1 by Sec. 1, Ch. 471, L. 1973; R.C.M. 1947, 92-701.1; amd. Sec. 5, Ch. 21, L. 1981; amd. Sec. 21, Ch. 464, L. 1987; amd. Sec. 4, Ch. 9, Sp. L. June 1989; amd. Sec. 1, Ch. 52, L. 1991; amd. Sec. 5, Ch. 296, L. 1993; amd. Sec. 25, Ch. 619, L. 1993; amd. Sec. 11, Ch. 243, L. 1995; amd. Sec. 1, Ch. 121, L. 2001.

**39-71-702. Compensation for permanent total disability.** (1) If a worker is no longer temporarily totally disabled and 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) The determination of permanent total disability must be supported by a preponderance of objective medical findings.

(3) 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.

(4) In cases in which it is determined that periodic disability benefits granted by the Social Security Act are payable because of the injury, the weekly benefits payable under this section are reduced, but not below zero, by an amount equal, as nearly as practical, to one-half the federal periodic benefits for the week, which amount is to be calculated from the date of the disability social security entitlement.

(5) A worker's benefit amount must be adjusted for a cost-of-living increase on the next July 1 after 104 weeks of permanent total disability benefits have been paid and on each succeeding July 1. The adjustment must be the percentage increase, if any, in the state's average weekly wage as adopted by the department over the state's average weekly wage adopted for the previous year.

(6) A worker may not receive both wages and permanent total disability benefits without the written consent of the insurer. A worker who receives both wages and permanent total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

(7) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

**History:** En. 92-702.1 by Sec. 1, Ch. 202, L. 1973; amd. Sec. 1, Ch. 272, L. 1974; R.C.M. 1947, 92-702.1; amd. Sec. 6, Ch. 21, L. 1981; amd. Sec. 22, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 5, Ch. 9, Sp. L. June 1989; amd. Sec. 3, Ch. 574, L. 1991; amd. Sec. 6, Ch. 296, L. 1993; amd. Sec. 27, Ch. 619, L. 1993; amd. Sec. 12, Ch. 243, L. 1995; amd. Sec. 1, Ch. 138, L. 2003.

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

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

(b) has a permanent impairment rating as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease that:

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

(ii) is established by objective medical findings; and

(iii) is more than zero.

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

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

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

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

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

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

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

(d) if a worker, at the time of the injury, was performing heavy labor activity and after the

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

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

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

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

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

(10) As used in this section:

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

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

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

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

**History:** En. 92-703.1 by Sec. 1, Ch. 155, L. 1973; amd. Sec. 1, Ch. 241, L. 1975; amd. Sec. 1, Ch. 278, L. 1975; R.C.M. 1947, 92-703.1; amd. Sec. 23, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 6, Ch. 9, Sp. L. June 1989; amd. Sec. 4, Ch. 574, L. 1991; amd. Sec. 13, Ch. 243, L. 1995; amd. Sec. 182, Ch. 42, L. 1997; amd. Sec. 12, Ch. 276, L. 1997; amd. Sec. 4, Ch. 464, L. 2003; amd. Sec. 8, Ch. 103, L. 2005; amd. Sec. 1, Ch. 36, L. 2011; amd. Sec. 9, Ch. 167, L. 2011.

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

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

including prescription drugs for conditions that are a direct result of the compensable injury or occupational disease, for those periods specified in this section.

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

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

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

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

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

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

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

(D) travel for unauthorized treatment or disallowed procedures.

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

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

(f) (i) The benefits provided for in this section terminate 60 months from the date of injury or diagnosis of an occupational disease. A worker may request reopening of medical benefits that were terminated under this subsection (1)(f) as provided in 39-71-717.

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

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

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

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

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

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

(2) (a) The department shall annually establish a schedule of fees for medical services that are necessary for the treatment of injured workers. Regardless of the date of injury, payment for medical services is based on the fee schedule rates in this section in effect on the date on which the medical service is provided. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

(b) (i) The department may not set the rate for medical services at a rate greater than 10% above the average of the conversion factors used by up to the top five insurers or third-party administrators providing group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

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

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

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

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

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

(ii) the healthcare common procedure coding system;

(iii) the medicare severity diagnosis-related groups;

(iv) the ambulatory payment classifications;

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

(vi) the national correct coding initiative edits; and

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

(d) On or after July 1, 2013, the fee schedule rates established in subsection (2)(b) must be

based on the following standards as adopted by the centers for medicare and medicaid services, regardless of where services are provided:

(i) the American medical association current procedural terminology codes, as those codes exist on March 31 of each year;

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

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

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

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

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

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

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

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

(3) (a) The department shall establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the adopted utilization and treatment guidelines establish compensable medical treatment for an injured worker.

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

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

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

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

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

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

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

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

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

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

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

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

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

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

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

**History:** En. 92-706.1 by Sec. 1, Ch. 252, L. 1973; amd. Sec. 1, Ch. 43, L. 1975; amd. Sec. 1, Ch. 189, L. 1975; R.C.M. 1947, 92-706.1(1); amd. Sec. 1, Ch. 90, L. 1981; amd. Sec. 2, Ch. 422, L. 1985; amd. Sec. 25, Ch. 464, L. 1987; amd. Sec. 4, Ch. 333, L. 1989; amd. Secs. 23, 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 9, Sp. L. June 1989; amd. Sec. 1, Ch. 131, L. 1991; amd. Sec. 6, Ch. 558, L. 1991; amd. Sec. 5, Ch. 574, L. 1991; amd. Sec. 3, Ch. 628, L. 1993; amd. Sec. 1, Ch. 308, L. 1997; amd. Sec. 8, Ch. 310, L. 1997; amd. Sec. 19, Ch. 442, L. 1999; amd. Sec. 1, Ch. 138, L. 2001; amd. Sec. 3, Ch. 192, L. 2001; amd. Sec. 1, Ch. 377, L. 2003; amd. Sec. 5, Ch. 69, L. 2005; amd. Sec. 5, Ch. 345, L. 2005; amd. Sec. 3, Ch. 330, L. 2007; amd. Sec. 16, Ch. 112, L. 2009; amd. Sec. 10, Ch. 167, L. 2011.

**39-71-708. Compensation for disfigurement.** (1) Injured workers who suffer serious face, head, or neck disfigurement may be entitled to benefits not to exceed $2,500, in addition to benefits payable under 39-71-703.

(2) A payment under this section may not be in lieu of the separate benefit of medical and hospital services or of any benefits paid under 39-71-701 for temporary total disability.

**History:** En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 8, Ch. 100, L. 1919; amd. Sec. 5, Ch. 196, L. 1921; re-en. Sec. 2920, R.C.M. 1921; amd. Sec. 16, Ch. 121, L. 1925; amd. Sec. 16, Ch. 177, L. 1929; re-en. Sec. 2920, R.C.M. 1935; amd. Sec. 5, Ch. 213, L. 1945; amd. Sec. 5, Ch. 230, L. 1947; amd. Sec. 6, Ch. 7, L. 1949; amd. Sec. 5, Ch. 48, L. 1951; amd. Sec. 5, Ch. 38, L. 1953; amd. Sec. 6, Ch. 253, L. 1955; amd. Sec. 7, Ch. 234, L. 1957; amd. Sec. 5, Ch. 162, L. 1961; amd. Sec. 5, Ch. 149, L. 1965; amd. Sec. 5, Ch. 207, L. 1967; amd. Sec. 1, Ch. 140, L. 1971; amd. Sec. 1, Ch. 204, L. 1973; amd. Sec. 2, Ch. 386, L. 1975; R.C.M. 1947, 92-709(part); amd. Sec. 26, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 555, L. 1993.

**39-71-710. Termination of benefits upon retirement.** (1) If a claimant is receiving disability or rehabilitation compensation benefits and the claimant receives social security retirement benefits or is eligible to receive or is receiving full social security retirement benefits or retirement benefits from a system that is an alternative to social security retirement, the claimant is considered to be retired. When the claimant is retired, the liability of the insurer is ended for payment of permanent partial disability benefits other than the impairment award, payment of permanent total disability benefits, and payment of rehabilitation compensation benefits. However, the insurer remains liable for temporary total disability benefits, any impairment award, and medical benefits.

(2) If a claimant who is eligible under subsection (1) to receive retirement benefits and while gainfully employed suffers a work-related injury, the insurer retains liability for temporary total disability benefits, any impairment award, and medical benefits.

**History:** En. Sec. 1, Ch. 386, L. 1981; amd. Sec. 27, Ch. 464, L. 1987; amd. Sec. 14, Ch. 243, L. 1995; amd. Sec. 13, Ch. 516, L. 1995.

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

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

(b) must be based on the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment;

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

(d) must be established by objective medical findings and may not be based exclusively on complaints of pain.

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

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

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

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

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

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

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

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

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

**History:** En. Sec. 24, Ch. 464, L. 1987; amd. Sec. 2, Ch. 161, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 558, L. 1991; amd. Sec. 15, Ch. 243, L. 1995; amd. Sec. 2, Ch. 141, L. 2005; amd. Sec. 17, Ch. 112, L. 2009; amd. Sec. 11, Ch. 167, L. 2011.

**39-71-712. Temporary partial disability benefits.** (1) Subject to the provisions of subsection (5), if prior to maximum healing an injured worker has a physical restriction and is approved to return to a modified or alternative employment that the worker is able and qualified to perform and the worker suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial disability benefits.

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

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

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

(b) the wages payable in the modified or alternative position, when combined with the temporary partial disability benefits, would result in an equivalent or higher wage than the worker received at the time of injury; and

(c) the worker refuses to accept the modified or alternative position. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available to the worker for any reason except for the worker's incarceration as provided for in 39-71-744, resignation, or termination for disciplinary reasons caused by a violation of the employer's

policies that provide for termination of employment and if the worker continues to be temporarily totally disabled as defined in 39-71-116.

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

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

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

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

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

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

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

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

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

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

**History:** En. Sec. 6, Ch. 619, L. 1993; amd. Sec. 16, Ch. 243, L. 1995; amd. Sec. 13, Ch. 276, L. 1997; amd. Sec. 2, Ch. 121, L. 2001; amd. Sec. 1, Ch. 292, L. 2001; amd. Sec. 18, Ch. 112, L. 2009.

**39-71-713. Compensation for occupational diseases and medical benefits -- diminution of compensation.** (1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.

(2) When the same medical condition may be claimed as an injury and an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents may not be duplicated for the same conditions over the same time period.

**History:** En. Sec. 2, Ch. 416, L. 2005.

**39-71-714. Autopsy.** Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

**History:** En. Sec. 3, Ch. 416, L. 2005.

**39-71-715. Benefits for pneumoconiosis -- definition.** (1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.

(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

**History:** En. Sec. 4, Ch. 416, L. 2005.

**39-71-716. Prohibiting supplementing of benefits.** A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

**History:** En. Sec. 5, Ch. 416, L. 2005.

**39-71-717. Reopening of terminated medical benefits -- medical review.** (1) A petition to reopen medical benefits that terminate under 39-71-704(1)(f) must be reviewed as provided in this section.

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

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

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

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

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

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

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

to change the previous recommendation.

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

**History:** En. Sec. 29, Ch. 167, L. 2011.

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

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

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

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

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

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

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

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

**History:** (1)En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; Sec. 92-608, R.C.M. 1947; (2) thru (6)Ap. p. 92-704.1 by Sec. 1, Ch. 203, L. 1973; amd. Sec. 2, Ch. 269, L. 1974; amd. Sec. 1, Ch. 270, L. 1974; amd.

Sec. 2, Ch. 272, L. 1974; Sec. 92-704.1, R.C.M. 1947; Ap. p. Sec. 7, Ch. 96, L. 1915; re-en. Sec. 2892, R.C.M. 1921; re-en. Sec. 2892, R.C.M. 1935; amd. Sec. 10, Ch. 23, L. 1975; Sec. 92-502, R.C.M. 1947; R.C.M. 1947, 92-704.1, 92-502, 92-608(1); amd. Sec. 67, Ch. 197, L. 1979; amd. Sec. 29, Ch. 464, L. 1987; amd. Sec. 8, Ch. 9, Sp. L. June 1989; amd. Sec. 6, Ch. 480, L. 1991; amd. Sec. 17, Ch. 243, L. 1995; amd. Sec. 14, Ch. 516, L. 1995; amd. Sec. 9, Ch. 310, L. 1997; amd. Sec. 2, Ch. 36, L. 2011; amd. Sec. 12, Ch. 167, L. 2011.

**39-71-722. Who constitutes beneficiary to be determined as of date of accident.** The question as to who constitutes a beneficiary shall be determined as of the date of the happening of the accident to the employee, whether death shall immediately result therefrom or not.

**History:** En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; R.C.M. 1947, 92-608(3).

**39-71-723. How compensation to be divided among beneficiaries.** Compensation that is due to beneficiaries must be paid to the surviving spouse, if any, or if none, divided equally among or for the benefit of the children. In cases in which beneficiaries are a surviving spouse and stepchildren of the spouse, the compensation must be divided equally among all beneficiaries. Compensation that is due to beneficiaries, as defined in 39-71-116(4)(e) and (4)(f), if there is more than one, must be divided equitably among them.

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2919, R.C.M. 1921; amd. Sec. 15, Ch. 121, L. 1925; re-en. Sec. 2919, R.C.M. 1935; amd. Sec. 4, Ch. 213, L. 1945; amd. Sec. 7, Ch. 235, L. 1947; amd. Sec. 7, Ch. 253, L. 1955; amd. Sec. 1, Ch. 205, L. 1973; amd. Sec. 3, Ch. 269, L. 1974; R.C.M. 1947, 92-708(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 480, L. 1991; amd. Sec. 18, Ch. 243, L. 1995; amd. Sec. 15, Ch. 516, L. 1995; amd. Sec. 7, Ch. 172, L. 1997.

**39-71-724. Payment of compensation to beneficiary not a resident of United States.** (1) Before payment of compensation to a beneficiary who is not residing within the United States, satisfactory proof of the relationship as to constitute a beneficiary under this chapter must be furnished by the beneficiary, authenticated under seal of an officer of a court of law in the

country where the beneficiary resides. The proof is conclusive as to the identity of the beneficiary, and any other claim of any other person to any compensation is barred from and after the filing of the proof.

(2) Payment of compensation to a beneficiary not residing within the United States may be made to any plenipotentiary, consul, or consular agent within the United States representing the country in which the nonresident beneficiary resides, and the written receipt of the plenipotentiary, consul, or consular agent acquits the employer or the insurer.

**History:** (1)En. Sec. 8, Ch. 96, L. 1915; re-en. Sec. 2896, R.C.M. 1921; re-en. Sec. 2896, R.C.M. 1935; amd. Sec. 11, Ch. 23, L. 1975; Sec. 92-506, R.C.M. 1947; (2)En. Sec. 9, Ch. 96, L. 1915; re-en. Sec. 2897, R.C.M. 1921; re-en. Sec. 2897, R.C.M. 1935; amd. Sec. 12, Ch. 23, L. 1975; Sec. 92-507, R.C.M. 1947; R.C.M. 1947, 92-506, 92-507; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 172, L. 1997.

**39-71-725. Payment of burial expense.** There must be paid, in case of the death of an employee whose death is the result of an accidental injury arising out of the employment and happening in the course of the employment, the reasonable burial expenses of the employee, not exceeding $4,000. The payment is not a part of the compensation that might be paid but is a benefit in addition to and separate from compensation.

**History:** En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 2, Ch. 196, L. 1921; re-en. Sec. 2916, R.C.M. 1921; amd. Sec. 13, Ch. 121, L. 1925; re-en. Sec. 2916, R.C.M. 1935; amd. Sec. 1, Ch. 128, L. 1943; amd. Sec. 1, Ch. 213, L. 1945; amd. Sec. 6, Ch. 38, L. 1953; amd. Sec. 5, Ch. 234, L. 1957; amd. Sec. 1, Ch. 194, L. 1974; R.C.M. 1947, 92-705; amd. Sec. 7, Ch. 21, L. 1981; amd. Sec. 14, Ch. 377, L. 1999.

**39-71-726. No compensation after death when death not result of injury.** If the employee dies from some cause other than the injury, there is no liability for compensation after the death.

**History:** En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; R.C.M. 1947, 92-608(2); amd. Sec. 1548, Ch. 56, L. 2009.

**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.

(5) The department shall establish a schedule of fees for prescription drugs.

