BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.29.601, 24.29.604, 24.29.607, 24.29.611, 24.29.616, 24.29.617, 24.29.618, 24.29.621, 24.29.624, 24.29.628, 24.29.703, 24.29.720, 24.29.721, 24.29.801, 24.29.813, 24.29.816, 24.29.818, 24.29.821, 24.29.824, 24.29.831, 24.29.837, 24.29.841, 24.29.844, 24.29.908, 24.29.1201, 24.29.1202, 24.29.1512, 24.29.1513, 24.29.1515, 24.29.1523, 24.29.1534, 24.29.1538, 24.29.1601, 24.29.1611, 24.29.1616, 24.29.1621, 24.29.1710, 24.29.1725, 24.29.1741, 24.29.2605, 24.29.2607, 24.29.2610, 24.29.2614, 24.29.2831, 24.29.2841, 24.29.2843, 24.29.2853, 24.29.3101, 24.29.3103, 24.29.3127, 24.29.3802, 24.29.4303, 24.29.4307, 24.29.4314, 24.29.4321, 24.29.4332, 24.29.4336, and 24.29.4339, the adoption of NEW RULES I through VII, and the repeal of ARM 24.29.205, 24.29.206, 24.29.207, 24.29.213, 24.29.215, 24.29.608, 24.29.610, 24.29.622, 24.29.623, 24.29.627, 24.29.704, 24.29.709, 24.29.713, 24.29.804, 24.29.851, 24.29.902, 24.29.907, 24.29.929, 24.29.954, 24.29.956, 24.29.962, 24.29.971, 24.29.1401, 24.29.1501, 24.29.1510, 24.29.1517, 24.29.1522, 24.29.1526, 24.29.1533, 24.29.1701, 24.29.1705, 24.29.1761, 24.29.2002, 24.29.2003, 24.29.2301, 24.29.2303, 24.29.2311, 24.29.2321, 24.29.2323, 24.29.2326, 24.29.2329, 24.29.2331, 24.29.2336, 24.29.2339, 24.29.2341, 24.29.2346, 24.29.2351, 24.29.2356, 24.29.2361, 24.29.2366, 24.29.2371, 24.29.2373, 24.29.2376, 24.29.2379, 24.29.2602, 24.29.2701, 24.29.2811, 24.29.2839, 24.29.2846, 24.29.2849, 24.29.2851, 24.29.2855, 24.29.3107, 24.29.3111,	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT, ADOPTION, AND REPEAL

24.29.3114, 24.29.3117, 24.29.3121,)
24.29.3124, 24.29.4301, 24.29.4311,)
24.29.4317, 24.29.4322, and)
24.29.4329 pertaining to workers')
compensation

TO: All Concerned Persons

1. On March 28, 2024, at 1:00 p.m., a public hearing will be held via remote conferencing to consider the proposed changes to the above-stated rules. There will be no in-person hearing. Interested parties may access the remote conferencing platform in the following ways:

a. Join Zoom Meeting, https://mt-gov.zoom.us/j/83341669516
Meeting ID: 833 4166 9516, Passcode: 356912
-OR-

b. Dial by telephone, +1 406 444 9999 or +1 646 558 8656
Meeting ID: 833 4166 9516, Passcode: 356912

2. The Department of Labor and Industry (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 March 21, 2024, to advise us of the nature of the accommodation that you need. Please contact the department at P.O. Box 1728, Helena, Montana 59624-1728; telephone (406) 444-5466; Montana Relay 711; or e-mail laborlegal@mt.gov.

3. GENERAL STATEMENT OF REASONABLE NECESSITY: There is necessity to substantially review and revise the current workers' compensation rules to provide greater clarity, simplicity, and usability of the administrative rules. The rules are proposed to be amended to eliminate duplication of statute, to repeal no longer applicable rules, and to clarify departmental processes for those who use the workers' compensation rules. This rulemaking is in furtherance of Executive Order 1-2021 and efforts to reduce red tape in administrative rules.

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

24.29.601 DEFINITIONS For the purposes of ARM Title 24, chapter 29, subchapter 6, the following definitions apply:

(1) remains the same.

(2) "Administrative review" as used in Title 39, chapter 71, part 21, MCA refers to the process set forth in [NEW RULE II], except that the timelines specified in 39-71-2105, MCA, apply.

(2) through (5) remain the same but are renumbered (3) through (6).

~~(6) "Department" means the Montana Department of Labor and Industry.~~

~~(7) "Employer" means an "employer" as defined in 39-71-117(1), MCA, except those state agencies that are excluded from the definition pursuant to 39-71-403, MCA.~~

(8) remains the same but is renumbered (7).

