BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the adoption of New Rules I and II, the amendment of ARM 24.29.609, 24.29.616, 24.29.703, 24.29.902, 24.29.929, 24.29.956, 24.29.971, 24.29.1401A, 24.29.1801, 24.29.1821, 24.29.2614, 24.29.3103, 24.29.3107, 24.29.3117, 24.29.3124, and the repeal of ARM 24.29.966, 24.29.1425, 24.29.1426, 24.29.1427, 24.29.1428, 24.29.1430, 24.29.1431, 24.29.1511, 24.29.1519, 24.29.1521, 24.29.1531, 24.29.1532, 24.29.1536, 24.29.1537, 24.29.1541, 24.29.1551, 24.29.1561, 24.29.1566, 24.29.1571, 24.29.1572, 24.29.1573, 24.29.1574, 24.29.1575, 24.29.1581, 24.29.1582, 24.29.1583, 24.29.1584, 24.29.1585, 24.29.1586, 24.29.1702, 24.29.1721, 24.29.1722, 24.29.1727, 24.29.1731, 24.29.1733, 24.29.1735, 24.29.1737 pertaining to workers' compensation	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On August 31, 2018, at 10:00 a.m., the Department of Labor and Industry (department) will hold a public hearing in conference rooms A and B of the Beck Building, 1805 Prospect Avenue, Helena, Montana, to consider the proposed adoption, amendment, and repeal of the above-stated rules.

2. The department will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., on August 24, 2018, to advise us of the nature of the accommodation that you need. Please contact Cindy Zimmerman, Employment Relations Division, P.O. Box 8011, Helena, Montana 59604-8011; telephone (406) 444-1752; Montana TTD (406) 444-5549; facsimile (406) 444-4140; or e-mail Cindy.Zimmerman@mt.gov.

3. The rules proposed to be adopted provide as follows:

NEW RULE I CALCULATING SIF PAID PREVIOUS YEAR THROUGH CURRENT YEAR (1) The total amount paid by SIF from April 1 of the previous

year through March 31 of the current year includes commitments for payments by SIF on individual reimbursements or settlements.

AUTH: 39-71-203, MCA
IMP: 39-71-915, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to adopt NEW RULE I so that the subsequent injury fund (SIF) can obtain sufficient funding during the annual assessment cycle to properly fund reimbursements and settlements it has authorized, without shorting other SIF claims which may arise during the SIF's fiscal year. The SIF is authorized only to obtain funding annually, and therefore there is no mechanism to fund claim payments as due if there is a shortfall.

NEW RULE II USE OF SIGNATURES WHEN DOCUMENTS ARE BEING ELECTRONICALLY TRANSMITTED (1) The department may accept signatures in an electronically reproduced format on claims filing forms and petitions for settlement. The document must bear an original, manual signature, but it may be transmitted to the department electronically. The document may be transmitted to the department by means of:

(a) a fax copy;

(b) a portable document format (.pdf copy), transmitted electronically;

(c) an electronic scan, transmitted electronically; or

(d) a photocopy.

(2) The department may, in its sole discretion, accept appropriately authenticated digital signatures on documents, except as provided in (4).

(3) An insurer may, at its discretion, require a document being submitted directly to it to bear an original manual signature.

(4) Electronically reproduced signatures are not accepted by the department for independent contractor exemption certificate applications or waivers, in order to ensure that all such signatures are genuine and made under oath as provided by law.

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-717, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to adopt NEW RULE II in order to clarify that commonly used electronically reproduced manual signatures such as faxes, .pdf documents, and such may be submitted to the department and are accepted in lieu of an original manual signature. The practice has been generally accepted by the department, but the adoption of NEW RULE II will provide certainty to injured workers, insurers, claims examiners, and other users in the workers' compensation system that the practice is allowed. The use of electronically reproduced manual signatures will allow the department, insurers, and injured workers to use commonly available technology and improve the speedy transmission of documents and the use of computer imaging systems. There is reasonable necessity to allow insurers to request original manual signatures

on documents, should the insurer find it desirable or necessary to verify the genuineness of a signature. Finally, there is reasonable necessity to specifically exclude the use of electronically reproduced signatures from the independent contractor exemption certificate application and waiver, in order that the identity verification and oath-taking function of notaries can be appropriately used as required by law. The department notes that an electronically reproduced original manual signature is distinguished from a "digital signature" in which no manual signature is made. The department may accept such digital signatures if the department is reasonably assured that such digital signatures provide suitable assurance of authenticity, including the identity of the party making the digital signature.