(6) Except as provided in subsection (8), a pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, the terms "brand name" and "generic name" have the meanings provided in 37-7-502.

(8) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy. However, an insurer may authorize up to a 90-day supply of medications from an in-state mail service pharmacy.

(9) The provisions of this section do not apply to an agreement between a preferred provider organization and an insurer.

**History:** En. Sec. 2, Ch. 131, L. 1991; amd. Sec. 4, Ch. 628, L. 1993; amd. Sec. 19, Ch. 243, L. 1995; amd. Sec. 7, Ch. 117, L. 2007; amd. Sec. 19, Ch. 112, L. 2009.

**39-71-736. Compensation -- from what dates paid.** (1) (a) 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 worker is totally disabled and unable to work because of an injury. A worker is eligible for compensation starting with the 5th day.

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

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

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

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

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

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

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

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

**History:** En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 4, Ch. 196, L. 1921; re-en. Sec. 2918, R.C.M. 1921; amd. Sec. 3, Ch. 177, L. 1929; re-en. Sec. 2918, R.C.M. 1935; amd. Sec. 3, Ch. 213, L. 1945; amd. Sec. 5, Ch. 7, L. 1949; amd. Sec. 1, Ch. 144, L. 1969; amd. Sec. 18, Ch. 23, L. 1975; amd. Sec. 45, Ch. 535, L. 1975; R.C.M. 1947, 92-707; amd. Sec. 9, Ch. 103, L. 1979; amd. Sec. 30, Ch. 464, L. 1987; amd. Sec. 6, Ch. 333, L. 1989; amd. Sec. 18, Ch. 619, L. 1993; amd. Sec. 1, Ch. 274, L. 2001; amd. Sec. 1, Ch. 486, L. 2003; amd. Sec. 13, Ch. 167, L. 2011.

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

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2919, R.C.M. 1921; amd. Sec. 15, Ch. 121, L. 1925; re-en. Sec. 2919, R.C.M. 1935; amd. Sec. 4, Ch. 213, L. 1945; amd. Sec. 7, Ch. 235, L. 1947; amd. Sec. 7, Ch. 253, L. 1955; amd. Sec. 1, Ch. 205, L. 1973; amd. Sec. 3, Ch. 269, L. 1974; R.C.M. 1947, 92-708(part); amd. Sec. 2, Ch. 374, L. 1985; amd. Sec. 1, Ch. 502, L. 1985; amd. Sec. 31, Ch. 464, L. 1987; amd. Sec. 16, Ch. 516, L. 1995.

**39-71-739. Compensation in case of changes in degree of injury.** If aggravation, diminution, or termination of disability takes place or is discovered after the rate of compensation is established or compensation is terminated in any case where the maximum payments for disabilities as provided in this chapter are not reached, adjustments may be made to meet such changed conditions by increasing, diminishing, or terminating compensation payments in accordance with the provisions of this chapter.

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2924, R.C.M. 1921; amd. Sec. 6, Ch. 177, L. 1929; re-en. Sec. 2924, R.C.M. 1935; R.C.M. 1947, 92-713; amd. Sec. 69, Ch. 397, L. 1979.

**39-71-740. Payments -- how made in most cases.** All payments of compensation as provided in this chapter shall be made at the end of each 2-week period, except as otherwise provided herein.

**History:** En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2925, R.C.M. 1921; re-en. Sec. 2925, R.C.M. 1935; amd. Sec. 9, Ch. 235, L. 1947; amd. Sec. 1, Ch. 197, L. 1961; R.C.M. 1947, 92-714.

**39-71-741. Settlements and lump-sum payments -- legislative intent.** (1) By written agreement, a claimant and an insurer may convert benefits under this chapter 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 (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 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 a settlement agreement to convert the following benefits to a lump sum only under the following conditions:

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

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

(c) permanent total disability benefits if the total of all lump-sum payments in part that are awarded to a claimant do not exceed $20,000. The approval or award of a lump-sum permanent total disability payment in whole or in part by the department or court is 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 settlements and lump-sum payments agreed to by a claimant and insurer;

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

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

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

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

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

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

(5) (a) An insurer may recoup any lump-sum 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.

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

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

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

**History:** En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 9, Ch. 100, L. 1919; re-en. Sec. 2926, R.C.M. 1921; re-en. Sec. 2926, R.C.M. 1935; amd. Sec. 1, Ch. 225, L. 1951; amd. Sec. 8, Ch. 234, L. 1957; amd. Sec. 2, Ch. 197, L. 1961; amd. Sec. 1, Ch. 9, L. 1975; amd. Sec. 1, Ch. 11, L. 1975; amd. Sec. 19, Ch. 23, L. 1975; R.C.M. 1947, 92-715; amd. Sec. 3, Ch. 63, L. 1979; amd. Sec. 1, Ch. 471, L. 1985; amd. Sec. 32, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 6, Ch. 574, L.

1991; amd. Sec. 20, Ch. 243, L. 1995; amd. Sec. 10, Ch. 310, L. 1997; amd. Sec. 9, Ch. 103, L. 2005; amd. Sec. 3, Ch. 36, L. 2011; amd. Sec. 14, Ch. 167, L. 2011.

**39-71-742. Who may receive payment.** (1) A payment due to a child under 18 years of age or to a person adjudged incompetent must be made to the parent or the appointed guardian, and the written receipt for the payment must acquit the employer, the insurer, or the department of further liability.

(2) A payment due to a member of the highway patrol receiving the salary benefit provided in 44-1-511 must be made to the department of justice to offset the salary benefit until the member is no longer eligible to receive the salary benefit.

(3) In other cases, payment must be made to the person entitled to the payment or to the person's authorized representative.

**History:** En. Sec. 9, Ch, 96, L. 1915; re-en. Sec. 2898, R.C.M. 1921; amd. Sec. 8, Ch. 121, L. 1925; re-en. Sec. 2898, R.C.M. 1935; amd. Sec. 13, Ch. 23, L. 1975; R.C.M. 1947, 92-508; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 12, L. 2007.

**39-71-743. Assignment or attachment of payments.** (1) Payments under this chapter are not assignable, subject to attachment or garnishment, or held liable in any way for debts, except:

(a) as provided in 71-3-1118;

(b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law;

(c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to this chapter;

(d) as provided in 39-71-742; or

(e) for workers' compensation benefits payable to an injured worker to pay restitution to an insurer whenever the injured worker is subject to court-ordered restitution for theft of workers' compensation benefits. The insurer shall notify the injured worker in writing of the withholding of any court-ordered restitution from the injured worker's benefits.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:

(a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or

(b) for any lump-sum award, an amount up to that portion of the award that is necessary to

pay current child support and a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(10), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

**History:** En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2927, R.C.M. 1921; re-en. Sec. 2927, R.C.M. 1935; R.C.M. 1947, 92-801; amd. Sec. 3, Ch. 496, L. 1983; amd. Sec. 1, Ch. 485, L. 1987; amd. Sec. 19, Ch. 702, L. 1989; amd. Sec. 14, Ch. 628, L. 1993; amd. Sec. 2, Ch. 424, L. 1995; amd. Sec. 104, Ch. 546, L. 1995; amd. Sec. 1, Ch. 31, L. 2005; amd. Sec. 10, Ch. 103, L. 2005; amd. Sec. 26, Ch. 416, L. 2005; amd. Sec. 2, Ch. 12, L. 2007; amd. Sec. 2, Ch. 330, L. 2007; amd. Sec. 20, Ch. 112, L. 2009.

**39-71-744. Benefits not due while claimant is incarcerated -- exceptions.** (1) Except as provided in subsection (2), a claimant is not eligible for disability or rehabilitation compensation benefits while the claimant is incarcerated for a period exceeding 30 days in a correctional institution or jail as the result of conviction of a felony or a misdemeanor. The insurer remains liable for medical benefits. A time limit on benefits otherwise provided in this chapter is not extended due to a period of incarceration.

(2) A person who is employed while participating in a prerelease center program or a diversionary program is eligible for temporary total benefits as provided in 39-71-701 and medical benefits for a work-related injury received while participating in a prerelease center program or a diversionary program. Other disability or rehabilitation benefits are not payable while the worker is participating in a prerelease center. This subsection does not prohibit the reinstatement of other benefits upon release from incarceration, nor does it apply to an employee performing community service described in 39-71-118(1)(e).

**History:** En. Sec. 28, Ch. 464, L. 1987; amd. Sec. 1, Ch. 457, L. 1993; amd. Sec. 21, Ch. 243, L. 1995; amd. Sec. 31, Ch. 308, L. 1995; amd. Sec. 105, Ch. 546, L. 1995.

**39-71-745. Calculation of volunteer firefighter benefits and premiums -- definitions.** (1) (a) A plan No. 1 or plan No. 2 insurer shall designate whether an employer, as defined in 7-33-4510, is to use actual volunteer hours or a flat assumed payroll amount for each volunteer firefighter for calculating premiums. The coverage option must be the same for all fire agencies organized under Title 7, chapter 33, that are covered by that insurer and meet the definition of employer in 7-33-4510. A plan No. 3 insurer shall use a flat assumed payroll amount for each

volunteer firefighter for calculating premiums.

(b) If a plan No. 1 or plan No. 2 insurer uses actual volunteer hours, the payroll calculation is the number of actual volunteer hours of each volunteer firefighter, not to exceed 60 hours a week, times the state's average weekly wage divided by 40 hours.

(c) When a plan No. 1, plan No. 2, or plan No. 3 insurer uses a flat assumed payroll amount, the assumed payroll for each volunteer firefighter must be reported as a full month for any month in which the volunteer firefighter is on the roster of service as defined in 7-33-4510. The employer shall maintain the roster of service with the effective date of membership for each volunteer firefighter.

(2) For benefit purposes, if concurrent employment under 39-71-123 does not apply, a volunteer firefighter injured in the course and scope of employment as a volunteer firefighter is eligible for medical and compensation benefits provided in Title 39, chapter 71. Any weekly compensation benefit must be based on either the actual volunteer hours if chosen as provided in subsection (1)(b) or the flat assumed payroll amount on which premiums are based, whichever is applicable.

(3) For the purposes of this section, the following definitions apply:

(a) "Volunteer firefighter" has the meaning provided in 7-33-4510.

(b) "Volunteer hours" means the time spent by a volunteer firefighter in the service of a fire agency organized under Title 7, chapter 33, that meets the definition of employer in 7-33-4510, including but not limited to training time, response time, and time spent at the premises of the fire agency.

**History:** En. Sec. 6, Ch. 412, L. 2013.

## Part 8. Compensation for Occupational Deafness (Repealed)

## Part 9. Subsequent Injury Received by Vocationally Handicapped

**39-71-901. Definitions.** As used in this part, the following definitions apply:

(1) "Certificate" means documentation issued by the department to an individual who is a person with a disability.

(2) "Fund" means the subsequent injury fund in the proprietary fund category.

(3) "Person with a disability" means a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the person should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(1); amd. Sec. 10, Ch. 103, L. 1979; amd. Sec. 73, Ch. 397, L. 1979; amd. Sec. 24, Ch. 613, L. 1989; amd. Sec. 40, Ch. 472, L. 1997; amd. Sec. 19, Ch. 389, L. 1999; amd. Sec. 7, Ch. 193, L. 2003.

**39-71-903. Procedure.** When a person with a disability receives an injury, as defined in 39-71-119, the procedure provided in this chapter applies to all proceedings under this part, except when specifically otherwise provided.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 75, Ch. 397, L. 1979; amd. Sec. 4, Ch. 284, L. 1997; amd. Sec. 41, Ch. 472, L. 1997.

**39-71-904. Rules for certification.** The department shall promulgate rules for certification of persons with disabilities.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(4); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 42, Ch. 472, L. 1997.

**39-71-905. Certification as person with disability -- eligibility for benefits under fund.** (1) A person who wishes to be certified as a person with a disability for purposes of this part shall apply to the department on forms furnished by the department. The department shall conduct an investigation and shall issue a certificate to a person who, in the department's discretion, meets the requirements for certification. A person shall apply for certification before an injury occurs that is covered by this part. The certification is effective retroactively to the date the department received the application.

(2) If a claimant has met the provisions of subsection (1) and a subsequent claim has been accepted by an insurer, the claim is eligible for the benefits under the fund.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(2); amd. Sec. 11, Ch. 103, L. 1979; amd. Sec. 1, Ch. 151, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 558, L. 1991; amd. Sec. 43, Ch. 472, L. 1997; amd. Sec. 15, Ch. 377, L. 1999; amd. Sec. 1, Ch. 257, L. 2005; amd. Sec. 21, Ch. 112, L. 2009.

**39-71-907. Certified person with a disability to be compensated for injury as provided by chapter -- insurer liability for compensation limited.** (1) A person certified as having a physical or mental disability that constitutes or results in a substantial impediment to employment who receives an injury, as defined in 39-71-119, that results in death or disability must be paid compensation in the manner and to the extent provided in this chapter or, in case of death resulting from the injury, the compensation must be paid to the person's beneficiaries or dependents. The liability of the insurer for payment of medical and burial benefits as provided in this chapter is limited to those benefits arising from services rendered during the period of 104 weeks after the date of injury. The liability of the insurer for payment of benefits as provided in this chapter is limited to 104 weeks of compensation benefits actually paid. Thereafter, all compensation and the cost of all medical care and burial are the liability of the fund.

(2) The liability of the fund for reimbursement under this section is limited to the amount currently in the fund at the time the reimbursement request is received by the fund and the amount collectible in the next assessment period pursuant to 39-71-915.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(5); amd. Sec. 76, Ch. 397, L. 1979; amd. Sec. 1, Ch. 213, L. 1987; amd. Sec. 9, Ch. 555, L. 1993; amd. Sec. 5, Ch. 284, L. 1997; amd. Sec. 45, Ch. 472, L. 1997; amd. Sec. 20, Ch. 389, L. 1999; amd. Sec. 7, Ch. 48, L. 2007.

**39-71-908. Notification of fund of its potential liability under part -- review by fund.** Not less than 90 or more than 150 days before the expiration of 104 weeks after the date of injury, the insurer shall notify the fund whether it is likely that compensation may be payable beyond a period of 104 weeks after the date of the injury. The fund thereafter may review, at reasonable times, such information as the insurer has regarding the accident and the nature and extent of the injury and disability.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 77, Ch. 397, L. 1979; amd. Sec. 25, Ch. 613, L. 1989.

**39-71-909. Effect of fund's failure to give notification of its intent to dispute liability -- subsequent notification by fund authorized.** If the fund does not notify the insurer of its intent to dispute the payment of compensation, medical, and burial benefits, the insurer shall continue to make payments on behalf of the fund and shall be reimbursed by the fund for all benefits paid in excess of the insurer's liability. However, at any time subsequent to 104 weeks after the date of injury, the fund may notify the insurer of a dispute as to payment of benefits. The liability of the fund to reimburse the insurer shall be suspended 30 days thereafter until the controversy is determined.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(7); amd. Sec. 2, Ch. 213, L. 1987.

**39-71-911. Obligation to make payments on behalf of fund not independent liability.** Except as provided in 39-71-909 and 39-71-920, the obligation imposed by this part on the insurer to make payments on behalf of the fund does not impose an independent liability on the insurer.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 27, Ch. 613, L. 1989; amd. Sec. 8, Ch. 193, L. 2003.

**39-71-912. Reimbursement to be promptly made.** After the right to reimbursement has been established, reimbursement payment shall be made promptly on a proper showing every 6 months.

**History:** En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part).

**39-71-915. Assessment of insurer -- employers -- definition -- collection.** (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for

injuries covered by the Workers' Compensation Act without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, 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 and the expenses of administration 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, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses 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. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall 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 a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) 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 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) 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 (6). 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 subsequent injury 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.

(8) (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) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) 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.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) 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 (6) for the following year's assessment premium surcharge.

(10) If the total assessment is less than $1 million 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.

**History:** En. Sec. 1, Ch. 284, L. 1997; amd. Sec. 16, Ch. 377, L. 1999; amd. Sec. 13, Ch. 214, L. 2001; amd. Sec. 9, Ch. 193, L. 2003; amd. Sec. 6, Ch. 69, L. 2005; amd. Sec. 27, Ch. 416, L. 2005; amd. Sec. 8, Ch. 48, L. 2007; amd. Sec. 22, Ch. 112, L. 2009.