~~(9) "Guaranty fund" means the Montana self-insurers guaranty fund, established pursuant to 39-71-2609, MCA.~~

~~(10) "Occupational Disease Act" means Title 39, chapter 72, MCA, as it existed prior to July 1, 2005.~~

(11) and (12) remain the same but are renumbered (8) and (9).

~~(13) "Workers' Compensation Act" means Title 39, chapter 71, MCA.~~

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2107, 39-71-2108, MCA

REASON: The definitions are proposed to be stricken which duplicate statute.

24.29.604 MONTANA SELF-INSURERS GUARANTY FUND--ACCEPTANCE REQUIRED FOR PRIVATE EMPLOYERS OR PRIVATE GROUPS

~~(1) The department's approval of requests from private applicants to self-insure is contingent upon the acceptance of membership in the guaranty fund in accordance with 39-71-2609, MCA. Public employers and groups of public employers are not eligible for membership in the guaranty fund, and the guaranty fund has no role in the approval of decisions regarding the eligibility of public employers or groups of employers to self-insure, or in the amount of security required.~~

~~(2)~~(1) The department will exchange all information with the guaranty fund ~~regarding financial statements, security deposit requirements, excess insurance requirements and any other information~~ pertinent to the department's review of the application.

(3) remains the same but is renumbered (2).

~~(4) If the department does not approve an applicant to self-insure, or if the guaranty fund does not accept the applicant as a member, then the applicant may not be granted permission to self-insure under plan No. 1.~~

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, ~~39-71-2608,~~ 39-71-2609, MCA

REASON: Section (1) is proposed to be stricken because its terms duplicate 39-71-2609(2), MCA, and public employers are described in ARM 24.29.607. The implementation statutes are proposed to be amended to strike a statute which does not exist in favor of the statute actually implemented. Section (2) is proposed to be amended to conform to current business practice. Section (4) is proposed to be repealed because 39-71-2103, MCA, makes clear that both the department and the guaranty fund must approve a self-insurer.

24.29.607 PUBLIC EMPLOYERS OTHER THAN STATE AGENCIES

(1) The provisions of ARM Title 24, chapter 29, subchapter 6 apply to public employers and public employer groups, other than state agencies as defined in 39-71-403, MCA, except that the guaranty fund has no involvement in department decisions regarding public employers or public employer groups and public employers are not required to be members of the guaranty fund.

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2107, 39-71-2108, 39-71-2603, 39-71-2609, MCA

REASON: The rule is proposed to be amended to clarify that public employers need not be members of the guaranty fund.

24.29.611 SECURITY DEPOSIT--CRITERIA (1) ~~When a security deposit is required under ARM 24.29.610, it may be a surety bond, government bond, letter of credit, or certificate of deposit acceptable to the department and the guaranty fund.~~ When a security deposit is required, the following criteria apply:

(a) through (f) remain the same.

AUTH: 39-71-203, 39-71-2106, MCA
IMP: 39-71-403, 39-71-2106, MCA

REASON: Section (1) is proposed to be shortened and was duplicative of statute.

24.29.616 EXCESS INSURANCE--WHEN REQUIRED (1) and (2) remain the same.

(3) The contract or policy of specific excess insurance and aggregate excess insurance must comply with the following:

(a) and (b) remain the same.

~~(c) It may be canceled or its renewal denied only upon written notice by registered or certified mail to the other party to the policy and to the department and the guaranty fund, not less than 60 days before termination by the party desiring to cancel or not renew the policy. A carrier is liable for payment of all claims that occur from the date of inception of the policy to the cancellation date of the policy.~~

~~(d) Any contract or policy containing a commutation clause must provide that any commutation effected thereunder will not relieve the underwriter or underwriters of further liability in respect to claims and expenses unknown at the time of such commutation or in regard to any claim apparently closed at the time of initial commutation which is subsequently reopened by the department or a court. If the underwriter proposes to settle the liability as provided in the commutation clause of the policy for future compensation benefits payable for accidents or occupational diseases occurring during the term of the policy by the payment of a lump sum to the self-insurer, then not less than 60 days prior notice to such commutation must be given by the underwriter(s) or agent(s) by registered or certified mail to the department and the guaranty fund. If any commutation is effected, the department with the concurrence of the guaranty fund, shall have the right to direct such sum be~~

~~placed in trust for payment of benefits of the injured employee(s) entitled to such future payments.~~

~~(e) If a self-insurer becomes insolvent and, or, fails to make benefit payments, the excess carrier, after it has been determined the retention level has been reached on the excess insurance policy, shall make payments to the entity making payments on behalf of the insolvent self-insured in the same manner as payments would have been made by the excess carrier to the self-insured.~~

(c) All excess policies must include department-approved endorsements for cancellation, commutation (if allowed), insolvency, and late claim reporting.

(f) through (h) remain the same but are renumbered (d) through (f).

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

REASON: Subsections (3)(c) through (f) are proposed to be consolidated and simplified.