4. The rules proposed to be amended are as follows, stricken matter interlined, new matter underlined:

24.29.609 ABILITY TO PAY--EVIDENCE REQUIRED (1) Employers or employer groups electing to be self-insured shall demonstrate ability to pay ~~by providing~~ benefits as required by the Workers' Compensation Act. The determination of the ability to pay is determined based on an analysis by the department, with the concurrence of the guaranty fund as provided by law. The employer or group shall provide the department with:

(a) audited financial statements~~,~~;

(b) evidence of excess insurance, if required~~, and~~;

(c) a security deposit, if required~~,~~;

(d) an agreement (or parental agreement) of assumption and guarantee of workers' compensation and occupational disease liabilities, on forms prescribed by the department, if required; and

(e) other documentation as required by the department ~~that upon analysis indicate ability to pay, as determined by the department, with the concurrence of the guaranty fund~~.

(2) and (3) remain the same.

AUTH: 39-71-203, 39-71-2102, MCA
IMP: 39-71-403, 39-71-2102, MCA

24.29.616 EXCESS INSURANCE--WHEN REQUIRED (1) through (3)(e) remain the same.

(f) It must include an endorsement regarding late claim reporting penalty waiver.

(f) and (g) remain the same but are renumbered (g) and (h).

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2103, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.609 and 24.29.616 in order to ensure that Plan No. 1 employers have provided adequate assurance of the timely payment of all claims when due.

The rule amendments are needed to make sure that Plan No. 1 insurers are given timely notice of the type of documentation needed for approval of self-insured status.

24.29.703 ELECTION TO BE BOUND BY COMPENSATION PLAN NO. 2 OR 3 (1) and (2) remain the same.

(3) Insurance policies as required by (1) and (2) must include section 3A, on the Insurance Declaration page, evidencing Montana coverage.

(4) In order to meet the requirements of this rule:

(a) the insurance policy must list Montana as a state under whose laws coverage is provided; or

(b) section 3A of the coverage declarations page must expressly list Montana as a state under whose laws coverage is provided.

AUTH: 39-71-203, MCA
IMP: 39-71-2201, 39-71-2301, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.703 in order to ensure that employers in Montana are properly covered under the terms of the Montana Workers' Compensation Act. The department has found that some employers, particularly those who operate in states other than Montana mistakenly assume that various statements such as "all states coverage" provide workers' compensation insurance coverage under Montana law when the policy does not actually provide that coverage.

24.29.902 DEFINITIONS For the purpose of this subchapter, the following definitions apply, unless the context of the rule clearly indicates otherwise:

(1) and (2) remain the same.

~~(3) "Industrial accident rehabilitation account" or "IARA" has the same meaning as provided by 39-71-1004, MCA.~~

(4) through (7) remain the same but are renumbered (3) through (6).

~~(8) "Paid losses" are as defined in 39-71-915, MCA.~~

(9) and (10) remain the same but are renumbered (7) and (8).

(9) "SAW/RTW" means stay-at-work/return-to-work assistance as defined in 39-71-1011, MCA.

(10) "Safety fund assessment" means the assessment for the occupational safety and health administration fund as defined in 50-71-128, MCA.

(11) remains the same.

AUTH: 39-71-203, 50-71-114, MCA
IMP: 39-71-201, 39-71-915, ~~39-71-1004~~, 39-71-1011, 39-71-2352, 50-71-128, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.902 in order to update the references to the split in assessments and other changes in terminology, and to update the AUTH and IMP citations.

24.29.929 ASSESSMENTS OTHER THAN THE ADMINISTRATION FUND ASSESSMENT (1) The department may combine the assessments for the administration fund, SIF, SAW/RTW, and safety fund ~~and IARA assessments~~ into one bill.