**39-71-916. Reimbursement of subsequent injury fund -- effect on claims experience rating.** An insurer that uses an employer's claims costs experience as a factor that influences the amount of premium charged to that particular employer by using an experience modification factor or similar rating technique may not base that factor on those claims costs that are reimbursed by the subsequent injury fund.

**History:** En. Sec. 2, Ch. 48, L. 2007.

**39-71-920. Concurrence of fund in settlements.** (1) Petitions for compromise settlements that potentially involve payments from the fund must have written concurrence by an authorized representative of the fund prior to submission for department approval.

(2) The failure to receive written concurrence from the fund's representative relieves the fund of any liability for payment of benefits for a compromise settlement, and the obligation to pay remains with the insurer.

**History:** En. Sec. 10, Ch. 193, L. 2003.

**Part 10. Stay-at-Work/Return-to-Work Assistance**

**39-71-1003. Payment for vocational rehabilitation expenses for injuries occurring on or before June 30, 1997.** For injuries occurring on or before June 30, 1997, a disabled worker may be paid vocational rehabilitation expenses from funds provided in 39-71-1004, in addition to benefits payable under the Workers' Compensation Act.

**History:** En. Sec. 3, Ch. 21, L. 1961; amd. Sec. 1, Ch. 363, L. 1971; R.C.M. 1947, 92-1403; amd. Sec. 80, Ch. 397, L. 1979; amd. Sec. 3, Ch. 374, L. 1985; amd. Sec. 35, Ch. 464, L. 1987; amd. Sec. 7, Ch. 574, L. 1991; amd. Sec. 106, Ch. 546, L. 1995; amd. Sec. 1, Ch. 122, L. 1997.

**39-71-1004. Industrial accident rehabilitation account.** (1) The payments provided in 39-71-1003 must be made from the industrial accident rehabilitation account in the state special revenue fund. Payments to the account must be made each year upon an assessment by the department as follows:

(a) by each employer operating under the provisions of plan No. 1 of the Workers' Compensation Act, an amount to be assessed by the department, not exceeding 1% of the compensation paid to the employer's injured employees in Montana for the preceding calendar year;

(b) by each insurer insuring employers under the provisions of plan No. 2 of the Workers' Compensation Act, an amount to be assessed by the department, not exceeding 1% of the compensation paid to injured employees of its insured in Montana during the preceding calendar year;

(c) by the state fund, an amount to be assessed by the department, not exceeding 1% of the compensation paid by the state fund to injured employees in Montana during the preceding calendar year.

(2) Separate accounts of the amounts that were collected and disbursements that were made from the industrial accident rehabilitation account in the state special revenue fund must be kept for each of the plans. If in any fiscal year the amount that was collected from the employers under any plan exceeds the amount of payments for employees of the employers under the plan, the assessment against the employers under the plan for the following year must be reduced.

(3) The payments provided for in this section must be made to the department, which shall credit the sums paid to the industrial accident rehabilitation account in the custody of the state treasurer. Disbursements from the account must be made after approval by the department.

(4) The board of investments shall invest the money of the industrial accident rehabilitation account, and the investment income must be deposited in the industrial accident rehabilitation account.

(5) The funds allocated or contributed as provided in this section may not be used for payment of administrative expenses of the department.

(6) The methods and processes used to disburse rehabilitation expense payments to eligible disabled workers are procedural and do not affect the substantive rights of those disabled workers.

**History:** En. Sec. 7, Ch. 21, L. 1961; amd. Sec. 3, Ch. 221, L. 1963; amd. Sec. 85, Ch. 23, L. 1975; R.C.M. 1947, 92-1406; amd. Sec. 2, Ch. 283, L. 1983; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 107, Ch. 546, L. 1995; amd. Sec. 2, Ch. 122, L. 1997; amd. Sec. 17, Ch. 377, L. 1999; amd. Sec. 11, Ch. 193, L. 2003.

**39-71-1006. Rehabilitation benefits.** (1) A worker is eligible for rehabilitation benefits if:

(a) (i) the worker meets the definition of a disabled worker as provided in 39-71-1011; or

(ii) the worker has, as a result of the work-related injury, a whole person impairment rating of 15% or greater, as established by objective medical findings, and has no actual wage loss;

(b) a rehabilitation provider, as designated by the insurer, certifies that the worker has reasonable vocational goals and reasonable reemployment opportunity. If eligible because of an impairment rating of 15% or more, with rehabilitation the worker will have a reasonable increase in the worker's wage compared to the wage that the worker received at the time of injury. If eligible because of a wage loss, the worker will have a reasonable reduction in the worker's actual wage loss with rehabilitation.

(c) a rehabilitation plan is agreed upon by the worker and the insurer and a written copy of the plan is provided to the worker. The plan must take into consideration the worker's age, education, training, work history, residual physical capacities, and vocational interests. The plan must specify a beginning date and a completion date. The plan must specify the cost of tuition, fees, books, and other reasonable and necessary retraining expenses required to complete the plan.

(2) A disabled worker is entitled to receive biweekly rehabilitation benefits at the worker's temporary total disability rate. The benefits must be paid for the period specified in the rehabilitation plan, not to exceed 104 weeks. The rehabilitation plan must be completed within 26 weeks of the completion date specified in the plan. Rehabilitation benefits must be paid biweekly while the worker is satisfactorily progressing in the agreed-upon rehabilitation plan. Rehabilitation benefits payable pursuant to a retraining rehabilitation plan under this section are not payable in a lump sum. Rehabilitation benefits may be paid in a lump sum for job placement services.

(3) In addition to rehabilitation benefits payable under subsection (2), a disabled worker who was injured on or after July 1, 1997, 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 39-71-1025, as set forth in department rules and as specified in the rehabilitation plan. Expenses must be paid directly by the insurer.

(4) A worker may not receive temporary total benefits and the benefits under subsection (2) during the same period of time.

(5) A rehabilitation provider authorized by the insurer shall continue to assist the injured worker until the rehabilitation plan is completed.

(6) To be eligible for benefits under this section, a worker is required to begin the rehabilitation plan within 78 weeks of reaching maximum medical healing.

(7) A worker may not receive both wages and rehabilitation benefits without the written consent of the insurer. A worker who receives both wages and rehabilitation benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

**History:** En. Sec. 10, Ch. 574, L. 1991; amd. Sec. 7, Ch. 296, L. 1993; amd. Sec. 24, Ch. 243, L. 1995; amd. Sec. 111, Ch. 546, L. 1995; Sec. 39-71-2001, MCA 1993; redes. 39-71-1006 by Code Commissioner, 1995; amd. Sec. 3, Ch. 122, L. 1997; amd. Sec. 14, Ch. 276, L. 1997; amd. Sec. 11, Ch. 103, L. 2005.

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

(1) "Assistance fund" means the stay-at-work/return-to-work assistance fund provided for in 39-71-1049.

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

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

(4) "Insurer's stay-at-work/return-to-work assistance policy" or "assistance policy" means a written stay-at-work/return-to-work policy that explains to the worker the process of evaluation, planning, implementation, and provision of services by the insurer prior to the determination that the worker meets the definition of a disabled worker. The services are intended to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan.

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

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

(7) "Rehabilitation provider" means a rehabilitation counselor certified by the commission on rehabilitation counselor certification and designated by the insurer.

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

(9) "Stay-at-work/return-to-work assistance" or "assistance" means the evaluation, planning, implementation, and provision of appropriate services prior to the determination that the worker meets the definition of a disabled worker that are designed to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan.

**History:** En. Sec. 34, Ch. 464, L. 1987; amd. Sec. 2, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 574, L. 1991; amd. Sec. 22, Ch. 243, L. 1995; amd. Sec. 108, Ch. 546, L. 1995; amd. Sec. 4, Ch. 122, L. 1997; amd. Sec. 49, Ch. 130, L. 2005; amd. Sec. 15, Ch. 167, L. 2011.

**39-71-1014. Rehabilitation services -- required and provided by insurers.** (1) Rehabilitation services are required for disabled workers and 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 designate a rehabilitation provider.

(2) Rehabilitation services provided under this part must be delivered through a rehabilitation counselor certified by the commission on rehabilitation counselor certification.

**History:** En. Sec. 37, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 109, Ch. 546, L. 1995; amd. Sec. 5, Ch. 122, L. 1997; amd. Sec. 50, Ch. 130, L. 2005.

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

(a) search for new employment;

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

(c) the implementation of a rehabilitation plan that has been filed with the department; or

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

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

**History:** En. Sec. 46, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 11, Ch. 574, L. 1991; amd. Sec. 22, Ch. 167, L. 2011.

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

**History:** En. Sec. 48, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 110, Ch. 546, L. 1995; amd. Sec. 6, Ch. 122, L. 1997; amd. Sec. 23, Ch. 167, L. 2011.

**39-71-1032. Termination of benefits for noncooperation with rehabilitation provider -- appeal.** (1) If an insurer believes that a worker is refusing unreasonably to cooperate with the rehabilitation provider, the insurer, with 14 days' written notice to the worker and the department, may terminate any benefits, except medical benefits and the impairment award, that the worker is receiving until the worker cooperates.

(2) If the worker disputes the termination of benefits, the worker may, after mediation pursuant to department rule, petition the workers' compensation court for resolution of the dispute.

**History:** En. Sec. 49, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 12, Ch. 574, L. 1991; amd. Sec. 23, Ch. 243, L. 1995; amd. Sec. 7, Ch. 122, L. 1997; amd. Sec. 20, Ch. 442, L. 1999.

**39-71-1036. Medical status form.** (1) The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease.

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

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

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

(c) the treatment plan for the worker;

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

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

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

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

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

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

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

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

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

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

**History:** En. Sec. 28, Ch. 167, L. 2011.

**39-71-1041. Stay-at-work/return-to-work goals and options -- notification by department -- agreement between worker and insurer.** (1) The goal of stay-at-work/return-to-work assistance is to minimize avoidable disruption caused by a work-related injury or occupational disease by assisting the worker in the worker's return to the same position with the same employer or to a modified position with the same employer as soon as possible after an injury or an occupational disease occurs.

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

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

**History:** En. Sec. 16, Ch. 167, L. 2011.

**39-71-1042. Request for and delivery of stay-at-work/return-to-work assistance.** (1) (a) A worker who is claiming an injury or occupational disease, an employer, or a medical provider may ask that the department furnish stay-at-work/return-to-work assistance. After the worker signs a claim for benefits, the department shall promptly attempt to determine which insurer is at risk for the injury or occupational disease and contact that insurer. The department shall advise the insurer of the request for stay-at-work/return-to-work assistance and shall coordinate the assistance with the insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**History:** En. Sec. 17, Ch. 167, L. 2011.

**39-71-1043. Rehabilitation provider -- evaluation.** (1) Stay-at-work/return-to-work assistance must be provided by a rehabilitation provider pursuant to this section if:

(a) the department provides assistance; or

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

(2) (a) The rehabilitation provider shall evaluate and determine the stay-at-work/return-to-work capabilities of the worker pursuant to the stay-at-work/return-to-work goals listed in 39-71-1041.

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

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

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

(i) the worker has returned to work earning wages that are at least as much as at the time of injury;

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

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

(iv) the worker receives a job offer to return to work in a position that is within the worker's physical abilities, for which the worker is qualified, for which the wages are less than the worker's wages at the time of injury, and that qualifies the worker for temporary partial disability benefits under39-71-712.

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

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

**History:** En. Sec. 18, Ch. 167, L. 2011.

**39-71-1049. Stay-at-work/return-to-work assistance fund -- purpose -- payment process -- rulemaking.** (1) There is a stay-at-work/return-to-work assistance fund in the proprietary fund category.

(2) The purpose of the assistance fund is to pay for stay-at-work/return-to-work assistance

provided by the department so that assistance may be provided as early as practicable in the workers' compensation claims process.

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

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

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

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

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

**History:** En. Sec. 19, Ch. 167, L. 2011.

**39-71-1050. Assessment for stay-at-work/return-to-work assistance fund -- definition.** (1) (a) The assistance fund must be maintained by assessing employers insured by plan No. 1, plan No. 2, and plan No. 3 an amount as provided in subsections (2) through (10).

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

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

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

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

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

(6) Employers insured under plan No. 2 or plan No. 3 shall pay their portion of the

assessment in a surcharge on premiums for policies written or renewed annually on or after July 1.

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

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

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

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

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter no later than 20 days following the end of the quarter.

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

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

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

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

**History:** En. Sec. 20, Ch. 167, L. 2011.

**39-71-1051. Rulemaking authority.** The department may adopt rules to implement this part.

**History:** En. Sec. 21, Ch. 167, L. 2011.

## Part 11. Treatment by Designated Providers

**39-71-1101. Choice of health care provider by worker -- insurer designation or approval of treating physician or referral to managed care or preferred provider organization -- payment terms -- definition.** (1) Prior to the insurer's designation or approval of a treating physician as provided in subsection (2) or a referral to a managed care organization or preferred provider organization as provided in subsection (8), a worker may choose a person who is listed in 39-71-116(41) for initial treatment. Subject to subsection (2), if the person listed under 39-71-116(41) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician.

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

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

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

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

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

(3) The treating physician may refer the worker to other health care providers for medical services, as provided in 39-71-704, for the treatment of a worker's compensable injury or

occupational disease. A health care provider to whom the worker is referred by the designated treating physician is not responsible for coordinating care or providing determinations as required of the treating physician.

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

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

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

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

(8) The insurer may direct the worker to a managed care organization or a preferred provider organization for designation of the treating physician.

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

(10) After the date that a worker [whose injury is] subject to the provisions of subsection (9) receives individual written notice of a referral, the worker must, unless otherwise authorized by the insurer, receive medical services from the organization designated by the insurer, in accordance with39-71-1102 and 39-71-1104. The designated treating physician in the organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a health care provider who is not a member of a managed care organization or a preferred provider organization.

(11) Posting of managed care requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to a managed care organization must be provided to the worker in written form by mail or in person after the date of injury or occupational disease.

**History:** En. Sec. 5, Ch. 628, L. 1993; amd. Sec. 1, Ch. 468, L. 1999; amd. Sec. 24, Ch. 167, L. 2011.

**39-71-1102. Preferred provider organizations -- establishment -- limitations.** (1) In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish

arrangements with suppliers of soft and durable medical goods and health care providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that an injured worker is given an individual written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers.

(2) Posting of preferred provider requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to preferred providers must be provided to the worker in written form by mail or in person after the date of injury.

**History:** En. Sec. 6, Ch. 628, L. 1993; amd. Sec. 2, Ch. 468, L. 1999; amd. Sec. 25, Ch. 167, L. 2011.

**39-71-1103. Workers' compensation managed care.** (1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to 39-71-1101, through appropriate health care professionals.

(2) The department shall develop criteria pursuant to 39-71-1105 for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A worker who is subject to managed care may choose from managed care organizations in the worker's community that have a contract with the insurer responsible for the worker's medical services.

**History:** En. Sec. 7, Ch. 628, L. 1993.

**39-71-1104. Managed care organizations -- notification.** Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in 39-71-1105. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

**History:** En. Sec. 8, Ch. 628, L. 1993.

**39-71-1105. Managed care organizations -- application -- certification.** (1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to workers for injuries or occupational diseases that are covered under this chapter. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent

excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (4)(f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

**History:** En. Sec. 9, Ch. 628, L. 1993; amd. Sec. 28, Ch. 416, L. 2005.

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

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

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

(3) to provide access to health care information to health care providers, the insurer, or an agent of the insurer.

**History:** En. Sec. 10, Ch. 628, L. 1993; amd. Sec. 26, Ch. 167, L. 2011.

**39-71-1107. Domiciliary care -- requirements -- evaluation.** (1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the hourly mean wage by area for home health aides, as published by the department in the most recent edition of the Montana Informational Wage Rates by Occupation and adopted annually by the department prior to January 1. The insurer is not liable for more than 8 hours of care each day at the rate in effect at the time that the services are rendered.

**History:** En. Sec. 11, Ch. 628, L. 1993; amd. Sec. 8, Ch. 117, L. 2007.

**39-71-1108. Physician self-referral prohibition.** (1) Unless authorized by the insurer, a treating physician may not refer a claimant to a health care facility at which the physician does not directly provide care or services when the physician has an investment interest in the

facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer or the claimant is not liable for charges incurred in violation of this section.