24.29.617 INITIAL ELECTION--INDIVIDUAL EMPLOYERS (1) An employer initially electing to be bound as a self-insurer shall provide the following:

(a) through (h) remain the same.

~~(i) certification that the self-insurance plan is not funded by a regulated or unregulated insurance company;~~

~~(j)~~(i) evidence that internal policies and procedures are satisfactory to administer a self-insurance program~~; and~~.

~~(k) evidence of permission to self-insure in other states, if applicable.~~

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA

REASON: Subsection (1)(i) is proposed to be stricken because the department analyzes the employer's individual financial statements, and the employer is liable for self-insurance. Subsection (1)(k) is proposed to be stricken because the requirements for self-insurance in other states can differ significantly from Montana.

24.29.618 INITIAL ELECTION--EMPLOYER GROUPS (1) An employer group applicant shall provide the following:

(a) through (d) remain the same.

(e) a copy of at least the most recent year's audited financial statements, or reviewed financial statements, if audited statements are not prepared as part of the employer's normal business practice, from each member of the employer group. The total premiums payable to the group from employers having reviewed financial statements shall not constitute more than 10 percent of the group's total premium. The department or the guaranty fund may require copies of additional years' audited or reviewed financial statements from the applicant~~. Upon request of the applicant, and when approved by the department and the guaranty fund, the submission of these financial statements may be to an independent certified public accountant (CPA). The department will advise the CPA of the nature and format of the~~

~~information to be provided to the department. The applicant shall pay the cost of such a submission and review~~;

(f) through (v) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2106, MCA

REASON: The rule is proposed to be amended because the CPA requirement is no longer used to evaluate financial statements.

24.29.621 NEW MEMBERS OF EMPLOYER GROUPS (1) An employer group which has been self-insured for at least one year may add employers with the approval of the department, and the concurrence of the guaranty fund. ~~New members may only be added on January 1, April 1, July 1 and October 1.~~ The employer group shall provide the following information about the new employer at least 90 days prior to the requested date of addition to the employer group:

(a) through (c) remain the same.

(d) copies of ~~additional~~ two years' audited or reviewed financial statements may be required from each new applicant by the department or the guaranty fund~~.~~; ~~Upon request of the applicant, and when approved by the department and the guaranty fund, the submission of these financial statements may be to an independent certified public accountant. The department will advise the CPA of the nature and format of the information to be provided to the department. The applicant shall pay the cost of such a submission and review;~~

~~(e) the employer group may accept a new applicant who provides reviewed financial statements, provided the total premiums payable to the group from individual members having reviewed financial statements, including the new applicant, shall not exceed 25% of the employer group's total normal premium for the year the applicant joins the employer group;~~

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

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2106, MCA

REASON: Section (1) is proposed to be updated because timing for entry into the group need not be governed by rule and can be left to the discretion of the group. Subsection (1)(d) is proposed to be amended to align with current requirements. Subsection (1)(e) is proposed to be stricken because such verifications are not practicable.

24.29.624 REVOCATION, SUSPENSION, TERMINATION, AND WITHDRAWAL OF PERMISSION (1) The department may revoke its order granting permission to self-insure after determining that the self-insurer no longer meets the requirements of the statutes or ARM Title 24, chapter 29, subchapter 6. The self-insurer may appeal the department's revocation order in accordance with ~~ARM 24.29.207~~ [NEW RULE II]. If a self-insurer's permission to self-insure is revoked, the employer(s) shall elect to be bound by compensation ~~plan No. 1,~~ plan

No. 2~~,~~ or plan No. 3 on the effective date of the revocation of permission to self-insure.

(2) and (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2107, 39-71-2108, 39-71-2609, MCA

REASON: Section (1) is proposed to be amended based on proposed amendments to subchapter 2 in this rulemaking. The subsection is further amended to reflect that a self-insured who is revoked may not elect plan No. 1.

24.29.628 NOTIFICATION OF CHANGES IN SELF-INSURER STATUS REQUIRED (1) The self-insurer shall notify the department in writing:

(a) remains the same.

(b) within 30 days subsequent to:

(i) and (ii) remain the same.

(iii) changes in excess coverage;

(iii) and (iv) remain the same but are renumbered (iv) and (v).

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2107, 39-71-2108, MCA

REASON: There is reasonable necessity to amend (1) to reflect the requirement to notify the department of changes in excess coverage.