~~(2) The IARA assessment is due by July 1 of the year it is billed, which is consistent with the due date for the SIF assessment.~~

AUTH: 39-71-203, 50-71-114, MCA
IMP: 39-71-201, 39-71-915, ~~39-71-1004,~~ 39-71-1011, 50-71-128, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.929 in order to update the references to the split in assessments and other changes in terminology, and to update the AUTH and IMP citations.

24.29.956 COMPUTATION AND COLLECTION OF THE ADMINISTRATION FUND AND SAFETY FUND ASSESSMENT PREMIUM SURCHARGE RATE FOR PLAN NO. 2 AND NO. 3 (1) The department will compute the premium surcharge to be paid by all employers insured by plan No. 2 insurers and by the plan No. 3 insurer in the manner provided by 39-71-201 and 50-71-128, MCA.

(a) In calculating the total administration fund and safety fund assessment premium surcharge rate, the department will use previous calendar year premium data reported to the ~~insurance commissioner pursuant to 33-2-705, MCA, and premium reported by~~ department by plan No. 2 insurers and the plan No. 3 insurer.

~~(b) If premium has not been reported to the insurance commissioner by the date the surcharge is computed, the department will use the premiums reported on the quarterly surcharge forms in computing the surcharge rate.~~

~~(c) A plan No. 2 insurer who has failed to report premium earned to the insurance commissioner, pursuant to 33-2-705, MCA, as of the date the surcharge is computed must pay an assessment of $500.00 and the department will use an estimated premium amount for purposes of the surcharge calculation.~~

~~(d) The resulting single premium surcharge rate will apply to all employers being insured by plan No. 2 insurers and the plan No. 3 insurer.~~

~~(2) In determining the premium surcharge for the coming fiscal year, the department shall compare the total amount of premium surcharge remitted by all plan No. 2 insurers and the plan No. 3 insurer for the most recently completed fiscal year to the amount of the administration fund assessment that the premium surcharge was calculated to fund.~~

~~(a) If the amount actually collected in premium surcharge is greater than the calculated assessment on paid losses from the preceding year, the department shall subtract the excess amount from the next assessment. If the amount actually collected in premium surcharge is less than the calculated assessment on paid losses from the preceding year, the department shall add the underfunded amount to the next assessment.~~

(b) remains the same.

~~(3)~~ (2) The administration fund and safety fund assessment premium surcharge rate is effective for policies written or renewed on or after July 1 of each year. For policies written or renewed during the fiscal year, the current surcharge

rate will apply to all payments made during the policy year regardless of any changes in the surcharge rate effective as of the next fiscal year.

(4) remains the same but is renumbered (3).

~~(5) If an insurer uses a deposit placed by a policyholder for payment of premium, the deposit must also be used for payment of the administration fund assessment premium surcharge. If the amount of the deposit is insufficient to cover both the cost of the premium and the surcharge, the deposit must first be applied to the surcharge and the remaining amount to the premium due.~~

~~(6)~~ (4) Each plan No. 2 insurer and the plan No. 3 insurer is responsible for correctly calculating the amount of the authorized premium surcharge for the administration fund and safety fund assessment that the insurer is to collect from each of its insured employers using the rate established by the department. Because the insurer, not the department, calculates the amount of premium due from the employer, disputes between the insurer and the insured regarding the amount of the premium surcharge are not disputes over which the department has jurisdiction.

(7) and (8) remain the same but are renumbered (5) and (6).

AUTH: 39-71-203, 50-71-114, MCA
IMP: 39-71-201, 39-71-203, 39-71-2352, 50-71-128, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.956 in order to update the references to the split in assessments and other changes in terminology, and to update the AUTH and IMP citations.