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

**History:** En. Sec. 12, Ch. 628, L. 1993; amd. Sec. 18, Ch. 516, L. 1995.

**39-71-1110. Schedule II and III drugs -- prescriber obligation.** (1) In order to ensure high-quality health care for an individual with a compensable occupational injury or disease, prescriptions for Schedule II or Schedule III drugs identified in Title 50, chapter 32, part 2, may be carefully monitored for potential abuse, dependence, interaction, and diversion. Ongoing prescriptions for Schedule II and Schedule III drugs may be prescribed only by a treating physician.

(2) (a) A treating physician authorized to prescribe prescription drugs may query the prescription drug registry provided for in Title 37, chapter 7, part 15, prior to the initial prescribing or refilling of a Schedule II or Schedule III drug for treatment of a workers' compensation injury or occupational disease. After consulting the prescription drug registry, a treating physician may decline to prescribe or refill a Schedule II or Schedule III drug if, in the treating physician's judgment, the drug should not be prescribed or refilled.

(b) Prior to the initial prescribing of a Schedule II or Schedule III drug, a treating physician may discuss the risks and benefits of the use of the controlled substance, including risk of tolerance and drug dependence, with the patient or the patient's legal guardian.

(c) A treating physician shall note in the patient's medical file each query conducted.

(3) This section does not apply to a health care provider administering a Schedule II or Schedule III drug under the following circumstances:

(a) immediately prior to or after surgery;

(b) at the scene of an emergency;

(c) in a licensed ambulance; or

(d) in the emergency department or intensive care unit of a licensed hospital.

**History:** En. Sec. 1, Ch. 407, L. 2013.

Part 12 through 14 reserved .

**Part 15. Montana Safety Culture Act**

**39-71-1501. Short title.** This part may be cited as the "Montana Safety Culture Act".

**History:** En. Sec. 1, Ch. 295, L. 1993; amd. Sec. 1, Ch. 170, L. 2003.

**39-71-1502. Purpose.** The purpose of this part is to reduce the incidence of occupational injury and illness by promoting safety in the workplace in order to control the costs of claims for workers' compensation insurance. The creation of a safety culture requires employers to provide training and education to make safety awareness part of the requirement for each worker's satisfactory job performance and requires the department to promote safety awareness for the public through the education and preparation of each student for entrance into the labor market. A reduction in workplace injuries, illnesses, and deaths through enhanced safety on the job benefits the public as well as the employers and the employees by lowering both financial and physical costs. Ensuring immunity to insurers in the provision of safety consultation services encourages and promotes safety in the workplace and improves the relationship between employers and employees.

**History:** En. Sec. 2, Ch. 295, L. 1993; amd. Sec. 2, Ch. 170, L. 2003.

**39-71-1503. Safety consultation.** (1) As used in this part, "safety consultation services" means assistance rendered by an insurer or the department to advise and aid an employer in the identification, evaluation, and control of existing and potential accidental and occupational health problems. The services may be delivered in person, by mail, electronically, or by telephone, based upon need.

(2) Safety consultation services include but are not limited to:

(a) surveys consisting of onsite identification and subsequent evaluation of exposures relative to employees, materials, equipment, work methods, processes, and facilities;

(b) recommendations expressed in the form of communications to an employer, with reference to control of exposures to occupational accident, injury, or illness and to

improvement of safety programs and systems;

(c) education and training programs, including aids, programs, and materials made available to assist in the control of exposures;

(d) consultations to advise employers relative to risk, exposure, and experience in the employer's business;

(e) accident analysis consisting of review of reported accidents to determine cause and trends; and

(f) industrial hygiene services, including recognition, evaluation, and control of chemical, physical, and biological exposures.

**History:** En. Sec. 3, Ch. 295, L. 1993; amd. Sec. 3, Ch. 170, L. 2003; amd. Sec. 16, Ch. 27, L. 2009.

**39-71-1504. Safety programs -- educational activities.** (1) To promote health and safety in places of employment in this state:

(a) each public or private employer shall establish and administer a safety program in accordance with rules adopted by the department pursuant to 39-71-1505; and

(b) the department, relying upon the support and assistance of concerned private entities or other governmental agencies, shall produce and distribute material to the schools of Montana and provide guest speakers intended to:

(i) educate students about the necessity for safe work practices;

(ii) prepare students to embark on accident-free careers; and

(iii) disseminate information promoting the reduction and control of the rate of incidence of workplace injuries or occupational disease.

(2) An employer who employs temporary workers shall include those workers in the employer's safety program. A temporary services contractor shall provide a safety program for employees not employed by other employers.

(3) The department may issue a safety recommendation to an employer who fails to comply with the requirements of this section or with rules adopted by the department pursuant to 39-71-1505.

**History:** En. Sec. 4, Ch. 295, L. 1993; amd. Sec. 1, Ch. 58, L. 2001.

**39-71-1505. Rulemaking authority.** The department shall adopt rules, including but not limited to rules that require:

(1) each employer to conduct an educational-based safety program, including but not limited

to:

(a) a safety training program to provide:

(i) new employee general safety orientation;

(ii) job- or task-specific safety training; and

(iii) continuous refresher safety training, including periodic safety meetings;

(b) periodic hazard assessment, with corrective actions identified; and

(c) appropriate documentation of performance of the activities; and

(2) an employer of more than five employees to have a comprehensive and effective safety program, including but not limited to:

(a) subject to subsection (3), a safety committee composed of employee and employer representatives that holds regularly scheduled meetings;

(b) procedures of reporting and investigating all work-related incidents, accidents, injuries, and illnesses; and

(c) policies and procedures that assign specific safety responsibilities and safety performance accountability.

(3) The department may adopt rules authorizing:

(a) a plan No. 2 or plan No. 3 insurer to waive the requirement in subsection (2)(a) for a safety committee if the employer presents sufficient evidence of an effective written safety plan and has a satisfactory modification factor, if applicable, or has a low incident record of injuries; or

(b) the department to waive the requirement in subsection (2)(a) for a safety committee if a plan No. 1 insurer approved by the department presents sufficient evidence of an effective safety program, including a written safety plan. A waiver granted under this subsection (3)(b) to a member of the self-insurers guaranty fund must be made with the concurrence of the fund.

**History:** En. Sec. 5, Ch. 295, L. 1993; amd. Sec. 1, Ch. 238, L. 1995.

**39-71-1506. Notification of safety consultation services available by insurer.** To implement safety requirements, each insurer shall notify each insured employer of the type of safety consultation services available and the location where the safety consultation services may be requested.

**History:** En. Sec. 6, Ch. 295, L. 1993.

**39-71-1507. Safety consultation services -- safety program as provision of insurance contract or agreement.** (1) Each insurer shall provide safety consultation services to each of its

insured employers who request the assistance.

(2) The safety consultation services to be provided are within the discretion of the insurer but must include consideration of the hazard, experience, and size of the insured employer's operations.

(3) The insurer shall establish a system of priorities to use in responding to worksite safety consultation service requests, giving first priority to insured employers that have an unreasonably high actual or potential loss experience.

(4) Each insurer's insurance contract or agreement must require each insured employer to implement a safety program as part of the contract or agreement to provide workers' compensation coverage.

**History:** En. Sec. 7, Ch. 295, L. 1993.

**39-71-1508. Safety consultation services -- insurer's exemption from civil liability -- exceptions.** (1) The furnishing of or the failure to furnish safety consultation services related to, in connection with, or incidental to a workers' compensation insurance contract or agreement to provide workers' compensation coverage does not subject the insurer or its agents, employees, or service contractors to liability for damages from injury, loss, or death, whether direct or consequential, occurring as a result of any act or omission by any person in the course of providing safety consultation services.

(2) Subsection (1) does not apply:

(a) if the injury, loss, or death occurred during the actual performance of safety consultation services and was directly and proximately caused by the negligence of the insurer or its agents, employees, or service contractors;

(b) to any safety consultation services required to be performed under the provisions of a written service contract for which a specific charge is made and not incidental to a policy of insurance; or

(c) in an action against an insurer or its agents, employees, or service contractors for damages caused by the act or omission of the insurer or its agents, employees, or service contractors in which it is judicially determined that the act or omission constituted a crime or involved actual malice.

**History:** En. Sec. 9, Ch. 295, L. 1993.

Part 16 through 19 reserved .

**Part 20. Rehabilitation Benefits (Renumbered)**

**39-71-2001. Renumbered . 39-71-1006,** Code Commissioner, 1995.

**Part 21. Compensation Plan Number One**

**39-71-2101. General requirements for electing coverage under plan.** (1) An employer may elect to be bound by compensation plan No. 1 upon furnishing satisfactory proof to the department and the Montana self-insurers guaranty fund of solvency and financial ability to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably likely to be incurred during the fiscal year for which the election is effective. The employer may, by order of the department and with the concurrence of the guaranty fund, make the payments directly to employees as they become entitled to receive payments under the terms and conditions of this chapter.

(2) Employers who comply with the provisions of this chapter and who are participating in collectively bargained, jointly administered Taft-Hartley trust funds are eligible to provide self-insured workers' compensation benefits for their employees.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2970, R.C.M. 1921; re-en. Sec. 2970, R.C.M. 1935; amd. Sec. 2, Ch. 443, L. 1973; R.C.M. 1947, 92-901; amd. Sec. 81, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 163, L. 1991; amd. Sec. 7, Ch. 619, L. 1993.

**39-71-2102. Proof of solvency to be filed.** Each employer who has elected to be bound by compensation plan No. 1 shall file proof of solvency within the time and in the form prescribed by the rules or orders of the department.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2971, R.C.M. 1921; amd. Sec. 5, Ch. 139, L. 1931; re-en. Sec. 2971, R.C.M. 1935; amd. Sec. 3, Ch. 176, L. 1957; amd. Sec. 169, Ch. 147, L. 1963; amd. Sec. 1, Ch. 183, L. 1965; amd. Sec. 1, Ch. 170, L. 1969; amd. Sec. 1, Ch. 143, L. 1971; amd. Sec. 3, Ch. 443, L. 1973; amd. Sec. 2, Ch. 318, L. 1975; R.C.M. 1947, 92-902; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1549, Ch. 56, L. 2009.

**39-71-2103. Employer permitted to carry on business and settle directly with employee -- individual liability.** (1) If the employer making the election is found by the department and the Montana self-insurers guaranty fund to have the requisite financial ability to pay the compensation and benefits in this chapter, then the department, with the concurrence of the guaranty fund, shall grant to the employer permission to carry on business for the year within which the election is made and proof filed, or the remaining portion of the year, and to make payments directly to the employees as they may become entitled to receive the payments.

(2) Each individual employer in an association, corporation, limited liability company, or organization of employers given permission by the department to operate as self-insured under plan No. 1 of this chapter is jointly and severally liable for all obligations incurred by the association, corporation, limited liability company, or organization under this chapter. An association, corporation, limited liability company, or organization of employers given permission to operate as self-insured shall maintain excess liability coverage in amounts and under conditions as provided by rules of the department.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2972, R.C.M. 1921; re-en. Sec. 2972, R.C.M. 1935; amd. Sec. 51, Ch. 23, L. 1975; R.C.M. 1947, 92-903(part); amd. Sec. 2, Ch. 480, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 2, Ch. 163, L. 1991; amd. Sec. 19, Ch. 516, L. 1995.

**39-71-2104. Renewal of application.** An employer, so long as that employer continues to employ and continues to be bound by compensation plan No. 1, shall annually renew the application to be permitted to continue to make payments directly to employees for the next year. The department may, with the concurrence of the Montana self-insurers guaranty fund, renew the application from year to year. The annual renewal application must be in the form, for the period, and subject to the time limits prescribed by the department.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2972, R.C.M. 1921; re-en. Sec. 2972, R.C.M. 1935; amd. Sec. 51, Ch. 23, L. 1975; R.C.M. 1947, 92-903(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 3, Ch. 163, L. 1991; amd. Sec. 10, Ch. 555, L. 1993.

**39-71-2105. Additional proof of solvency -- revocation of order.** (1) The department, with the concurrence of the Montana self-insurers guaranty fund, may at any time require from any

employer acting under compensation plan No. 1 additional proof of solvency and financial ability to pay the benefits provided by this chapter.

(2) The department may, after providing an opportunity for an administrative review conference to consider information submitted by a plan No. 1 employer, revoke any order of approval upon 20 days' notice to the employer. A decision to revoke approval involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund. A plan No. 1 employer that is dissatisfied with the decision following the administrative review conference may appeal the decision and request a contested case hearing pursuant to 39-71-2401(2).

(3) A decision revoking an order of approval is final unless the employer files an appeal with the department within 20 days of the issuance of the notice. An employer may not continue to self insure after the 20-day period provided for in subsection (2) has expired unless the department is satisfied that the employer has provided sufficient security and financial ability to pay the benefits provided by this chapter. A decision issued pursuant to this subsection involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2973, R.C.M. 1921; re-en. Sec. 2973, R.C.M. 1935; amd. Sec. 52, Ch. 23, L. 1975; R.C.M. 1947, 92-904; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 150, L. 1993; amd. Sec. 7, Ch. 69, L. 2005.

**39-71-2106. Requiring security of employer.** (1) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require any employer who elects to be bound by compensation plan No. 1 to provide a security deposit in accordance with rules adopted by the department. All securities of the United States treasury must be in book-entry form. The security deposit may be a surety bond, government bond, certificate of deposit, or letter of credit approved by the department and the Montana self-insurers guaranty fund. For the first 3 years of operating as a self-insured employer, the employer's security deposit must be the greater of:

(i) $250,000; or

(ii) an average of the workers' compensation liabilities incurred by the employer in Montana for the first 3 of the last 4 completed calendar years.

(b) The department, with the concurrence of the Montana self-insurers guaranty fund, may, in accordance with rules adopted by the department, require a larger deposit as additional evidence of ability to pay the benefits provided by this chapter.

(c) The department may, with the concurrence of the Montana self-insurers guaranty fund, reduce the amount of the security deposit if the evidence indicates that the full amount of the deposit is unnecessary.

(2) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require an employer to give security in addition to the security deposit described in

subsection (1) if:

(i) the department, with the concurrence of the Montana self-insurers guaranty fund, determines that the employer lacks the ability to pay the benefits that are expected to be paid by the employer under the terms and conditions of this chapter that are chargeable to the employer during the year to be covered by the permission provided for in 39-71-2103; or

(ii) the employer is a group of individual employers seeking permission to operate under compensation plan No. 1.

(b) The additional security required in subsection (2)(a) must be an amount that the department, with the concurrence of the Montana self-insurers guaranty fund, finds reasonable and necessary to pay the benefits provided under the terms and conditions of this chapter that the employer may accrue during the year.

(3) (a) The security deposit provided for in subsection (1) must be deposited with the department. The security deposit may consist of:

(i) a bond executed to the department with a surety. The security deposit must state that the employer will pay or cause to be paid to employees the amount for which the employer was given permission under 39-71-2103 and for which the employer is liable under the terms and conditions of this chapter during the year.

(ii) any Montana state, county, municipal, or school district bonds that the department and the Montana self-insurers guaranty fund consider solvent; or

(iii) other security deposits allowed in subsection (1)(a).

(b) Each security deposit and the character and amount of the security deposit are subject to approval, revision, or change considered necessary by the department and the Montana self-insurers guaranty fund.

(c) Upon proof of the final payment of the liability for which the security deposit is given, the security deposit or any remainder of the security deposit must be returned to the depositor.

(d) Payment must be made from the security deposit within 30 days of a demand by the department for payment. If payment is not made within 30 days by the obligor on the security deposit, the obligor is liable to the department for interest at the annual rate of 10% on the amount unpaid.

(4) The department is liable for the value and safekeeping of all security deposits and shall, at any time, upon demand of the depositor, account for the security deposits.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2974, R.C.M. 1921; re-en. Sec. 2974, R.C.M. 1935; amd. Sec. 53, Ch. 23, L. 1975; R.C.M. 1947, 92-905; amd. Sec. 3, Ch. 480, L. 1985; amd. Sec. 51, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 120, L. 1991; amd. Sec. 9, Ch. 558, L. 1991; amd. Sec. 2, Ch. 150, L. 1993; amd. Sec. 11, Ch. 555, L. 1993; amd. Sec. 1, Ch. 83, L. 1995; amd. Sec. 9, Ch. 117, L. 2007.