24.29.703 ~~ELECTION TO BE BOUND BY COMPENSATION PLAN NO. 2 OR 3~~ EVIDENCE OF COVERAGE ~~(1) Any employer, except state agencies specified in 39-71-403, MCA, may elect coverage under plan No. 2 by owning an insurance policy that is in force, sold by a private insurance carrier authorized by the insurance commissioner's office to sell workers' compensation insurance in Montana.~~

~~(2) Any employer may elect coverage under plan No. 3 by owning an insurance policy that is in force, sold by the state compensation insurance fund.~~

~~(3)~~(1) Insurance policies ~~as required by (1) and (2)~~ under plan No. 2 or 3 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.~~

(a) Montana in section 3A of the coverage declarations page; or

(b) Montana in section 3C of the other or all-states coverage declarations page, expressly as a state to which the policy extends coverage.

(2) To be valid for the purpose of electing coverage, the insurer must be authorized by the insurance commissioner to sell workers' compensation insurance in Montana.

AUTH: 39-71-203, MCA
IMP: ~~39-71-2201, 39-71-2301,~~ 39-71-401, MCA

REASON: Reasonable necessity exists to strike (1) and (2) because they are primarily not substantive. The rule is amended to recognize that all states and fifty states coverage is permissible for Montana workers' compensation in Montana. Reasonable necessity exists to strike 39-71-2301, MCA, from the implementation citations because it was repealed in 1989. Reasonable necessity exists to set the implementation citation as 39-71-401, MCA, because the rule discusses an election to be bound.

24.29.720 PAYMENTS THAT ARE NOT WAGES--EMPLOYEE EXPENSES

(1) ~~Effective January 1, 1993, payments~~ Payments made to an employee to reimburse the employee for ordinary and necessary expenses incurred in the course and scope of employment are not wages if all of the following are met:

(a) through (d) remain the same.

(2) Reimbursement for expenses may be based on any of the following methods that apply:

(a) remains the same.

(b) for meals and lodging, at a flat rate no greater than the amount allowed to employees of the state of Montana pursuant to 2-18-501~~(1)(b) and (2)(b)~~, MCA, for meals~~,~~ and ~~2-18-501(5), MCA for~~ lodging, unless, through documentation, the employer can substantiate a higher rate;

(c) remains the same.

(d) for equipment other than vehicles, the reasonable rental value for that equipment~~, which for individuals involved in timber falling may not exceed $22.50 per working day for chain saw and related timber falling expenses~~;

(e) remains the same.

(f) for drivers utilized or employed by a motor carrier ~~with intrastate operating authority~~, meal and lodging expenses may be reimbursed by either of the methods provided in (2)(a) or (b) for each calendar day the driver is on travel status~~; or~~

~~(g) for drivers utilized or employed by a motor carrier with interstate operating authority, meal and lodging expenses may be reimbursed by the methods provided in (2)(a) or (b), or by a flat rate not to exceed $30.00 for each calendar day the driver is on travel status~~.

AUTH: 39-71-203, MCA
IMP: 39-71-123, MCA

REASON: Reasonable necessity exists to amend (2)(b) because 2-18-501(1)(b), MCA no longer exists. For purposes of this rule, specific reference to subsections is unnecessary, and so the pin cites have been removed. Reasonable necessity exists to combine (2)(f) and (g) to simplify the rule and remove duplicative language. Flat

rates are proposed to be repealed in (2)(d) and (g) because they have not been tracked and timely updated and so are of limited value to stakeholders.

24.29.721 VALUE OF EMPLOYER-FURNISHED HOUSING (1) remains the same.

(2) For the purposes of calculating wages pursuant to 39-71-123, MCA, the monthly fair rental value, in U.S. dollars, for housing is established for each county in Montana. ~~as specified~~ The rental value is specified in the publications ~~entitled~~ below, available on the department's website or on request:

(a) "Montana Workers Compensation Housing, Rent or Lodging Monthly Rates." for the period from April 1, 2018, through [the day before the effective date of this rulemaking]; and

~~(a) The publication is available online via the department's web site, http://erd.dli.mt.gov.~~

~~(b) A printed copy of the publication is available to the public at no cost, upon request to the department's Employment Relations Division.~~

(b) "Montana Workers Compensation Housing, Rent or Lodging Monthly Rates, 2024" beginning July 1, 2024.

(3) and (4) remain the same.

~~(5) The provisions of this rule apply to housing furnished any worker.~~

AUTH: 39-71-203, MCA
IMP: 39-71-123, MCA

REASON: Reasonable necessity exists to update the state's lodging rates because they have not been updated since 2018. In the intervening years, there has been a noticeable increase in lodging rates statewide, totaling a 17% increase across lodging sizes according to Housing and Urban Development's Fair Market Rents. Because of this marked increase, the department proposes an increase in the state's recognized lodging rates. Reasonable necessity exists to strike (5) because it is unnecessary to state the general applicability of a rule which is, by its terms, not limited in applicability.

24.29.801 ACCIDENT REPORTING (1) ~~Upon notice of an accident, injury, or occupational disease an employer shall, within six days of such notice, submit to the employer's workers' compensation insurer or to the department, a completed form known as the first report of occupational injury/occupational disease.~~ An employer shall submit the first report of injury/occupational disease form to its insurer within six days of notice of an accident, injury, or occupational disease. If a first report is improperly sent to the department, it will be forwarded to the insurer, if any.