24.29.971 FAILURE OF INSURER TO TIMELY REPORT PAID LOSSES--DEPARTMENT ESTIMATE OF PAID LOSSES--RECALCULATION OF ASSESSMENT AND PREMIUM SURCHARGE--PENALTY (1) In the event an insurer fails to timely and accurately report its paid losses for the previous year by the following March 1, the department ~~will estimate~~ may base the insurers' paid losses using the quarterly information submitted by the insurer pursuant to 39-71-306, MCA. ~~The~~ If the insurer has not filed all of the quarterly reports as required by 39-71-306, MCA, the department may consult with the advisory organization or other sources regarding the appropriate amount to estimate as those paid losses. The department may also use that estimate as the basis for the SIF~~,~~ ~~and IARA~~ SAW/RTW, and safety fund assessment as well.

(2) remains the same.

(3) An annual paid loss report received after March 1, but received by or before March 31, may be considered pursuant to ARM 24.29.954 for assessment calculation purposes.

~~(3)~~(4) The department ~~will~~ may, in its sole discretion, recalculate the ~~assessments after the insurer reports its paid losses~~ assessment and surcharge rates if the insurer makes a late report as provided by (3). ~~The department will then give the insurer whatever credit may be due if the July 1 payment of the estimated assessments exceeds the amount due following the recalculation.~~

(5) Pursuant to 39-71-306, MCA, a penalty of up to $1,000 may be assessed against the insurer for an annual report received after March 1.

AUTH: 39-71-203, 39-71-306, 50-71-114, MCA
IMP: 39-71-201, 39-71-306, 39-71-915, ~~39-71-1004,~~ 50-71-128, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.971 in order to update the references to the split in assessments and other changes in terminology, and to update the AUTH and IMP citations, and to more accurately assess insurers that have not timely filed required reports to the department.

24.29.1401A DEFINITIONS As used in subchapters 14 and 15, the following definitions apply:

(1) and (2) remain the same.

(3) "Ambulatory surgery center (ASC)" means a health care facility ~~that operates primarily for the purpose of furnishing outpatient surgical services to patients~~ where surgical procedures not requiring an overnight hospital stay are performed.

(4) "Base rate" means the dollar value published by the department annually which is multiplied by the relative weight of the MS-DRG or APC to determine payment.

(5) through (7) remain the same.

(8) "Correct Coding Initiative (CCI)" means the code edits adopted by the department ~~that~~ which are used to correct contradictory billing information.

(9) and (10) remain the same.

(11) "Designated Treating Physician" means a provider ~~who is~~ designated or formally approved by the insurer as the physician who ~~will be~~ is responsible for coordinating the injured worker's care, according to the criteria in 39-71-1101, MCA.

(12) and (13) remain the same.

(14) "Evidence-based" means use of the best evidence available in making decisions about the care of the individual patient, gained from the scientific method of medical decision-making ~~and~~. It includes use of techniques from science, engineering, and statistics, such as:

(a) randomized controlled trials (RCTs)~~,~~;

(b) meta-analysis of medical literature~~,~~;

(c) integration of individual clinical expertise with the best available external clinical evidence from systematic research~~,~~; and

(d) a risk-benefit analysis of treatment (including lack of treatment).

(15) "Facility" or "health care facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual.

(a) The term includes the following facilities, as defined in 50-5-101, MCA:

(i) chemical dependency facilities~~,~~;

(ii) critical access hospitals~~,~~;

(iii) end-stage renal dialysis facilities~~,~~;

(iv) home health agencies~~,~~;

(v) home infusion therapy agencies~~,~~;

(vi) hospices~~,~~;

(vii) hospitals~~,~~;

(viii) long-term care facilities~~,~~;

(ix) intermediate care facilities for the developmentally disabled~~,~~;

(x) medical assistance facilities~~,~~;

(xi) mental health centers~~,~~;

(xii) outpatient centers for surgical services~~,~~;

(xiii) rehabilitation facilities~~,~~;

(xiv) residential care facilities~~,~~; and

(xv) residential treatment facilities. ~~The above facilities are defined in 50-5-101, MCA.~~

(b) The term does not include outpatient centers for:

(i) primary care~~,~~;

(ii) infirmaries~~,~~;

(iii) provider-based clinics~~,~~; and

(iv) offices of private physicians, dentists~~,~~ or other physical or mental health care workers, including licensed addiction counselors.