**39-71-2107. When employer to make deposit or security to guarantee payment of compensation.** Within 30 days after the happening of an accident where death or the nature of

the injury renders the amount of future payments certain or reasonably certain, the employer shall make a deposit or give security, as herein defined, with the department for the protection and guaranty of the payment of such liability in such sum as the department may direct. However, if sufficient securities are already on deposit with the department or if the department determines that the employer has sufficient financial responsibility to meet the liability of the employer, together with other liabilities already accrued, no such additional deposit or security shall be demanded.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2976, R.C.M. 1921; re-en. Sec. 2976, R.C.M. 1935; amd. Sec. 55, Ch. 23, L. 1975; R.C.M. 1947, 92-907; amd. Sec. 64, Ch. 613, L. 1989.

**39-71-2108. Failure of employer to pay benefits -- duty of department.** Upon the failure of the employer to pay any benefits provided for in this chapter upon the terms, in the amounts, and at the times when the benefits become due and payable, the department shall, upon demand of the person to whom benefits are due, apply any deposits made with the department to the payment of the benefits, and the department shall take the proper steps to convert any securities on deposit with the department or sufficient deposits to pay the liabilities of the employer accruing under the terms of this chapter. The department shall, when necessary, collect and enforce the collection of the liability of all sureties upon any bonds that may be given by the employer to ensure the payment of the employer's liability. The department is considered the owner of the deposit and security and the obligee in the bond in trust for the purposes and may proceed in its own name to recover upon the bonds or foreclose and liquidate the securities. All interest earnings on liquidated security deposits must be retained by the department for payment of benefits pursuant to this section.

**History:** En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2975, R.C.M. 1921; re-en. Sec. 2975, R.C.M. 1935; amd. Sec. 54, Ch. 23, L. 1975; R.C.M. 1947, 92-906; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 69, L. 2005.

**39-71-2115. Transfer of claim liabilities -- rules.** (1) A current or former self-insurer or group may transfer existing workers' compensation claim liabilities to another entity upon authorization from the department and concurrence of the Montana self-insurers guaranty fund by:

(a) submitting an application on a form designated by the department;

(b) completing an agreement of assumption and guarantee of workers' compensation liabilities;

(c) submitting a loss portfolio transfer agreement; and

(d) posting a security deposit.

(2) If the assuming entity fails to meet the terms of the transfer agreement, liability reverts to the original self-insurer.

(3) The entity assuming liability for a claim shall comply with all reporting requirements set by the department.

(4) The department shall adopt rules to implement this section.

**History:** En. Sec. 2, Ch. 112, L. 2009.

## Part 22. Compensation Plan Number Two

**39-71-2201. Election to be bound by plan -- captive reciprocal insurers.** (1) Any employer except those specified in 39-71-403 may, by filing an election to become bound by compensation plan No. 2, insure the employer's liability to pay the compensation and benefits provided by this chapter with any insurance company authorized to transact such business in this state.

(2) Any employer electing to become bound by compensation plan No. 2 shall make the election on the form and in the manner prescribed by the department.

(3) A captive reciprocal insurer established by or on behalf of an employer or a group of employers is considered to be a compensation plan No. 2 insurer. Pursuant to 33-28-205, a captive reciprocal insurer may not be a member of an insurance guaranty association or guaranty fund.

**History:** (1)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2978, R.C.M. 1921; re-en. Sec. 2978, R.C.M. 1935; amd. Sec. 1, Ch. 49, L. 1961; Sec. 92-1001, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; Sec. 92-1002, R.C.M. 1947; R.C.M. 1947, 91-1001, 92-1002(1); amd. Sec. 82, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 117, L. 2007.

**39-71-2202. Policies made subject to chapter.** Every policy for insurance written under compensation plan No. 2 shall be considered to be made subject to the provisions of this chapter.

**History:** En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2982, R.C.M. 1921; re-en. Sec. 2982, R.C.M. 1935; amd. Sec. 1, Ch. 217, L. 1951; amd. Sec. 5, Ch. 176, L. 1957; amd. Sec. 1, Ch. 203, L. 1959; amd. Sec. 170, Ch. 147, L. 1963; amd. Sec. 1, Ch. 142, L. 1971; amd. Sec. 59, Ch. 23, L. 1975; amd. Sec. 3, Ch. 318, L. 1975; R.C.M. 1947, 92-1005; amd. Sec. 13, Ch. 103, L. 1979.

**39-71-2203. Content of policies -- policies subject to approval, change, or revision by department.** (1) All policies insuring the payment of compensation under this chapter must contain a clause to the effect that, as between the employee and the insurer:

(a) the notice to or knowledge of the occurrence of the injury on the part of the insured constitutes notice or knowledge, as the case may be, on the part of the insurer;

(b) jurisdiction of the insured for the purpose of this chapter is the jurisdiction of the insurer; and

(c) the insurer is in all things bound by and subject to the awards, orders, judgments, or decrees rendered against the insured.

(2) A policy may not be issued unless it contains the agreement of the insurer that it will promptly pay to the person entitled to compensation all the installments of compensation or other payments provided for in this chapter and that the obligation is not affected by any default of the insured after the injury or by any default in the giving of any notice required by the policy or by this chapter or otherwise. The agreement must be construed to be a direct promise by the insured to the person entitled to compensation.

(3) Every policy or contract insuring against liability for compensation under compensation plan No. 2 must contain a clause to the effect that the insurer is directly and primarily liable to and will pay directly to the employee or in case of death to the employee's beneficiaries or major or minor dependents the compensation, if any, for which the employer is liable.

(4) Every policy must at all times be subject to approval, change, or revision by the department and must contain the clauses, agreements, and promises required by this chapter.

(5) All Montana operations of an employer, as defined in 39-71-117, covered under plan No. 2 must be insured by the same insurer.

**History:** (1)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2980, R.C.M. 1921; amd. Sec. 6, Ch. 139, L. 1931; re-en. Sec. 2980, R.C.M. 1935; amd. Sec. 4, Ch. 176, L. 1957; Sec. 92-1003, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; amd. Sec. 10, Ch. 100, L. 1919; re-en. Sec. 2981, R.C.M. 1921; amd. Sec. 11, Ch. 177, L. 1929; re-en. Sec. 2981, R.C.M. 1935; amd. Sec. 1, Ch. 141, L. 1971; amd. Sec. 58, Ch. 23, L. 1975; Sec. 92-1004, R.C.M. 1947; (3), (4)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2988, R.C.M. 1921; re-en. Sec. 2988, R.C.M. 1935; Sec. 92-1011, R.C.M. 1947; R.C.M.

1947, 92-1003, 92-1004(part), 92-1011; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 9, Ch. 69, L. 2005.

**39-71-2204. Insurer to submit notice of coverage within 30 days -- penalty for failure.** (1) The insurer shall, within 30 days after the issuance of a policy of workers' compensation insurance, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information that may be required by the department. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

(b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the insurer's notice of coverage.

(3) The department may, in its discretion, assess a penalty of not more than $200 against an insurer that does not comply with the 30-day notice requirement set forth in subsection (1). The penalty may be assessed for each policy that is not reported to the department in a timely manner.

**History:** En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; R.C.M. 1947, 92-1002(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 12, Ch. 555, L. 1993; amd. Sec. 25, Ch. 186, L. 1995; amd. Sec. 14, Ch. 214, L. 2001; amd. Sec. 10, Ch. 69, L. 2005; amd. Sec. 11, Ch. 117, L. 2007.

**39-71-2205. Policy in effect until canceled or replaced -- 20-day notification of cancellation required -- penalty.** (1) The policy remains in effect until canceled, and cancellation may take effect only by written notice to the named insured and to the department at least 20 days prior to the date of cancellation. However, the policy terminates on the effective date of a replacement or succeeding workers' compensation insurance policy issued to the insured. Nothing in this section prevents an insurer from canceling a policy of workers' compensation insurance before a replacement policy is issued to the insured. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the insurer's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against an insurer that does not comply with the notice requirement in subsection (1). The penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

(b) An insurer may contest the penalty assessment in a hearing conducted according to department rules.

**History:** En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; R.C.M. 1947, 92-1002(part); amd. Sec. 1, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 13, Ch. 555, L. 1993; amd. Sec. 26, Ch. 186, L. 1995; amd. Sec. 15, Ch. 214, L. 2001; amd. Sec. 11, Ch. 69, L. 2005; amd. Sec. 12, Ch. 117, L. 2007.

**39-71-2211. Premium rates for construction industry -- filing required.** (1) With respect to each classification of risk in the construction industry under plan No. 2, the advisory organization designated under 33-16-1023 shall file with the commissioner of insurance a method of computing premiums that does not impose a higher insurance premium solely because of an employer's higher rate of wages paid.

(2) The commissioner shall accept a filing under subsection (1) that includes a reasonable method of recognizing differences in rates of pay. This method must use a credit scale with the starting point set at 1.168 times the state's average weekly wage as reported by the department.

(3) The advisory organization shall file a revenue neutral plan for new and renewed policies for prompt and orderly transition to a method of computing premiums that is in compliance with the requirements of this section.

(4) The state compensation insurance fund, plan No. 3, shall adopt the plan filed by the designated advisory organization or adopt a credit scale plan that meets the requirements of this section.

**History:** En. Sec. 3, Ch. 480, L. 1991; amd. Sec. 1, Ch. 224, L. 1993; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 27, Ch. 186, L. 1995; amd. Sec. 1, Ch. 131, L. 1999; amd. Sec. 8, Ch. 26, L. 2005.

**39-71-2215. Security deposit to ensure payment of liability of plan No. 2 insurer.** (1) Except as provided in subsection (7), a plan No. 2 insurer issuing or renewing a policy on or after

January 1, 2008, shall post a security deposit with the department as provided by this section. The purpose of the security deposit is to provide a ready source of funds to pay claims arising under this chapter if the plan No. 2 insurer:

(a) becomes insolvent;

(b) is placed in receivership;

(c) declares bankruptcy;

(d) seeks protection from its creditors; or

(e) is otherwise unwilling or unable to pay its liabilities arising under this chapter.

(2) The amount of the security deposit, which is subject to the discretion of the department, must be in an amount from $25,000 to $250,000. The security deposit must be posted in the form of:

(a) a certificate of deposit;

(b) a United States treasury note; or

(c) an irrevocable letter of credit.

(3) If a plan No. 2 insurer fails to discharge any determined liability within the time set by the department, the department may convert the security deposit to cash and use the proceeds to pay the liability. Upon the conversion, the plan No. 2 insurer shall immediately furnish additional security to the department in an amount determined by the department to provide reasonable assurance that all current and future liabilities incurred by the plan No. 2 insurer as a result of the coverage provided under this chapter can be fully paid.

(4) (a) The security deposit required by this section is the property of the department and is held in trust by the department for the payment of the liabilities of the plan No. 2 insurer incurred under this chapter.

(b) Any earnings made by the security deposit accrue to the insurer.

(c) Upon proof of final payment of all liabilities incurred under this chapter, the unexpended portion of the security deposit must be discharged and any proceeds remaining are payable to the plan No. 2 insurer.

(5) In the event of the insolvency of a plan No. 2 insurer, the department may, in its discretion, release part or all of the security deposit to the Montana insurance guaranty association, provided for in 33-10-103, for payment of the plan No. 2 insurer's Montana workers' compensation claims if:

(a) the plan No. 2 insurer has been determined to be insolvent by a court of competent jurisdiction or is the debtor in a bankruptcy proceeding;

(b) the plan No. 2 insurer is unable to pay its workers' compensation claims; and

(c) the plan No. 2 insurer's Montana workers' compensation liabilities have become the responsibility of the Montana insurance guaranty association.

(6) The department is authorized to share information and coordinate its actions with the Montana insurance commissioner and other appropriate regulatory agencies with respect to actions taken pursuant to this section.

(7) A captive reciprocal insurer specified in 39-71-2201 is not subject to this section.

**History:** En. Sec. 15, Ch. 117, L. 2007; amd. Sec. 3, Ch. 150, L. 2011.

**Part 23. Compensation Plan Number Three**

**39-71-2311. Intent and purpose of plan -- expense constant defined.** (1) It is the intent and purpose of the state fund to allow employers an option to insure their liability for workers' compensation and occupational disease coverage with the state fund. The state fund must be neither more nor less than self-supporting. Premium rates must be set at least annually at a level sufficient to ensure the adequate funding of the insurance program, including the costs of administration, benefits, and adequate reserves, during and at the end of the period for which the rates will be in effect. In determining premium rates, the state fund shall make every effort to adequately predict future costs. When the costs of a factor influencing rates are unclear and difficult to predict, the state fund shall use a prediction calculated to be more than likely to cover those costs rather than less than likely to cover those costs. The prediction must take into account the goal of pooling risk and may not place an undue burden on employers that are not eligible for the tier with the lowest-rated premium for workers' compensation purposes.

(2) Unnecessary surpluses that are created by the imposition of premiums found to have been set higher than necessary because of a high estimate of the cost of a factor or factors may be refunded by the declaration of a dividend as provided in this part. For the purpose of keeping the state fund solvent, the board of directors may implement multiple rating tiers as provided in 39-71-2330 and may assess an expense constant, a minimum premium, or both.

(3) As used in this section, "expense constant" means a premium charge applied to each workers' compensation policy to pay expenses related to issuing, servicing, maintaining, recording, and auditing the policy.

**History:** En. Sec. 1, Ch. 613, L. 1989; amd. Sec. 7, Ch. 4, Sp. L. May 1990; amd. Sec. 6, Ch. 323, L. 1991; amd. Sec. 12, Ch. 295, L. 1993; amd. Sec. 1, Ch. 305, L. 1995; amd. Sec. 7, Ch. 314, L. 2001; amd. Sec. 3, Ch. 218, L. 2009.

**39-71-2312. Definitions.** Unless the context requires otherwise, in this part the following definitions apply:

(1) "Board" means the board of directors of the state compensation insurance fund provided for in 2-15-1019.

(2) "Executive director" means the chief executive officer of the state compensation insurance fund.

(3) "State fund" means the state compensation insurance fund provided for in 39-71-2313. It is also known as compensation plan No. 3 or plan No. 3.

**History:** En. Sec. 2, Ch. 613, L. 1989; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 9, Ch. 26, L. 2005.

**39-71-2313. State compensation insurance fund created -- obligation to insure.** (1) There is a state compensation insurance fund known as the state fund that is a nonprofit, independent public corporation established for the purpose of allowing an option for employers to insure their liability for workers' compensation and occupational disease coverage under this chapter.

(2) The state fund is required to insure any employer in this state who requests coverage, and it may not refuse to provide coverage unless an employer or the employer's principals have defaulted on a state fund obligation and the default remains unsatisfied.

**History:** En. Sec. 4, Ch. 613, L. 1989; amd. Sec. 8, Ch. 4, Sp. L. May 1990; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 2, Ch. 305, L. 1995.

**39-71-2314. State fund subject to laws applying to state agencies.** The state fund is subject to laws that generally apply to state agencies, including but not limited to Title 2, chapters 2, 3, 4 (only as provided in 39-71-2316), and 6, and Title 5, chapter 13. The state fund is not exempt from a law that applies to state agencies unless that law specifically exempts the state fund by name and clearly states that it is exempt from that law.

**History:** En. Sec. 10, Ch. 613, L. 1989; amd. Sec. 9, Ch. 4, Sp. L. May 1990; amd. Sec. 3, Ch. 630, L. 1993; amd. Sec. 11, Ch. 310, L. 1997.

**39-71-2315. Management of state fund -- powers and duties of the board -- business plan required.** (1) The management and control of the state fund is vested solely in the board.

(2) The board is vested with full power, authority, and jurisdiction over the state fund. The board may perform all acts necessary or convenient in the exercise of any power, authority, or jurisdiction over the state fund, either in the administration of the state fund or in connection with the insurance business to be carried on under the provisions of this part, as fully and

completely as the governing body of a private mutual insurance carrier, in order to fulfill the objectives and intent of this part. Bonds may not be issued by the board, the state fund, or the executive director.

(3) The board shall adopt a business plan no later than June 30 for the next fiscal year. At a minimum, the plan must include:

(a) specific goals for the fiscal year for financial performance. The standard for measurement of financial performances must include an evaluation of premium to surplus.

(b) specific goals for the fiscal year for operating performance. Goals must include but not be limited to specific performance standards for staff in the area of senior management, underwriting, and claims administration. Goals must, in general, maximize efficiency, economy, and equity as allowed by law.

(4) The business plan must be available upon request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(5) No sooner than July 1 or later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board shall publish, by November 30 of each year, a report of the state fund's actual performance as compared to the business plan.

