AN ACT REVISING WORKERS' COMPENSATION LAWS TO REQUIRE NOTICE TO CLAIMANTS OF CLAIMS EXAMINER CHANGES, UPDATE AND SIMPLIFY FEE SCHEDULE INFORMATION, PERMIT PAID TIME OFF TO BE USED FOR A WAITING PERIOD, AND MAKE ASSESSMENT PERIODS CURRENT FOR CERTAIN FUNDS; AMENDING SECTIONS 39-71-107, 39-71-704, 39-71-736, AND 39-71-915, MCA; AND PROVIDING AN EFFECTIVE DATE.

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

Section 1. Section 39-71-107, MCA, is amended to read:

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

(2) All workers' compensation and occupational disease claims filed pursuant to the Workers' Compensation Act must be examined by a claims examiner in Montana. For a claim to be considered as examined by a claims examiner in Montana, the claims examiner examining the claim is required to determine the entitlement to benefits, authorize payment of all benefits due, 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.

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

(7) An insurer shall:

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

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

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

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

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

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

Section 2. Section 39-71-704, MCA, is amended to read:

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

(a) After the happening of a compensable injury or occupational disease and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services, including prescription drugs for conditions that are a direct result of the compensable injury or occupational disease, for those periods specified in this section.

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

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

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

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

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

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

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

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident 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)~~(c) ~~On or after July 1, 2013, the~~ The fee schedule rates established in subsection (2)(b), when adopted, must be based on the following standards as adopted by the centers for medicare and medicaid services, regardless of where services are provided:

(i) the American medical association current procedural terminology codes, as those codes exist on ~~March 31~~ January 1 of each year;

(ii) the healthcare common procedure coding system, as those codes and their relative weights exist on ~~March 31~~ January 1 of each year;

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

(iv) the ambulatory payment classifications, as those codes and their relative weights exist on ~~March 31~~ January 1 of each year;

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

(vi) the national correct coding initiative edits, as those codes exist on ~~March 31~~ January 1 of each year; and

(vii) the relative value units in the published resource-based relative value scale, as those codes exist on ~~March 31~~ January 1 of each year.

~~(e)~~(d) 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."

Section 3. Section 39-71-736, MCA, is amended to read:

"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 or paid time off leave, other than sick leave, by a worker may not affect the worker's eligibility for temporary total disability benefits."

Section 4. Section 39-71-915, MCA, is amended to read:

"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 from April 1 of the previous year through March 31 of the current year paid by the fund ~~in the preceding fiscal year and~~ plus 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."

Section 5. Effective date. [This act] is effective July 1, 2015.

- END -

I hereby certify that the within bill,

HB 0090, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2015.

President of the Senate

Signed this _____ day

of _____, 2015.

HOUSE BILL NO. 90

INTRODUCED BY A. OLSEN

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

AN ACT REVISING WORKERS' COMPENSATION LAWS TO REQUIRE NOTICE TO CLAIMANTS OF CLAIMS EXAMINER CHANGES, UPDATE AND SIMPLIFY FEE SCHEDULE INFORMATION, PERMIT PAID TIME OFF TO BE USED FOR A WAITING PERIOD, AND MAKE ASSESSMENT PERIODS CURRENT FOR CERTAIN FUNDS; AMENDING SECTIONS 39-71-107, 39-71-704, 39-71-736, AND 39-71-915, MCA; AND PROVIDING AN EFFECTIVE DATE.