(16) "Functional status" means written information that is complete, clear, and legible, and ~~that~~ identifies objective findings indicating the claimant's physical capabilities and provides information about the change in ~~the~~ status ~~as a result of~~ resulting from treatment.

(17) through (19) remain the same.

(20) "Inpatient services" means services rendered to a person ~~who has been~~ admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation ~~that~~ the patient will remain at least overnight and occupy a bed even though it later develops ~~that~~ the patient can be discharged or transferred to another hospital and not actually use the hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient ~~should be~~ is admitted as an inpatient.

~~(21) "Insurer" has the same meaning as provided by 39-71-116, MCA.~~

(22) remains the same but is renumbered (21).

~~(23) "Maintenance care" has the same meaning as provided by 39-71-116, MCA.~~

~~(24)~~ (22) "Medical director" means a person who is an employee of, or contractor to, the department, and who is responsible for the independent medical review of requests for treatment(s) or procedure(s)~~,~~ when those requests are denied, petitions to reopen medical benefits according to 39-71-717, MCA, and whose responsibility will also include other areas to be determined by the department. A person serving as a medical director must be a physician licensed by the state of Montana under Title 37, chapter 3, MCA.

~~(25) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical healing" has the same meaning as provided by 39-71-116, MCA.~~

(26) and (27) remain the same but are renumbered (23) and (24).

~~(28)~~ (25) "Objective medical findings" means medical evidence ~~that is~~ substantiated by clinical findings. Clinical findings include, but are not limited to,

range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not ~~considered~~ objective medical findings.

~~(29)~~ (26) "Outpatient" means a patient ~~who is~~ not admitted for inpatient or residential care.

~~(30) "Palliative care" has the same meaning as provided by 39-71-116, MCA.~~

(31) remains the same but is renumbered (27).

~~(32) "Primary medical services" has the same meaning as provided by 39-71-116, MCA.~~

~~(33)~~ (28) "Prior authorization" means:

(a) ~~with respect to services provided on or before June 30, 2011, that~~ for those matters identified by ARM 24.29.1517 the provider requests and receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure; and

(b) ~~with respect to services provided on or after July 1, 2011,~~ the interested party requests and receives ~~prior~~ authorization (either verbally or in writing) from the insurer ~~to perform~~ prior to providing treatment for those cases identified by ARM 24.29.1593.

(34) remains the same but it renumbered (29).

~~(35)~~ (30) "Rebuttable presumption" means that the Montana Guidelines, as adopted in ARM 24.29.1591, are presumed to be compensable medical treatment for an injured worker. The presumption ~~can~~ may be rebutted by a preponderance of credible medical evidenced-based material and medical reasons to justify ~~that~~ the medical treatment(s) or procedure(s) ~~that require~~ requiring prior authorization are reasonable and necessary care for the injured worker.

(36) and (37) remain the same but are renumbered (31) and (32).

~~(38) "Secondary medical services" has the same meaning as provided by 39-71-116, MCA.~~

~~(39)~~ (33) "Service or services" means treatment including procedures and supplies ~~provided in a facility or nonfacility that is~~ billable under these rules.

(40) through (42) remain the same but are renumbered (34) through (36).

(a) ~~With respect to~~ For services provided on or before June 30, 2011, the treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities ~~that will be~~ employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate ~~that~~ treatment ~~is to~~ be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider in the selection of the most appropriate method of treatment~~;~~.. However, the treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

(b) ~~With respect to~~ For services provided on or after July 1, 2011, a treatment plan must be made in accordance with the Montana Guidelines adopted in ARM 24.29.1591 and made in accordance with any insurer authorized treatments or procedures.

AUTH: 39-71-203, MCA
IMP: 39-71-116, 39-71-704, MCA

24.29.1801 DEFINITIONS As used in this subchapter, the following definitions apply:

~~(1) "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, as defined in 39-71-116, MCA.~~

(2) through (10) remain the same but are renumbered (1) through (9).