(6) The state fund board of directors shall establish in-house guidelines for procurement of insurance-related services and shall include guidelines for the solicitation of submissions of information regarding insurance-related services from more than one vendor. The board may include guidelines for the circumstances when business necessity or expedience may preclude the solicitation of submissions from more than one vendor. The board may also include in the guidelines the exemptions to the procurement process in 18-4-132.

**History:** En. Sec. 5, Ch. 613, L. 1989; amd. Sec. 10, Ch. 4, Sp. L. May 1990; amd. Sec. 19, Ch. 619, L. 1993; amd. Sec. 2, Ch. 407, L. 1999.

**39-71-2316. Powers of state fund.** (1) For the purposes of carrying out its functions, the state fund may:

(a) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, as part of the coverage, provide related employers' liability insurance upon approval of the board;

(b) sue and be sued;

(c) enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(d) collect and disburse money received;

(e) adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may be adopted and changed only by using a process, a procedure, formulas, and factors set forth in

rules adopted under Title 2, chapter 4, parts 2 through 4. After the rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate. The state fund is required to belong to a licensed workers' compensation advisory organization or a licensed workers' compensation rating organization under Title 33, chapter 16, part 4, and may use the classifications of employment adopted by the designated workers' compensation advisory organization, as provided in Title 33, chapter 16, part 10, and corresponding rates as a basis for setting its own rates. Except as provided in Title 33, chapter 16, part 10, a workers' compensation advisory organization or a licensed workers' compensation rating organization under Title 33, chapter 16, part 4, or other person may not, without first obtaining the written permission of the employer, use, sell, or distribute an employer's specific payroll or loss information, including but not limited to experience modification factors.

(f) pay the amounts determined to be due under a policy of insurance issued by the state fund;

(g) hire personnel;

(h) declare dividends if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside.

(i) adopt and implement one or more alternative personal leave plans pursuant to 39-71-2328;

(j) upon approval of the board, contract with licensed resident insurance producers;

(k) upon approval of the board, enter into agreements with licensed workers' compensation insurers, insurance associations, or insurance producers to provide workers' compensation coverage in other states to Montana-domiciled employers insured with the state fund;

(l) upon approval of the board, expend funds for scholarship, educational, or charitable purposes;

(m) upon approval of the board, including terms and conditions, provide employers coverage under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901, et seq., the federal Merchant Marine Act, 1920 (Jones Act), 46 U.S.C. 688, and the federal Employers' Liability Act, 45 U.S.C. 51, et seq.;

(n) perform all functions and exercise all powers of a private insurance carrier that are necessary, appropriate, or convenient for the administration of the state fund.

(2) The state fund shall include a provision in every policy of insurance issued pursuant to this part that incorporates the restriction on the use and transfer of money collected by the state fund as provided for in 39-71-2320.

**History:** En. Sec. 8, Ch. 613, L. 1989; amd. Sec. 11, Ch. 4, Sp. L. May 1990; amd. Sec. 4, Ch. 630, L. 1993; amd. Sec. 28, Ch. 186, L. 1995; amd. Sec. 3, Ch. 305, L. 1995; amd. Secs. 15, 16, Ch. 276, L. 1997; amd. Sec. 8, Ch. 314, L. 2001; amd. Sec. 1, Ch. 603, L. 2003; amd. Sec. 51, Ch. 130, L. 2005.

**39-71-2317. Appointment of executive director -- management staff.** The board shall appoint an executive director of the state fund who has general responsibility for the operations of the state fund. The executive director must have executive level experience, with knowledge of the insurance industry. The executive director must receive compensation as set by the board and serve at the pleasure of the board. The executive director may hire the management staff of the state fund, each of whom serves at the pleasure of the executive director.

**History:** En. Sec. 7, Ch. 613, L. 1989.

**39-71-2318. Personal liability excluded.** The members of the board, the executive director, and employees of the state fund are not liable personally, either jointly or severally, for any debt or obligation created or incurred by the state fund.

**History:** En. Sec. 6, Ch. 613, L. 1989.

**39-71-2319. Assets and liabilities of prior state fund.** All assets and funds held by the state compensation insurance fund established in former 39-71-2301, 39-71-2302, 39-71-2304 through 39-71-2306, and 39-71-2324 and 39-71-2321 through 39-71-2323, 39-71-2325 through 39-71-2327,39-71-2336, 39-71-2339, and 39-71-2340 must be transferred to the state fund, and the state fund shall assume liability for all outstanding claims and indebtedness of the previously existing state fund.

**History:** En. Sec. 11, Ch. 613, L. 1989.

**39-71-2320. Property of state fund -- investment required -- exception.** All premiums and other money paid to the state fund, all property and securities acquired through the use of money belonging to the state fund, and all interest and dividends earned upon money belonging to the state fund are the sole property of the state fund and must be used exclusively for the operations and obligations of the state fund. The money collected by the state fund for claims for injuries occurring on or after July 1, 1990, may not be used for any other purpose and may not be transferred by the legislature to other funds or used for other programs. However,

state fund money must be invested by the board of investments provided for in 2-15-1808, and subject to the investment agreement with the board of investments, the earnings on investments are the sole property of the state fund as provided in this section.

**History:** En. Sec. 9, Ch. 613, L. 1989; amd. Sec. 3, Ch. 424, L. 1995; amd. Sec. 17, Ch. 276, L. 1997; amd. Sec. 2, Ch. 603, L. 2003.

**39-71-2321. What to be deposited in state fund.** (1) All premiums, penalties, recoveries by subrogation, interest earned upon money belonging to the state fund, securities acquired by or through use of money, and all interest and penalties on taxes in accordance with 17-2-124 must be deposited in the state fund. Except for a transfer authorized under 39-71-2352, the money must be separated into two accounts based upon whether they relate to claims for injuries resulting from accidents that occurred before July 1, 1990, or claims for injuries resulting from accidents that occur on or after that date.

(2) All funds deposited in the state fund may be spent as provided in 17-8-101(2)(b).

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2993, R.C.M. 1921; re-en. Sec. 2993, R.C.M. 1935; amd. Sec. 4, Ch. 123, L. 1957; amd. Sec. 176, Ch. 147, L. 1963; amd. Sec. 22, Ch. 329, L. 1969; amd. Sec. 69, Ch. 23, L. 1975; amd. Sec. 1, Ch. 171, L. 1975; R.C.M. 1947, 92-1105(2); amd. Sec. 5, Ch. 283, L. 1983; amd. Sec. 32, Ch. 613, L. 1989; amd. Sec. 12, Ch. 4, Sp. L. May 1990; amd. Sec. 4, Ch. 797, L. 1991; amd. Sec. 10, Ch. 630, L. 1993; amd. Secs. 18, 19, Ch. 276, L. 1997; amd. Sec. 6, Ch. 184, L. 1999; amd. Sec. 21, Ch. 389, L. 1999; amd. Sec. 26, Ch. 475, L. 2007.

**39-71-2322. Money in state fund held in trust -- disposition of funds upon repeal of chapter.** The money coming into the state fund must be held in trust for the purpose for which the money was collected. If this chapter is repealed, the money is subject to the disposition provided by the legislature repealing this chapter. In the absence of a legislative provision, distribution must be in accordance with the justice of the matter, due regard being given to obligations of compensation incurred and existing.

**History:** En. Sec. 24, Ch. 96, L. 1915; re-en. Sec. 2966, R.C.M. 1921; re-en. Sec. 2966, R.C.M. 1935; amd. Sec. 168, Ch. 147, L. 1963; R.C.M. 1947, 92-840; amd. Sec. 6, Ch. 283, L. 1983; amd. Sec. 33, Ch. 613, L. 1989; amd. Sec. 20, Ch. 276, L. 1997; amd. Sec. 3, Ch. 603, L. 2003.

**39-71-2323. Surplus in state fund -- payment of dividends.** Subject to the provisions of 39-71-2316, if at the end of any fiscal year there exists in the state fund account created by 39-71-2321 for claims for injuries resulting from accidents that occur on or after July 1, 1990, an excess of assets over liabilities, including necessary reserves and an appropriate surplus as determined by the board in accordance with 39-71-2330, and if the excess may be refunded safely, then the board, after consultation with the independent actuary engaged pursuant to 39-71-2330, may declare a dividend. The rules of the state fund must prescribe the manner of payment to those employers who have paid premiums into the state fund in excess of liabilities.

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2998, R.C.M. 1921; re-en. Sec. 2998, R.C.M. 1935; amd. Sec. 6, Ch. 123, L. 1957; amd. Sec. 180, Ch. 147, L. 1963; amd. Sec. 72, Ch. 23, L. 1975; R.C.M. 1947, 92-1110; amd. Sec. 7, Ch. 283, L. 1983; amd. Sec. 34, Ch. 613, L. 1989; amd. Sec. 13, Ch. 4, Sp. L. May 1990; amd. Sec. 5, Ch. 630, L. 1993; amd. Sec. 3, Ch. 407, L. 1999.

**39-71-2325. State fund to keep accounts of segregations.** The state fund shall keep an accurate account of all the segregations of the state fund and shall divert from the fund any sums necessary to meet monthly payments, pending the conversion into cash of any security, and in such case shall repay the same out of the cash realized from the security.

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3001, R.C.M. 1921; re-en. Sec. 3001, R.C.M. 1935; amd. Sec. 187, Ch. 147, L. 1963; amd. Sec. 74, Ch. 23, L. 1975; R.C.M. 1947, 92-1113; amd. Sec. 9, Ch. 283, L. 1983; amd. Sec. 35, Ch. 613, L. 1989.

**39-71-2327. Earnings of state fund to be credited to fund -- improper use a felony.** All earnings made by the state fund by reason of interest paid for the deposit of funds or otherwise must be credited to and become a part of the fund, and the making of profit, either directly or indirectly, by any person out of the use of the fund is a felony. A person convicted of an offense under this section is punishable by imprisonment in the state prison for a term not to exceed 2 years or a fine of not more than $5,000, or both.

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3011, R.C.M. 1921; re-en. Sec. 3011, R.C.M 1935; amd. Sec. 185, Ch. 147, L. 1963; amd. Sec. 82, Ch. 23, L. 1975; R.C.M. 1947, 92-1123; amd.

Sec. 11, Ch. 283, L. 1983; amd. Sec. 36, Ch. 613, L. 1989; amd. Sec. 21, Ch. 276, L. 1997; amd. Sec. 4, Ch. 603, L. 2003.

**39-71-2328. State fund alternative personal leave plan -- exception -- collective bargaining negotiation -- personal leave definition.** (1) Except as provided in subsection (2), the state fund, after consultation with the department of administration, may develop an alternative personal leave plan for all state compensation insurance fund employees. The number of days and the rate at which the number of days are earned for the alternative personal leave plan must be the same as the combined total of days provided for in 2-18-612 and 2-18-618. Prior to implementation, the alternative personal leave plan must be adopted by the board and the board may adopt changes to the plan.

(2) The state fund, after consultation with the department of administration, may develop one or more alternative personal leave plans for some or all of its employees or may choose to develop an alternative personal leave plan for a particular class of employees or work unit.

(3) To the extent that an alternative personal leave plan applies to an employee who is a member of a collective bargaining unit, the implementation of the personal leave plan is subject to negotiation under 39-31-305.

(4) As used in this section, "personal leave" means all leave provided to an employee under the provisions of Title 2, chapter 18, part 6.

**History:** En. Sec. 1, Ch. 314, L. 2001.

**39-71-2330. Rate setting -- surplus -- multiple rating tiers.** (1) The board has the authority to establish the rates to be charged by the state fund for insurance. The board shall engage the services of an independent actuary who is a member in good standing with the American academy of actuaries to develop and recommend actuarially sound rates. Rates must be set at amounts sufficient, when invested, to carry the estimated cost of all claims to maturity, to meet the reasonable expenses of conducting the business of the state fund, and to amass and maintain an excess of surplus over the amount produced by the national association of insurance commissioners' risk-based capital requirements for a casualty insurer.

(2) Because surplus is desirable in the insurance business, the board shall annually determine the level of surplus that must be maintained by the state fund pursuant to this section, but shall maintain a minimum surplus of 25% of annual earned premium. The state fund shall use the amount of the surplus above the risk-based capital requirements to secure the state fund against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements.

(3) The board may implement multiple rating tiers for classifications that take into consideration losses, premium size, and other factors relevant in placing an employer within a rating tier.

**History:** En. Sec. 7, Ch. 630, L. 1993; amd. Sec. 4, Ch. 407, L. 1999; amd. Sec. 9, Ch. 314, L. 2001

**39-71-2331. Workplace safety program.** (1) An employer that is not eligible for the tier with the lowest-rated premium for workers' compensation purposes is eligible to join a state fund pooled risk safety group, as provided in 39-71-2332, if the employer:

(a) adopts and maintains a written, comprehensive workplace safety program that has been in place for more than 1 year and that meets the criteria established by rule implementing Title 39, chapter 71, part 15;

(b) adopts transitional and return-to-work programs;

(c) has at least 3 years of experience without losses;

(d) uses available safety consultation services or programs offered by the department or the state fund. Safety consultation may be provided to individual employers or to groups. The department and the state fund shall notify each employer in a group, as provided in 39-71-2332, regarding the availability of safety and return-to-work resources.

(e) complies with the terms and conditions of the state fund pooled risk safety group as provided in 39-71-2332.

(2) The state fund and the department shall share information on workplace safety programs and transitional and return-to-work programs.

**History:** En. Sec. 1, Ch. 218, L. 2009.

**39-71-2332. Pooled risk safety group.** (1) The state fund may establish one or more groups of individual policies in a pooled risk safety group to promote safety as a way to reduce losses among members of the pooled risk safety group.

(2) Each member of a pooled risk safety group must be eligible as provided in 39-71-2331 and must have an individual workers' compensation plan No. 3 policy. An individual policy may be included in only one group.

(3) The state fund shall annually establish the terms and conditions of the plan that defines the requirements of participation for a pooled risk safety group. The plan must include the criteria to be eligible for an aggregate return of premium and a method for apportioning the return of premium among members of the group.

(4) The aggregate record of the individual members of the pooled risk safety group is the basis for determining if the members of the pooled risk safety group qualify for a return on premiums.

**History:** En. Sec. 2, Ch. 218, L. 2009.

**39-71-2336. Manner of electing -- contract or policy of insurance -- payment of premium.** The state fund shall prescribe the procedure by which an employer may elect to be bound by compensation plan No. 3, the effective time of the election, and the manner in which the election is terminated for reasons other than default in payment of premiums. Every employer electing to be bound by compensation plan No. 3 must receive from the state fund a contract or policy of insurance in a form approved by the department. All Montana operations of an employer, as defined in 39-71-117, covered by compensation plan No. 3 must be insured by the state compensation insurance fund. The premium must be paid by the employer to the state fund at times that the state fund prescribes and must be paid over by the state fund to the state treasurer to the credit of the state fund.

**History:** En. Sec. 40, Ch. 96, L. 1915; amd. Sec. 6, Ch. 196, L. 1921; re-en. Sec. 2991, R.C.M. 1921; re-en. Sec. 2991, R.C.M. 1935; amd. Sec. 2, Ch. 123, L. 1957; amd. Sec. 178, Ch. 147, L. 1963; amd. Sec. 2, Ch. 233, L. 1969; amd. Sec. 67, Ch. 23, L. 1975; R.C.M. 1947, 92-1103; amd. Sec. 3, Ch. 283, L. 1983; amd. Sec. 29, Ch. 613, L. 1989; Sec.39-71-2303, MCA 1987; redes. 39-71-2336 by Code Commissioner, 1989; amd. Sec. 12, Ch. 69, L. 2005.

**39-71-2337. State fund to submit notice of coverage within 30 days -- penalty for failure.** (1) The state fund shall, within 30 days after the issuance of an insurance policy, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information the department requires. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the state fund's notice of coverage.

(3) The department may assess a penalty of not more than $200 against the state fund if the

state fund does not comply with the 30-day notice requirement. The penalty may be assessed for each policy that is not reported to the department in a timely manner.

**History:** En. Sec. 44, Ch. 613, L. 1989; amd. Sec. 16, Ch. 214, L. 2001; amd. Sec. 13, Ch. 69, L. 2005; amd. Sec. 13, Ch. 117, L. 2007.