(2) An employer not covered by workers' compensation shall submit the report to the department.

(3) An employee may submit a report to the department.

AUTH: 39-71-203, 39-71-307, MCA
IMP: 39-71-307, 39-71-603, MCA

REASON: Reasonable necessity exists to amend this rule to simplify its form for the reader. Additionally, the rule is amended to clarify that FROIs for insured employers should be provided to the employer's insurance, and only those instances where the employer is uninsured should the report come to the department.

24.29.813 DEFINITIONS For purposes of this subchapter, the following definitions apply:

~~(1) "Approved continuing education course" or "course" means any course, seminar, or program of instruction that has been approved by the department for presentation as part of the continuing education requirements for claims examiner certification and that relates to the state workers' compensation system or to interactions among injured workers, medical providers, and employers.~~

~~(2) "Certificate of completion" means a document issued by the sponsoring organization to the claims examiner signifying satisfactory completion of a course and reflecting credit hours earned by the claims examiner.~~

(3) remains the same but is renumbered (1).

~~(4) "Claims examiner" means a claims examiner as defined under 39-71-116, MCA.~~

(5) through (8) remain the same but are renumbered (2) through (5).

~~(9) "Proctor" means a person who monitors the attendance, conduct, and the examination process for course participants, but who does not participate in course presentations, activities or discussions, or complete any required examinations.~~

~~(10) "Remote training" means a course format in which a body of students attend a training session using a web meeting tool and/or conference telephone service with a method approved by the department to ensure full participation of each student.~~

~~(11) "Self-study" means those independent study methods taught outside the classroom setting through approved text or prerecorded audio or video content, or another method of information exchange where both the means and content are approved by the department.~~

(12) through (14) remain the same but are renumbered (6) through (8).

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to strike the definition of "approved continuing education course" because it is the common definition. Reasonable necessity exists to strike the definition of "certificate of completion" because the term was not used in these rules. Reasonable necessity exists to strike the definition of "claims examiner" because it is not necessary to restate in rule what is set forth in statute. Reasonable necessity exists to strike the definition of "proctor" because it is the common, dictionary definition of the term and need not be restated in rule. Reasonable necessity exists to strike the definitions of "remote training" and "self-study" because their only use in these rules is proposed to be stricken as well.

24.29.816 DECISIONS WHICH MUST BE MADE BY A CERTIFIED CLAIMS EXAMINER (1) Except as provided by ARM 24.29.818 and this rule, only a certified claims examiner may perform the tasks identified by 39-71-116, MCA, as being the responsibility of a claims examiner. ~~As provided by 39-71-116, MCA, those tasks are to:~~

~~(a) determine liability;~~

~~(b) apply the requirements of the Workers' Compensation Act;~~

~~(c) settle workers' compensation or occupational disease claims; and~~

~~(d) determine survivor benefits.~~

(2) remains the same.

~~(3) Examples of decisions made under (2) include, but are not necessarily limited to:~~

~~(a) changing the disability status of a worker; and~~

~~(b) denying medical benefits.~~

(4) and (5) remain the same but are renumbered (3) and (4).

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-107, 39-71-116, 39-71-320, MCA

REASON: Reasonable necessity exists to strike portions of (1) because they explicitly restate statute. Reasonable necessity exists to strike (3) because it is not necessary to state examples which are necessarily included in the provisions of (2).

24.29.818 NEW HIRES AND CLAIMS EXAMINER TRAINEES – DESIGNATION OF CERTIFIED CLAIMS EXAMINER TO BE ACCOUNTABLE FOR DECISIONS (1) remains the same.

(2) ~~The employer of a new hire or claims examiner trainee must maintain documentation for each claim being handled by a new hire or claims examiner trainee, of the certified claims examiner who is accountable for the decisions made by that new hire or claims examiner trainee.~~ Record of the accountable certified claims examiner must be maintained, including any change of accountability. The records must be provided to the department and the injured worker or their attorney if requested in writing.

~~(a) The employer may change the certified claims examiner designated as being accountable for decisions on a claim being handled by a new hire or claims examiner trainee at any time, so long as that change is appropriately documented within the insurer's records.~~

~~(b) The documentation required by this section must be promptly made available to the department, the injured worker, or the attorney of an injured worker, if that information is requested in writing.~~

~~(3) A person who is a new hire or claims examiner trainee that does not timely become a certified claims examiner is not allowed to perform tasks that are required to be performed by a certified claims examiner.~~

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to amend (2) to simplify the rule for ease of use. Reasonable necessity exists to strike (3) because it is duplicative of (1), which sets forth a definitive requirement that a new hire or claims examiner trainee may only work in such capacity for 180 days.