AUTH: 39-71-203, 39-71-1051, MCA
IMP: 39-71-105, 39-71-116, 39-71-1011, 39-71-1036, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.1401A and 24.29.1801 to streamline the rules by eliminating redundant references to terms defined in statute. In addition, there is reasonable necessity to make certain formatting changes to ensure that ARM 24.29.1401A conforms with the style requirements of the Secretary of State's Administrative Rules Bureau.

24.29.1821 VOCATIONAL REHABILITATION COUNSELOR ~~POOL~~ FOR DEPARTMENT-PROVIDED SAW/RTW ASSISTANCE ~~(1) The department shall obtain qualified vocational rehabilitation counselors under contract to provide SAW/RTW services to injured workers.~~

(2) and (3) remain the same but are renumbered (1) and (2).

~~(4)~~ (3) The vocational rehabilitation counselor shall notify the department of the services provided, the progress toward transitional employment, and assistance outcomes, as ~~specified by the contract with~~ directed by the department.

~~(5) The department shall periodically request proposals from vocational rehabilitation counselors and execute contracts for services with qualified applicants.~~

AUTH: 39-71-203, 39-71-1051, MCA
IMP: 39-71-105, 39-71-1043, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.1821 to eliminate references to contracts that are not being used by the department.

24.29.2614 REIMBURSEMENT PROCESS (1) remains the same.

(2) ~~The insurer shall provide written notice to the department no sooner than 150 days or later than 90 days before the SIF becomes liable to reimburse the insurer for medical or indemnity benefits paid on behalf of the SIF-certified individual.~~ An insurer shall send the following to the department to document 104 weeks of payments for medical and indemnity after SIF has been notified of the insurer's intent to seek reimbursement:

(a) for medical benefit reimbursements:

(i) a cover letter;

(ii) medical notes from first and last visit from the treating physician; and

(iii) a spreadsheet documenting all medical benefits, including prescriptions, paid by the insurer for the first 104 weeks.

(b) for indemnity benefit reimbursements:

(i) a cover letter; and

(ii) a spreadsheet documenting all indemnity benefits paid.

(3) remains the same.

(a) The department ~~may~~ shall not reimburse the insurer for medical benefits paid to or on behalf of an SIF-certified individual during the first 104 weeks following the date of injury. ~~The insurer shall submit copies of the SIF-certified individual's first report of injury and all related medical reports for department review.~~

(b) The department ~~may~~ shall not reimburse an insurer for indemnity benefits until after the insurer has paid a total of 104 weeks of indemnity benefits to the SIF-certified individual.

(4) remains the same.

(a) computer printout or comparable listing that identifies the type of indemnity payment to the SIF-certified individual (temporary partial disability, temporary total disability, permanent partial disability, or permanent total disability) and includes:

(i) ~~check numbers,~~ dates checks were issued~~,~~;

(ii) dates of indemnity~~,~~;

(iii) total weeks of indemnity~~,~~; and

(iv) the total amount paid~~;~~.

(b) computer printout or comparable listing of all medical bills paid, including:

(i) ~~check numbers,~~ dates checks were issued~~,~~;

(ii) provider names~~,~~; ~~and~~

(iii) dates of service;

(iv) billed amount;

(v) paid amount;

(vi) NDC# or drug type and dosage;

(vii) date of fill; and

(viii) amount paid; and

(c) through (6) remain the same.

(a) Attorney fees must be itemized separately from medical and/or indemnity benefits.

(7) remains the same.

AUTH: 39-71-203, 39-71-904, MCA
IMP: 39-71-907, 39-71-908, 39-71-909, 39-71-912, 39-71-920, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.2614 in order to clarify and modernize the procedures used by the SIF to timely provide reimbursement, including the documentation required to be submitted to support the request for reimbursement.

24.29.3103 DEFINITIONS Terms defined in 39-71-116, MCA, are used in subchapter 31 as they are defined by statute. As used in subchapter 31, the following definitions apply unless the context clearly indicates otherwise:

(1) and (2) remain the same.

(3) "Approved" means that after the medical review has been performed, medical benefits are reopened~~, as specified in the medical director's report~~ for two years before being subject to a biennial review.