**39-71-2339. Cancellation of coverage -- 20-day notice required.** (1) The state fund may cancel an employer's coverage under this part for failure to report payroll or pay the premiums due or for another cause provided in the insurance policy. Cancellation may take effect only by written notice to the named insured and the department at least 20 days prior to the date of cancellation or, in cases of nonreporting of payroll or nonpayment of a premium, by failure of the employer to submit payroll reports or pay a premium within 20 days after the due date. The state fund shall notify the department of the names and effective dates of all policies canceled. However, the policy terminates on the effective date of a replacement or succeeding insurance policy issued to the insured. This section does not prevent the state fund from canceling an insurance policy before a replacement policy is issued to the insured. After the cancellation date, the employer has the same status as an employer who is not enrolled under the Workers' Compensation Act unless a replacement or succeeding insurance policy has been issued. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the state fund's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against the state fund if it does not comply with the notice requirement in subsection (1).

(b) The penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

(c) The state fund may contest the penalty assessment in a hearing conducted according to department rules.

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3002, R.C.M. 1921; amd. Sec. 1, Ch. 201, L. 1935; re-en. Sec. 3002, R.C.M. 1935; amd. Sec. 10, Ch. 235, L. 1947; amd. Sec. 7, Ch. 123, L. 1957; amd. Sec. 181, Ch. 147, L. 1963; amd. Sec. 75, Ch. 23, L. 1975; amd. Sec. 1, Ch. 225, L. 1975; R.C.M. 1947, 92-1114(part); amd. Sec. 30, Ch. 613, L. 1989; Sec. 39-71-2307, MCA 1987; redes. 39-71-2339 by Code Commissioner, 1989; amd. Sec. 7, Ch. 323, L. 1991; amd. Sec. 4, Ch. 305, L. 1995; amd. Sec. 17, Ch. 214, L. 2001; amd. Sec. 14, Ch. 69, L. 2005; amd. Sec. 23, Ch. 112, L. 2009.

**39-71-2340. Collection in case of default.** (1) If an employer under plan No. 3 defaults in any payment to the state fund, the state fund may collect the sum due in a civil action in the name of the state. The right of action is cumulative.

(2) If an employer's right to operate has been canceled by the state fund for failure to pay premiums and the state fund finds that the property and assets of the employer are not sufficient to pay the premiums, the state fund may compromise the claim for premiums and accept a payment of an amount less than the total amount due.

**History:** En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3002, R.C.M. 1921; amd. Sec. 1, Ch. 201, L. 1935; re-en. Sec. 3002, R.C.M. 1935; amd. Sec. 10, Ch. 235, L. 1947; amd. Sec. 7, Ch. 123, L. 1957; amd. Sec. 181, Ch. 147, L. 1963; amd. Sec. 75, Ch. 23, L. 1975; amd. Sec. 1, Ch. 225, L. 1975; R.C.M. 1947, 92-1114(part); amd. Sec. 31, Ch. 613, L. 1989; Sec. 39-71-2308, MCA 1987; redes. 39-71-2340 by Code Commissioner, 1989.

**39-71-2351. Purpose of separation of state fund liability as of July 1, 1990, and of separate funding of claims before and on or after that date.** (1) An unfunded liability exists in the state fund. It has existed since at least the mid-1980s and has grown each year. There have been numerous attempts to solve the problem by legislation and other methods. These attempts have alleviated the problem somewhat, but the problem has not been solved.

(2) The legislature has determined that it is necessary to the public welfare to make workers' compensation insurance available to all employers through the state fund as the insurer of last resort. In making this insurance available, the state fund has incurred the unfunded liability. The legislature has determined that the most cost-effective and efficient way to provide a source of funding for and to ensure payment of the unfunded liability and the best way to administer the unfunded liability is to separate the liability of the state fund on the basis of whether a claim is for an injury resulting from an accident that occurred before July 1, 1990, or an accident that occurs on or after that date.

(3) The legislature further determines that in order to prevent the creation of a new unfunded liability with respect to claims for injuries for accidents that occur on or after July 1, 1990, certain duties of the state fund should be clarified and legislative oversight of the state fund should be increased.

**History:** En. Sec. 1, Ch. 4, Sp. L. May 1990; amd. Sec. 5, Ch. 797, L. 1991; amd. Sec. 1, Ch. 637, L. 1993; amd. Sec. 22, Ch. 276, L. 1997.

**39-71-2352. Separate payment structure and sources for claims for injuries resulting from accidents that occurred before July 1, 1990, and on or after July 1, 1990 -- spending limit -- authorizing transfer of money.** (1) Premiums paid to the state fund based upon wages payable before July 1, 1990, may be used only to administer and pay claims for injuries resulting from accidents that occurred before July 1, 1990. Premiums paid to the state fund based upon wages payable on or after July 1, 1990, may be used only to administer and pay claims for injuries resulting from accidents that occur on or after July 1, 1990.

(2) The state fund shall:

(a) determine the cost of administering and paying claims for injuries resulting from accidents that occurred before July 1, 1990, and separately determine the cost of administering and paying claims for injuries resulting from accidents that occur on or after July 1, 1990;

(b) keep adequate and separate accounts of the costs determined under subsection (2)(a); and

(c) fund administrative expenses and benefit payments for claims for injuries resulting from accidents that occurred before July 1, 1990, and claims for injuries resulting from accidents that occur on or after July 1, 1990, separately from the sources provided by law.

(3) The state fund may not spend more than $1.25 million a year to administer claims for injuries resulting from accidents that occurred before July 1, 1990.

(4) As used in this section, "adequately funded" means the present value of:

(a) the total cost of future benefits remaining to be paid; and

(b) the cost of administering the claims.

(5) An amount of funds in excess of the adequate funding amount established in subsection (4), based on audited financial statements adjusted for unrealized gains and losses, must be transferred to the general fund.

(6) If in any fiscal year after the old fund liability tax is terminated claims for injuries resulting from accidents that occurred before July 1, 1990, are not adequately funded, any amount necessary to pay claims for injuries resulting from accidents that occurred before July 1, 1990, must be transferred from the general fund to the account provided for in 39-71-2321.

(7) The independent actuary engaged by the state fund pursuant to 39-71-2330 shall project the unpaid claims liability for claims for injuries resulting from accidents that occurred before July 1, 1990, each fiscal year until all claims are paid.

**History:** En. Sec. 2, Ch. 4, Sp. L. May 1990; amd. Sec. 6, Ch. 797, L. 1991; amd. Sec. 6, Ch. 630, L. 1993; amd. Secs. 23, 24, Ch. 276, L. 1997; amd. Sec. 7, Ch. 184, L. 1999; amd. Sec. 1, Ch. 16, Sp. L. August 2002; amd. Sec. 1, Ch. 588, L. 2003; amd. Sec. 57, Ch. 2, L. 2009.

**39-71-2356. Mutually agreeable lump-sum settlements.** During the period beginning October 1, 1991, and ending September 30, 1992, a workers' compensation claimant and the

state fund may, regardless of the lump-sum law in effect on the date of the injury, mutually agree to a lump-sum settlement of a claim. If a mutual agreement is not reached, the lump-sum law in effect on the date of the injury applies.

**History:** En. Sec. 3, Ch. 797, L. 1991.

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

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

(2) provide the results of the financial and compliance audit for operations related to claims for injuries resulting from accidents on or after July 1, 1990, as provided in subsection (1), and the rate review as provided in 39-71-2362 to the insurance commissioner. The insurance commissioner shall review the financial and compliance audit and rate review and report any concerns or recommendations based on the review to the governor, the legislative audit committee, and the economic affairs interim committee.

**History:** En. Sec. 5, Ch. 4, Sp. L. May 1990; amd. Sec. 27, Ch. 167, L. 2011.

**39-71-2362. Authority of legislative auditor with respect to state fund.** The legislative auditor shall review rates established by the board to determine if the rates are excessive, inadequate, or unfairly discriminatory. Each year, the legislative auditor shall:

(1) examine the state fund beginning no sooner than October 1 following the end of the fiscal year; and

(2) report the findings of the examination and rate review to the governor, the legislature, and the board of directors of the state fund.

**History:** En. Sec. 8, Ch. 630, L. 1993.

**39-71-2363. Agency law -- submission of budget -- annual report.** (1) The state fund is subject to state laws applying to state agencies, except as otherwise provided by law, and it is exempt from the provisions of The Legislative Finance Act in Title 5, chapter 12, and the provisions of Title 17, chapter 7, parts 1 through 4. The state fund may use the debt collection procedures provided in Title 17, chapter 4, part 1.

(2) (a) Except as provided in 2-15-2015, the executive director shall annually submit to the board for its approval an estimated budget of the entire expense of administering the state fund for the succeeding fiscal year, with due regard to the business interests and contract obligations of the state fund. A copy of the approved budget must be delivered to the governor and the legislature.

(b) Upon approval of the estimated budget for the succeeding fiscal year, the state fund shall, no later than October 1 of each year, submit the approved annual budget for review to the legislative fiscal analyst. The budget must be submitted in an electronic format.

(c) Dividends may not be included as administrative expenditures as provided in subsection (2)(a), but are a disbursement of excess surplus pursuant to 39-71-2323 after a determination by the state fund of income from operations.

(3) The board shall submit an annual financial report to the governor and to the legislature as provided in 5-11-210, indicating the business done by the state fund during the previous year and containing a statement of the estimated liabilities of the state fund as determined by an independent actuary.

**History:** En. Sec. 9, Ch. 630, L. 1993; amd. Sec. 4, Ch. 424, L. 1995; amd. Sec. 25, Ch. 276, L. 1997; amd. Sec. 52, Ch. 7, L. 2001; amd. Sec. 10, Ch. 314, L. 2001; amd. Sec. 12, Ch. 120, L. 2013.

**39-71-2370. Claims expenditures codes.** The state fund shall continually review its claims expenditure coding structure to separately account for claims and administrative expenses. If a review demonstrates a compelling need for expenditure information that is not available, the state fund shall expand or modify its claims expenditure coding structure.

**History:** En. Sec. 20, Ch. 555, L. 1993; Sec. 39-71-226, MCA 2003; redes. 39-71-2370 by Sec. 11, Ch. 26, L. 2005.

**Part 24. Mediation**

**39-71-2401. Disputes -- jurisdiction -- settlement requirements -- mediation.** (1) A dispute concerning benefits arising under this chapter, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) The party making a demand shall present the other party with a specific written demand that contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) The party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response must state the basis of the denial.

(c) Upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if the mediator finds that either party did not comply with this subsection (4). A decision dismissing a petition under this subsection (4)(c) must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) This subsection (4) does not relieve a party of an obligation otherwise contained in this chapter.

**History:** En. Sec. 8, Ch. 464, L. 1987; amd. Sec. 1, Ch. 427, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 558, L. 1991; amd. Sec. 29, Ch. 416, L. 2005; amd. Sec. 1550, Ch. 56, L. 2009.

**39-71-2406. Purpose.** The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under this chapter if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers'

compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration.

**History:** En. Sec. 52, Ch. 464, L. 1987; amd. Sec. 2, Ch. 427, L. 1989; amd. Sec. 30, Ch. 416, L. 2005.

**39-71-2407. Department authority -- rules.** (1) The department shall designate mediators and shall implement the provisions of this part.

(2) The department may adopt the rules necessary to implement this part. The rules may prescribe:

(a) the qualifications of mediators; and

(b) a procedure for the conduct of mediation proceedings.

(3) The cost to the department of implementing this part must be paid out of the workers' compensation administration fund.

**History:** En. Sec. 53, Ch. 464, L. 1987.

**39-71-2408. Mandatory, nonbinding mediation.** (1) Except as otherwise provided, in a dispute arising under this chapter, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.

(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties.

**History:** En. Sec. 54, Ch. 464, L. 1987; amd. Sec. 31, Ch. 416, L. 2005.

**39-71-2409. Duties of mediator.** A mediator shall assist the parties in negotiating a resolution to their dispute by:

(1) facilitating an exchange of information between the parties;

(2) assuring that all relevant information is brought forth during the mediation process;

(3) suggesting possible solutions to issues of dispute between the parties;
(4) recommending a solution; and
(5) assisting the parties to voluntarily resolve their dispute.

**History:** En. Sec. 55, Ch. 464, L. 1987; amd. Sec. 3, Ch. 427, L. 1989.

**39-71-2410. Limitations on mediation proceedings.** (1) Except as may be necessary for the workers' compensation court to rule on issues arising under 39-71-2401(4)(c) or 39-71-2411(8)(c), mediation proceedings must be:
(a) held in private;
(b) informal and held without a verbatim record; and
(c) confidential.
(2) All communications, verbal or written, from the parties to the mediator and any information and evidence presented to the mediator during the proceeding are confidential.
(3) A mediator's files and records are closed to all persons but the parties.
(4) (a) A mediator may not be called to testify in any proceeding concerning the issues discussed in the mediation process.
(b) The mediator's report and any of the information or recommendations contained in the report are not admissible as evidence in any action subsequently brought in any court of law.
(5) Subsections (1) through (4) do not prohibit a mediator from issuing a report and the parties and the mediator may be required to attend a conference before the workers' compensation court as set forth in 39-71-2411.

**History:** En. Sec. 56, Ch. 464, L. 1987; amd. Sec. 4, Ch. 427, L. 1989; amd. Sec. 11, Ch. 558, L. 1991; amd. Sec. 1, Ch. 39, L. 2005.

**39-71-2411. Mediation procedure.** (1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under this chapter may petition the department for mediation of the dispute.
(2) A party may take part in mediation proceedings with or without representation.
(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.
(4) The claimant and an employee of the insurer or an authorized third-party examiner with settlement authority shall attend any scheduled mediation conference in person or shall participate by telephone conference call.
(5) The mediator shall request that each party offer an argument summarizing the party's

position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.

(6) After the parties have presented all their information and arguments to the mediator, the mediator shall recommend a solution to the parties within a reasonable time to be established by rule.

(7) A party shall notify the mediator within 25 days of the mailing of the mediator's report as to whether the party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.

(8) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (8)(c), the parties shall repeat the mediation process, but only one time.

(b) A mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:

(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) If a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute.

**History:** En. Sec. 57, Ch. 464, L. 1987; amd. Sec. 5, Ch. 427, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 20, Ch. 516, L. 1995; amd. Sec. 2, Ch. 39, L. 2005; amd. Sec. 32, Ch. 416, L. 2005.

## Part 25. Employer's Old Fund Liability Tax (Repealed)

## Part 26. Self-Insurers Guaranty Fund

**39-71-2601. Short title.** This part may be cited as the "Montana Self-Insurers Guaranty Fund Act".

**History:** En. Sec. 1, Ch. 244, L. 1989.

**39-71-2602. Purpose -- construction.** (1) The purposes of this part are to provide a mechanism for the payment of covered workers' compensation claims of employers bound by compensation plan No. 1 who are unable to pay the claims because of insolvency, to establish a fund from which the claims may be paid, and to establish a board to assess the cost of the protection among those employers.

(2) This part must be liberally construed to effect its purposes. The statement of its purposes constitutes an aid and a guide to the act's interpretation.

**History:** En. Sec. 2, Ch. 244, L. 1989.

**39-71-2603. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Board" means the board of directors of the Montana self-insurers guaranty fund.

(2) "Fund" means the Montana self-insurers guaranty fund established pursuant to 39-71-2609.

(3) "Insolvent private self-insurer" means an employer:

(a) (i) that is unable to pay workers' compensation claims because:

(A) it has been determined to be insolvent by a court of competent jurisdiction; or

(B) bankruptcy proceedings have been instituted by or against it; or

(ii) whose claims are not being paid on its behalf; and

(b) whose security has been exhausted pursuant to 39-71-2108.

(4) "Member" means an employer bound by compensation plan No. 1 that participates in the Montana self-insurers guaranty fund.

(5) "Private self-insurer" means a private employer bound by compensation plan No. 1 that has secured the payment of workers' compensation claims pursuant to 39-71-2101.

**History:** En. Sec. 3, Ch. 244, L. 1989.

**39-71-2604. Board of directors of fund.** (1) There is a board of directors of the Montana self-insurers guaranty fund.

(2) The board consists of five members who are representatives of private self-insurers and who shall serve staggered 4-year terms.

(3) Board members are elected by the members of the fund, with each member having one vote.

(4) Board members may be reimbursed from the assets of the fund for the actual expenses incurred in connection with their duties as board members.