24.29.821 CERTIFICATION OF CLAIMS EXAMINERS (1) Claims examiners must be certified by the department upon the following:

(a) remains the same.

~~(b) meeting the minimum qualifications for certification in (2);~~

(c) and (d) remain the same but are renumbered (b) and (c).

~~(2) To meet the minimum qualifications, the applicant for certification shall be:~~

~~(a) at least 18 years of age; and~~

~~(b) have a high school diploma or equivalent certificate.~~

(3) remains the same but is renumbered (2).

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to strike the requirement of a high school diploma and age limitation because it sets forth an artificial barrier to entry into the field of claims examination. While certification without a diploma may be atypical, there is not a reason to mandate the diploma.

24.29.824 EXAMINATION FOR CLAIMS EXAMINERS (1) ~~Each applicant for certification as a workers' compensation claims examiner shall, prior to the issuance of such certification, personally take and pass an examination given by the department or a department-approved agent as a test of qualifications and competency.~~ Certified claims examiner applicants must take and pass the department-approved examination.

~~(2) Satisfactory completion of an examination demonstrates the individual's:~~

~~(a) familiarity with Montana's workers' compensation statutes;~~

~~(b) ability to navigate the administrative rules found in this chapter;~~

~~(c) knowledge of workers' compensation definitions and concepts.~~

(3) through (5) remain the same but are renumbered (2) through (4).

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to restate (1) for ease of reading. Reasonable necessity exists to strike (2) because it sets forth aspirational, nonessential language regarding the purpose for the statutorily required examination.

24.29.831 LAPSE IN CERTIFICATION (1) and (2) remain the same.

~~(3) A person may not perform the functions of a certified claims examiner with a lapsed certification.~~

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to strike (3) because it is not necessary to restate in this rule that an individual who is not a certified claims examiner may not act on claims. This is already stated in ARM 24.29.816.

24.29.837 REVIEW AND APPROVAL OF CONTINUING EDUCATION COURSES BY DEPARTMENT (1) remains the same.

(2) The department shall review the course submission and determine whether to approve the course and the number of credit hours to be awarded for completion of the course.

~~(3) Courses subject to an award of continuing education credits may include but are not limited to:~~

~~(a) classroom setting or seminars;~~

~~(b) self-study, electronic media;~~

~~(c) correspondence course;~~

~~(d) computer-based training; or~~

~~(e) remote training.~~

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to amend (2) to clarify that courses submitted to the department may be approved or disapproved based on the information provided. Reasonable necessity exists to strike (3) because CE may be offered in any format; providing a list of possible formats may cause confusion as to what might be intended to be excluded.

24.29.841 COURSE SUBMISSIONS (1) remains the same.

(2) Submissions for approval of courses must include ~~at least the following information:~~ all information requested by the department on the form for submission.

~~(a) the name of the sponsoring organization;~~

~~(b) the title of the course;~~

~~(c) the proposed date(s) of offering or the dates the course was held;~~

~~(d) course goals and objectives;~~

~~(e) major course topic(s);~~

~~(f) course length;~~

~~(g) a list of other states, if any, that have approved the course and the credits granted the course in those states;~~

~~(h) a syllabus or course outline;~~

~~(i) a summary of each course outline element;~~

~~(j) method of instruction, such as classroom, self-study, videotape, audiotape, teleconference, etc.;~~

~~(k) method of administering examinations, if any;~~

~~(l) method of attendance verification;~~

~~(m) method of student record maintenance;~~
~~(n) instructors, if any;~~
~~(o) a designated contact person;~~
~~(p) a written explanation of examination security measures and examination administration methods; and~~
~~(q) written notification of additional dates of course offering to the department three days in advance of presentation of any course.~~
(3) and (4) remain the same.
~~(5) Approved accredited university or college courses will be allowed 15 continuing education credits for each semester credit and ten continuing education credits for each quarter credit.~~
(6) through (12) remain the same but are renumbered (5) through (11).

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-320, MCA

REASON: Reasonable necessity exists to strike the subsections of (2) in favor of the simplicity of mandating the form for submission of approval produced by the department. Reasonable necessity exists to strike (5) because, while those courses may be approved, they will be approved through the regular application process based on a review of the application submitted.

24.29.844 QUALIFICATIONS FOR INSTRUCTORS (1) Instructors must ~~meet the following qualifications~~ have experience in at least one of the following for the department to approve the course:
~~(a) a high school diploma or equivalent certificate;~~
~~(b) experience in at least one of the following:~~
(i) through (iii) remain the same but are renumbered (a) through (c).
(2) through (4) remain the same.

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-320, MCA

REASON: There is reasonable necessity to strike the requirement of a high school diploma for an instructor because the level of formal education completed has no bearing on the knowledge or expertise the instructor might have. A training is approved based on the materials to be presented, rather than the completion of high school by the instructor.