(4) through (22) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-116, 39-71-717, MCA

24.29.3107 TIMELINES AND EXPLANATION OF STATUS CLASSIFICATIONS OF A PETITION (1) through (4) remain the same.

(5) Once filed, the parties have 14 days to submit medical records and additional information to be considered during the medical review. Once the medical review is completed and the report is issued by the medical director, the petition will have one of the two following status conditions:

(a) the petition is approved, with a recommendation in the report ~~as to the nature and extent of the~~ that medical benefits ~~that~~ should be provided by the insurer for two years before being subject to a biennial review; or

(b) through (7) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-717, MCA

24.29.3117 JOINT PETITION FOR REOPENING (1) If the worker and the insurer agree ~~on the nature and duration of the~~ to reopen medical benefits ~~to be reopened~~, the worker and the insurer may file a joint petition for reopening. A joint petition for reopening must be made on the department's joint petition form. Joint petition forms are available from the department in the manner described in ARM 24.29.3111.

(2) remains the same.

(3) Because the parties agree on the need for reopening medical benefits, the department's medical director will summarily review and approve the petition, reopening medical benefits for two years before being subject to a biennial review.

(4) remains the same.

AUTH: 39-71-203, MCA
IMP: 39-71-717, MCA

24.29.3124 REVIEW BY MEDICAL REVIEW PANEL - REPORT AND RECOMMENDATIONS (1) through (3) remain the same.

(4) If a panel member concludes that additional medical benefits are necessary, ~~the panel member shall identify the extent of~~ the medical benefits ~~that~~ should be provided for two years before being subject to a biennial review. The analysis must include the reasons and rationale that explain:

(a) through (6) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-717, MCA

STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to amend ARM 24.29.3101, 24.29.3107, 24.29.3117, and 24.29.3124 to clarify that medical benefits, once reopened for two years, will be reviewed on a biennial basis, as well as to clarify that reopened benefits are subject to the normal claims examination process for relevance and need.

5. The rules proposed to be repealed are as follows:

GENERAL STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to repeal the following rules to eliminate rules that apply to programs that are no longer in existence, or pertain to services or processes that have been superseded by the passage of time and subsequent statutes and rules.

24.29.966 INDUSTRIAL ACCIDENT REHABILITATION ACCOUNT ASSESSMENT

AUTH: 39-71-203, MCA
IMP: 39-71-1004, MCA

24.29.1425 RATES FOR HOSPITAL SERVICES PROVIDED PRIOR TO JULY 1, 1997

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1426 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM APRIL 1, 1998, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1427 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH NOVEMBER 30, 2008

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1428 HOSPITAL RATES FOR JULY 1, 1997, THROUGH JUNE 30, 1998

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1430 HOSPITAL RATES FROM JULY 1, 1998, THROUGH JUNE 30, 2001

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1431 HOSPITAL RATES FROM JULY 1, 2001, THROUGH NOVEMBER 30, 2008

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1511 SELECTION OF PHYSICIAN FOR CLAIMS ARISING BEFORE JULY 1, 1993

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1519 SECOND OPINIONS FOR SERVICES PROVIDED ON OR BEFORE JUNE 30, 2011

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1521 MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE BEFORE JANUARY 1, 2008

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1531 USE OF FEE SCHEDULES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH JUNE 30, 2002

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1532 USE OF FEE SCHEDULES FOR SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1536 CONVERSION FACTORS--METHODOLOGY FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

24.29.1537 SPECIAL MONITORING AND ADJUSTMENT OF PHYSICAL MEDICINE FEES DURING THE PERIOD JULY 1, 2002, THROUGH DECEMBER 31, 2003

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1541 ACUPUNCTURE FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1551 DENTAL SPECIALTY AREA FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1561 PHYSICIAN FEES -- MEDICINE FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1566 PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1571 CHIROPRACTIC FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993 THROUGH JUNE 30, 2002

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1572 CHIROPRACTIC FEES FOR SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1573 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR CHIROPRACTIC SERVICES PROVIDED FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1574 CHIROPRACTIC FEE SCHEDULE FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH JUNE 30, 2011