**History:** En. Sec. 4, Ch. 244, L. 1989.

**39-71-2609. Establishment of fund -- employer participation required.** (1) There is a nonprofit unincorporated legal entity, to be known as the Montana self-insurers guaranty fund, financed as provided in 39-71-2615 and 39-71-2616. The fund shall perform its functions under rules adopted by, and powers exercised through, the board established under 39-71-2604.

(2) A private self-insurer shall participate as a member in the fund as a condition of the authority to self-insure in this state under 39-71-2101.

**History:** En. Sec. 5, Ch. 244, L. 1989; amd. Sec. 5, Ch. 163, L. 1991.

**39-71-2610. Rulemaking -- powers of fund.** (1) The board shall establish the rules necessary to carry out the purposes of this part and to meet the responsibilities of the fund.

(2) The fund may carry out its responsibilities directly or by contract. It may, if it considers necessary, purchase services and insurance and borrow funds.

(3) The fund may receive confidential information concerning the financial condition of a private self-insurer whose liabilities to pay compensation may devolve upon the fund. The board shall adopt rules to prevent dissemination of the information.

**History:** En. Sec. 6, Ch. 244, L. 1989.

**39-71-2611. Duties, liabilities, and rights of fund.** (1) The fund shall assume the workers' compensation obligations of a private self-insurer that come due after the private self-insurer has been determined to be an insolvent self-insurer.

(2) The fund is not liable for the payment of any penalties or interest assessed for any act or omission of a person acting on behalf of the fund.

(3) The fund is a party in interest in all proceedings involving workers' compensation claims against an insolvent private self-insurer whose workers' compensation obligations have been paid or assumed by the fund. The fund has the same rights and defenses as the insolvent private self-insurer, including but not limited to all of the following:

(a) to appear and deny, defend, and appeal a claim; and

(b) to receive notice of, investigate, adjust, compromise, settle, and pay a claim.

(4) The fund shall concur in department decisions relating to allowing an employer to self-insure.

**History:** En. Sec. 7, Ch. 244, L. 1989; amd. Sec. 6, Ch. 163, L. 1991.

**39-71-2615. Initial fee -- assessment.** (1) A private self-insurer shall pay to the fund an initial fee of $1,000 upon becoming a member. Thereafter, a member's financial obligation to the fund must be established by assessment as provided in subsection (2).

(2) (a) The fund may assess each of its members a pro rata share of the amount necessary to carry out the purposes of this part. However, the total annual assessments in any calendar year may not exceed 5% of the following benefits paid by each member during the preceding calendar year:

(i) compensation benefits; and

(ii) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, the total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(b) Funds obtained by assessment pursuant to this subsection may be used only for the purposes of this part.

(3) A former member is liable for assessments made by the fund in any year following the date the member's status as a private self-insurer is terminated, whether the termination is by action of the private self-insurer or the department. A former member's assessment must be based on the benefits paid during the last calendar year immediately preceding the annual assessment.

(4) The board shall certify to the department the collection and receipt of assessments, noting any delinquencies. The board shall take appropriate action to collect a delinquent assessment.

**History:** En. Sec. 8, Ch. 244, L. 1989; amd. Sec. 15, Ch. 555, L. 1993; amd. Sec. 1, Ch. 68, L. 2001; amd. Sec. 1, Ch. 226, L. 2003.

**39-71-2616. Reimbursement for obligations paid and assumed.** (1) The fund shall obtain reimbursement from an insolvent private self-insurer up to the amount of the insolvent private self-insurer's workers' compensation obligations paid and assumed by the fund. This includes reimbursement for reasonable administrative and legal costs.

(2) This right, as subrogee of any claimants in any action to collect against the private self-insurer as the debtor, includes but is not limited to a right to a claim for wages and other necessities of life advanced to any claimants.

(3) The fund may obtain from the security deposit or proceeds of other workers' compensation insurance of an insolvent private self-insurer the amount of the insolvent private self-insurer's compensation obligations, including reasonable administrative and legal costs, paid or assumed by the fund.

(4) The fund may bring an action against any other insurance carrier and person to recover compensation paid and liability assumed by the fund, including but not limited to:

(a) any excess insurance carrier of the private self-insurer; and

(b) any person whose negligence or breach of any obligation contributed to any underestimation of the private self-insurer's total accrual of liability as reported to the department.

**History:** En. Sec. 9, Ch. 244, L. 1989.

**39-71-2617. Tax exemption.** The fund is exempt from payment of all fees and taxes levied by this state or by any city, county, or other political subdivision, except taxes levied on real or personal property.

**History:** En. Sec. 10, Ch. 244, L. 1989.

**39-71-2618. Immunity.** There is no liability on the part of, and no claim for relief of any nature may arise against, any member, the fund, its agents or employees, or the board for any action taken by them in the performance of their powers and duties under this part.

**History:** En. Sec. 11, Ch. 244, L. 1989.

**39-71-2619. Notification of insolvency by private self-insurer.** As a condition of the privilege to self-insure pursuant to Title 39, chapter 71, part 21, a private self-insurer shall agree in writing to notify the department and the fund within 24 hours of the filing of any bankruptcy or determination of insolvency relating to that private self-insurer.

**History:** En. Sec. 12, Ch. 244, L. 1989.

**39-71-2620. Audit requirement.** Biannually or within 6 months after the close of any fiscal year in which the fund has assumed the workers' compensation obligations of an insolvent private self-insurer, the fund shall:

(1) contract for an independent certified audit of the financial activities of the fund; and

(2) report on the financial status of the fund to the department and to fund members.

**History:** En. Sec. 13, Ch. 244, L. 1989.

Part 27 and 28 reserved .

**Part 29. Workers' Compensation Judge**

**39-71-2901. Location of office -- court powers -- withdrawal -- substitution.** (1) The principal office of the workers' compensation judge must be in the city of Helena.

(2) The workers' compensation court has power to:

(a) preserve and enforce order in its immediate presence;

(b) provide for the orderly conduct of proceedings before it and its officers;

(c) compel obedience to its judgments, orders, and process in the same manner and by the same procedures as in civil actions in district court;

(d) compel the attendance of persons to testify; and

(e) punish for contempt in the same manner and by the same procedures as in district court.

(3) The workers' compensation judge shall withdraw from all or part of any matter if the judge believes the circumstances make disqualification appropriate. In the case of a withdrawal, the workers' compensation judge shall designate and contract for a substitute workers' compensation judge to preside over the proceeding from the list provided for in subsection (4). The substitute judge must be compensated at the same hourly rate charged by the department of justice agency legal services bureau for the provision of legal services to state agencies. The substitute judge must be reimbursed for travel expenses as provided for in 2-18-501 through 2-18-503. When the substitute judge has accepted jurisdiction, the clerk of the workers' compensation court shall mail a copy of the assumption of jurisdiction to each attorney or party of record. The certificate of service must be attached to the assumption of jurisdiction form in the court file.

(4) The workers' compensation judge shall maintain a list of persons who are interested in serving as a substitute workers' compensation judge in the event of a recusal by the judge and who prior to being put on the list of potential substitutes have been admitted to the practice of law in Montana for at least 5 years, currently reside in Montana, and have resided in the state for 2 years.

**History:** En. 92-850 by Sec. 4, Ch. 537, L. 1975; R.C.M. 1947, 92-850; amd. Sec. 58, Ch. 464, L. 1987; amd. Sec. 1, Ch. 20, L. 2009.

**39-71-2902. Operating expenses.** The workers' compensation judge may employ such employees as may be required to carry out the duties under this part. All expenditures of the workers' compensation judge, including but not limited to salaries, traveling expenses, office rent, office equipment, and supplies, shall be paid out of the workers' compensation administration fund.

**History:** En. 92-851 by Sec. 5, Ch. 537, L. 1975; R.C.M. 1947, 92-851.

**39-71-2903. Administrative procedure act and rules of evidence applicable.** All proceedings and hearings before the workers' compensation judge shall be in accordance with the appropriate provisions of the Montana Administrative Procedure Act. The workers' compensation judge is bound by common law and statutory rules of evidence.

**History:** En. 92-852 by Sec. 6, Ch. 537, L. 1975; R.C.M. 1947, 92-852(1); amd. Sec. 59, Ch. 464, L. 1987.

**39-71-2904. Direct appeal to supreme court.** Notwithstanding 2-4-701 through 2-4-704, an appeal from a final decision of the workers' compensation judge shall be filed directly with the supreme court of Montana in the manner provided by law for appeals from the district court in civil cases.

**History:** En. 92-852 by Sec. 6, Ch. 537, L. 1975; R.C.M. 1947, 92-852(2).

**39-71-2905. Petition to workers' compensation judge -- time limit on filing.** (1) If a claimant, an insurer, an employer alleged to be an uninsured employer, or the uninsured employers' fund has a dispute concerning any benefits under this chapter, it may petition the workers' compensation judge for a determination of the dispute after satisfying dispute resolution requirements otherwise provided in this chapter. In addition, the district court that has jurisdiction over a pending action under 39-71-515 may request the workers' compensation judge to determine the amount of recoverable damages due to the employee. The judge, after a hearing, shall make a determination of the dispute in accordance with the law as set forth in this chapter. If the dispute relates to benefits due to a claimant under this chapter, the judge shall fix and determine any benefits to be paid and specify the manner of payment. After parties have satisfied dispute resolution requirements provided elsewhere in this chapter, the workers' compensation judge has exclusive jurisdiction to make determinations concerning disputes under this chapter, except as provided in 39-71-317 and 39-71-516. The penalties and assessments allowed against an insurer under this chapter are the exclusive penalties and assessments that can be assessed by the workers' compensation judge against an insurer for disputes arising under this chapter.

(2) A petition for a hearing before the workers' compensation judge must be filed within 2 years after benefits are denied.

**History:** En. 92-848 by Sec. 2, Ch. 537, L. 1975; R.C.M. 1947, 92-848(1); amd. Sec. 4, Ch. 63, L. 1979; amd. Sec. 11, Ch. 601, L. 1985; amd. Sec. 60, Ch. 464, L. 1987; amd. Sec. 21, Ch. 516, L. 1995; amd. Sec. 29, Ch. 276, L. 1997; amd. Sec. 24, Ch. 112, L. 2009.

**39-71-2907. Increase in award for unreasonable delay or refusal to pay.** (1) The workers' compensation judge may increase by 20% the full amount of benefits due a claimant during the

period of delay or refusal to pay, when:

(a) the insurer agrees to pay benefits but unreasonably delays or refuses to make the agreed-upon payments to the claimant; or

(b) prior or subsequent to the issuance of an order by the workers' compensation judge granting a claimant benefits, the insurer unreasonably delays or refuses to make the payments.

(2) The question of unreasonable delay or refusal shall be determined by the workers' compensation judge, and such a finding constitutes good cause to rescind, alter, or amend any order, decision, or award previously made in the cause for the purpose of making the increase provided herein.

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

**History:** En. 92-849 by Sec. 3, Ch. 537, L. 1975; R.C.M. 1947, 92-849; amd. Sec. 5, Ch. 63, L. 1979; amd. Sec. 61, Ch. 464, L. 1987; amd. Sec. 1, Ch. 174, L. 1991.

**39-71-2909. Authority to review, diminish, or increase awards.** The judge may, upon the petition of a claimant or an insurer that the disability of the claimant has changed or that the claimant received benefits through fraud or deception, review, diminish, or increase, in accordance with the law on benefits as set forth in chapter 71 of this title, any benefits previously awarded by the judge. An insurer's petition alleging that the claimant received benefits through fraud or deception must be filed within 2 years after the insurer discovers the fraud or deception.

**History:** En. 92-848 by Sec. 2, Ch. 537, L. 1975; R.C.M. 1947, 92-848(4); amd. Sec. 6, Ch. 63, L. 1979; amd. Sec. 62, Ch. 464, L. 1987; amd. Sec. 2, Ch. 235, L. 1995.

**39-71-2910. Stay pending posttrial motions and appeal.** (1) Upon the filing of a judgment or order of the workers' compensation judge, a party may apply to the workers' compensation judge, upon notice or ex parte, for a stay of execution of the judgment or order. The stay may be for a period of time and be under conditions that the judge considers proper. A stay of execution under this subsection may not extend for more than 30 days following the judge's disposition of posttrial motions.

(2) The appellant may request of the workers' compensation judge or the supreme court, upon service of a notice of appeal, a stay of execution of the judgment or order pending resolution of the appeal. The appellant may request a stay by presenting a supersedeas bond to

the workers' compensation judge and obtaining the approval of the bond. The bond must have two sufficient sureties or a corporate surety as authorized by law. A court granting a stay may waive the bond requirement. The procedure for requesting a stay and posting a supersedeas bond must be the same as the procedure in Rule 22, Montana Rules of Appellate Procedure.

**History:** En. Sec. 1, Ch. 74, L. 1989; amd. Sec. 1551, Ch. 56, L. 2009.

**39-71-2911. Stay pending determination by district court.** Upon a motion and filing of an affidavit by either party and after a hearing, the workers' compensation judge may grant a stay of proceedings in the workers' compensation court if a criminal action involving workers' compensation insurance fraud by a claimant has been filed in district court.

**History:** En. Sec. 1, Ch. 243, L. 1995.

**39-71-2914. Signing of petitions, pleadings, motions, and other papers -- requirements -- sanctions.** (1) Every petition, pleading, motion, or other paper of a party appearing before the workers' compensation court and represented by an attorney must be signed by at least one attorney of record in the attorney's individual name. The signer's address also must be stated.

(2) A party who is not represented by an attorney shall sign the party's petition, pleading, motion, or other paper and state the party's address.

(3) The signature of an attorney or party constitutes a certificate by the attorney or party that:

(a) the attorney or party has read the petition, pleading, motion, or other paper;

(b) to the best of the attorney's or party's knowledge, information, and belief formed after reasonable inquiry, it is well grounded in fact;

(c) it is warranted by existing law or by a good faith argument for the extension, modification, or reversal of existing law; and

(d) it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

(4) If a petition, pleading, motion, or other paper is signed in violation of this section, the court, upon motion or upon its own initiative, shall impose an appropriate sanction upon the person who signed it, a represented party, or both. The sanction may include an order to pay to the other party or parties the amount of the reasonable expense incurred because of the filing of the petition, pleading, motion, or other paper, including reasonable attorney fees.

**History:** En. Sec. 63, Ch. 464, L. 1987; amd. Sec. 1552, Ch. 56, L. 2009.

Part 30 through 39 reserved .

**Part 40. Catastrophically Injured Worker's Travel Assistance Act**

**39-71-4001. Short title.** This part may be cited as the "Catastrophically Injured Worker's Travel Assistance Act".

**History:** En. Sec. 1, Ch. 345, L. 2005.

**39-71-4002. Purpose and intent.** The purpose of this part is to assist catastrophically injured workers and their families by providing that funds raised by community service organizations may be matched with funds from insurers to help the workers and their families defray the costs of travel and lodging expenses incurred by family members or, if a family member is unavailable, by a person designated by the injured worker or approved by the insurer when traveling to be with the worker.

**History:** En. Sec. 2, Ch. 345, L. 2005.

**39-71-4003. Definitions.** As used in this part, the following definitions apply:

(1) "Catastrophically injured" means a physical injury or occupational disease incurred by a worker to the extent that treatment for the injury or occupational disease:

(a) requires inpatient care for at least 21 consecutive days in a hospital or rehabilitation center that is in Montana but that is more than 100 miles from the worker's place of residence; or

(b) requires inpatient care for at least 21 consecutive days in a hospital or rehabilitation center that is located outside Montana; and

(c) occurs within 90 days of the accident or events causing the worker to be catastrophically

injured.

(2) "Community service organization" means a community-based, nonprofit, tax-exempt organization under section 501(c)(3) of the Internal Revenue Code that raises money to assist the catastrophically injured worker.

(3) "Worker" has the meaning as provided in 39-71-118.

**History:** En. Sec. 3, Ch. 345, L. 2005.

**39-71-4004. Catastrophically injured worker's travel assistance program -- rulemaking authority.** (1) Pursuant to subsection (3), the department of labor and industry shall establish criteria to certify that the funds raised by community service organizations are eligible for matching funds from an insurer.

(2) Money raised by community service organizations to pay travel expenses for a catastrophically injured worker pursuant to this section may not be used by community service organizations to require matching funds by an insurer in an amount greater than $2,500 for each catastrophic injury.

(3) The department shall adopt rules to administer 39-71-704 and this section.

**History:** En. Sec. 4, Ch. 345, L. 2005.