24.29.908 PENALTIES, ADMINISTRATIVE FINES, AND INTEREST
(1) remains the same.

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-306, 39-71-915, 39-71-1049, 50-71-128, MCA

REASON: There is reasonable necessity to update the implementation citations to clarify and specify the applicability of this rule to all funds administered in workers' compensation.

24.29.1201 ~~INTRODUCTION~~ APPROVAL – WHEN REQUIRED ~~(1) The department may approve a petition for a lump-sum settlement between an insurer and an injured worker or the worker's beneficiary, which converts permanent disability biweekly payments to a lump-sum payment, in accordance with the provisions of 39-71-741, MCA.~~

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

~~(4) Conversion of biweekly permanent partial disability benefits to a lump sum must meet the requirements of (3) only when the claimant's date of injury was prior to July 1, 1991.~~

~~(5)~~(3) Conversion of biweekly permanent total disability benefits to a lump sum must meet the test of ~~(3)~~ this rule for all dates of injury.

~~(6) The Workers' Compensation Court has jurisdiction over disputes between claimants and insurers regarding conversion of biweekly disability payments to a lump sum and disputes arising from the department's denial of approval of a petition for conversion. A dispute between an insurer and claimant is subject to mediation. A dispute arising from department denial of a petition for conversion is not subject to mandatory mediation.~~

AUTH: 39-71-203, MCA~~, Chapter 471, Laws of 1985~~
IMP: 39-71-741, MCA

REASON: Reasonable necessity exists to amend the catchphrase to clarify that the rule provides substance, not merely an introduction to substantive rules, and to set forth the reason for the rule. Reasonable necessity exists to strike (1) because it is duplicative of 39-71-741(1), MCA. Reasonable necessity exists to strike (4) because it applies to claims that are at least 33 years old. Reasonable necessity exists to strike (6) because it is duplicative of 39-71-741(6) and (7), MCA. Reasonable necessity exists to update the authorizing statutes to clarify the rulemaking authority for this rule.

24.29.1202 DOCUMENTATION REQUIREMENTS (1) A petition to the department for lump-sum conversion of biweekly permanent total disability benefits for all dates of injury must include a description of the lump-sum proposal, including but not limited to:

(a) analysis of the worker's current financial conditions as described in (3);

(b) analysis of the worker's financial condition under the proposed lump-sum conversion, that includes a description of the use of the lump sum and how this use will contribute to financially sustaining the worker over the same period biweekly payments would have been paid;

(c) analysis of financial condition that would be reasonably expected had the worker not been injured ~~as described in (6)~~; and

(d) through (2) remain the same.

(3) "Analysis of current financial condition" for purposes of (1) shall include a detailed list of all the worker's ~~income,~~ assets, ~~and~~ liabilities, ~~as well as other available resources, including but not limited to:~~ sources of income, and monthly obligations.

~~(a) periodic income (specify periods reported):~~
~~(i) social security disability income,~~
~~(ii) social security retirement income,~~
~~(iii) retirement or pension income,~~
~~(iv) other disability insurance,~~
~~(v) health insurance benefits,~~
~~(vi) mortgage insurance benefits,~~
~~(vii) spousal or other family income,~~
~~(viii) life insurance proceeds,~~
~~(ix) credit disability benefits,~~
~~(x) interest or dividend income,~~
~~(xi) workers' compensation benefits,~~
~~(xii) third party recovery (actual or potential);~~
~~(b) monetary assets:~~
~~(i) cash on hand,~~
~~(ii) checking account,~~
~~(iii) savings account,~~
~~(iv) accounts and notes receivable,~~
~~(v) savings bonds,~~
~~(vi) stocks and bonds,~~
~~(vii) mutual funds,~~
~~(viii) cash value of life insurance,~~
~~(ix) cash value of annuities,~~
~~(x) cash value of retirement fund;~~
~~(c) fixed assets:~~
~~(i) home and property,~~
~~(ii) other real estate,~~
~~(iii) retirement fund,~~
~~(iv) motor vehicles,~~
~~(v) personal property;~~
~~(d) liabilities:~~
~~(i) all monthly living expenses,~~
~~(ii) existing delinquent or outstanding debts,~~
~~(iii) periodic payments on debts,~~
~~(iv) long-term liabilities,~~
~~(v) attorney fees and costs.~~

(4) ~~If a~~ A petition for lump-sum conversion of permanent total benefits that involves the partial or total elimination of existing delinquent or outstanding debts~~, a debt management plan must be described and include:~~ must include a plan for debt consolidation.