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1575 CHIROPRACTIC--PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH JUNE 30, 2011

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1581 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993 THROUGH JUNE 30, 2002

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1582 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM JULY 1, 2002, THROUGH SEPTEMBER 30, 2003

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1583 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED BY OCCUPATIONAL THERAPISTS AND PHYSICAL THERAPISTS FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1584 PROVIDER FEES--OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM OCTOBER 1, 2003, THROUGH DECEMBER 31, 2007

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1585 OCCUPATIONAL AND PHYSICAL THERAPY FEE SCHEDULE FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH JUNE 30, 2011

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1586 OCCUPATIONAL AND PHYSICAL THERAPISTS--PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH JUNE 30, 2011

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1702 REHABILITATION PANELS FOR CLAIMS BETWEEN JULY 1, 1987 AND JUNE 30, 1991

AUTH: 39-71-203, MCA
IMP: 39-71-1015 to 39-71-1019, MCA

24.29.1721 PAYMENT OF REHABILITATION EXPENSES FROM THE INDUSTRIAL ACCIDENT REHABILITATION ACCOUNT FOR CLAIMS ARISING BEFORE JULY 1, 1991

AUTH: 39-71-203, MCA
IMP: Title 39, chap. 71, part 10, MCA (1987) (1989) and (1991)

24.29.1722 PAYMENT OF REHABILITATION EXPENSES FROM THE INDUSTRIAL ACCIDENT REHABILITATION ACCOUNT FOR CLAIMS ARISING ON OR AFTER JULY 1, 1991, AND BEFORE JULY 1, 1997

AUTH: 39-71-203, MCA
IMP: Title 39, chap. 71, part 10, MCA

24.29.1727 DEPARTMENT'S NOTICE OF AUTHORIZATION OR DENIAL OF USE OF TRUST FUNDS

AUTH: 39-71-203, MCA
IMP: Title 39, chap. 71, part 10, MCA

24.29.1731 ALLOWABLE REHABILITATION EXPENSES

AUTH: 39-71-203, MCA
IMP: Title 39, chapter 71, part 10, MCA

24.29.1733 DISALLOWED REHABILITATION EXPENSES

AUTH: 39-71-203, MCA
IMP: Title 39, chapter 71, part 10, MCA

24.29.1735 DOCUMENTATION REQUIRED

AUTH: 39-71-203, MCA
IMP: Title 39, chapter 71, part 10, MCA

24.29.1737 INSURER RESPONSIBILITY TO PROVIDE INFORMATION TO THE DEPARTMENT

AUTH: 39-71-203, MCA
IMP: Title 39, chap. 71, part 10, MCA

6. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Jason Swant, Employment Relations Division, P.O. Box 8011, Helena, Montana 59604-8011, by facsimile to (406) 444-4140, or e-mail to JSwant@mt.gov, and must be received no later than 5:00 p.m., September 7, 2018.

7. An electronic copy of this notice of public hearing is available through the department's web site at http://dli.mt.gov/events/calendar.asp, under the Calendar of Events, Administrative Rules Hearings Section. The department strives to make its electronic copy of this notice of public hearing conform to the official version of the notice, as published in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy, only the official text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that a person's difficulties in sending an e-mail do not excuse late submission of comments.

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request, which includes the name and e-mail or mailing address of the person to receive notices, and specifies the particular subject matter or matters regarding which the person wishes to receive notices. Such written request may be mailed or delivered to the Department of Labor and Industry, attention: Mark Cadwallader, 1315 E. Lockey Avenue, P.O. Box 1728, Helena, Montana 59624-1728, faxed to the department at (406) 444-1394, or e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency.

9. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

10. Pursuant to 2-4-111, MCA, the department has determined that the rule changes proposed in this notice do not have a significant and direct impact upon small businesses.

11. The department's Office of Administrative Hearings has been designated to preside over and conduct this hearing.

/s/ Mark Cadwallader	/s/ Galen Hollenbaugh
Mark Cadwallader	Galen Hollenbaugh
Rule Reviewer	Commissioner
	Department of Labor and Industry

Certified to the Secretary of State July 31, 2018.