~~(a) plan of management, through applying the proposed lump-sum payment, of all existing delinquent or outstanding debts, both short- and long-term; and~~

~~(b) description of how the worker will be sustained financially through use of the lump-sum payment and other available resources, including cash available throughout the life of the debt management plan, to manage delinquent or outstanding debts.~~

(5) If a permanent total benefit lump-sum proposal involves a business venture, the proposal must include a business plan ~~must be described and include:~~ that shows the net income available to the worker after business expenses are paid.

~~(a) Information indicating the worker's capability in proposed business venture, including:~~

~~(i) relevant educational and work history,~~

~~(ii) knowledge of the proposed business,~~

~~(iii) if managerial, managerial capability,~~

~~(iv) role to be assumed in the proposed business.~~

~~(b) If the venture is a new business, information about the proposed business venture including, but not limited to:~~

~~(i) description of the proposed business venture,~~

~~(ii) estimate of the purchase price of the business,~~

~~(iii) work sheets showing: total source of dollars, start-up costs, projected expenses and net income forecast,~~

~~(iv) feasibility study of the market conditions in the intended market area, showing that the business is a feasible venture.~~

~~(c) If the venture is an existing business, information about the proposed business including, but not limited to:~~

~~(i) description of proposed business venture,~~

~~(ii) legal agreement showing intent to sell the existing business, purchase price of the business, and any conditions placed upon such sale,~~

~~(iii) income tax statements and balance sheets for the two consecutive years prior to the agreement to sell the business,~~

~~(iv) work sheets showing total source of dollars, start-up costs, projected expenses and net income forecast,~~

~~(v) market analysis showing market conditions in the intended market area.~~

~~(d) A statement of cash that will be available to the worker as income on a biweekly basis after start-up costs and other business expenses are considered throughout the life of the venture.~~

~~(6) "Analysis of financial condition that would be reasonably expected had the worker not been injured" for purposes of (1) must include a description of the income the worker would have received and the basis upon which the estimate is derived. The analysis must include:~~

~~(a) evidence of education and work experience, including:~~

~~(i) work history, dates and descriptions of employment or unemployment, names and locations of employers;~~

~~(ii) highest level of formal education attained, degrees received, dates of attendance, names and locations of schools; and~~

~~(iii) special training, professional licenses, registrations, or certifications, certifications received; dates of attendance, names and locations of institutions providing training, licenses, registrations or certifications.~~

~~(b) evidence of probable job promotions and pay increases, including:~~

~~(i) supportive documentation from employers, union contracts, or other reasonable substantiation of probable job promotions,~~

~~(ii) wage history,~~

~~(iii) statement from employer at the date of the accident of last wage rate paid; and~~

~~(iv) supportive documentation estimating wage rates from the date of the accident up to age 65.~~

~~(7)~~(6) A request for lump-sum settlement of medical benefits must include ~~the following information~~ the following completed forms:

~~(a) copy of medical reports documenting maximum medical improvement, current diagnosis, and recommendations for future treatment, if any;~~

~~(b) specific dollar amount of the settlement allocated to medical benefits;~~

~~(c) statement from the claimant and insurer as to why it is in the best interest of the parties to settle medical benefits;~~

~~(d) statement signed by the claimant to acknowledge the claimant understands which specific medical benefits will terminate upon settlement;~~

~~(e) statement signed by the claimant to acknowledge the claimant is on notice and understands that the future medical benefits settled under the agreement may not be covered by secondary healthcare payers such as Medicare, Medicaid, or other health insurers; and~~

~~(f) submission of the following completed forms to the department:~~

~~(i) "Summary of Settlement of Medical Benefits" form with original signatures by the claimant and the insurer or the insurer's authorized representative; and~~

~~(ii)~~(a) "Petition for Settlement Injury/Occupational Disease Medical Benefits Closed On An Accepted Claim" form ~~with original signatures~~ signed by the claimant, a witness, and the insurer or the insurer's authorized representative;~~.~~

(b) "Recap Sheet" form signed by the claimant and the insurer or the insurer's authorized representative; and

(c) "Summary of Settlement of Medical Benefits" form signed by the claimant and the insurer or the insurer's authorized representative.

~~(8)~~(7) The total value of the workers' compensation benefits may be discounted at the current rate established by the department when an insurer calculates a conversion to a lump-sum payment. ~~Only for~~ For claims with dates of injury between April 15, 1985 and June 30, 1987, the lump-sum payment may be discounted by 7%, compounded annually.

AUTH: 39-71-203, MCA
IMP: 39-71-741, MCA

REASON: There is reasonable necessity to amend this rule to remove unnecessary detail and better communicate current practice. Section (7) is proposed to be amended to recognize the available use of electronic signatures and to remove the detail of what is already in the form. The forms required are additionally reordered and include the recap sheet, which is collected as part of current business practice.

24.29.1512 SELECTION OF PHYSICIAN FOR CLAIMS ARISING ON OR AFTER JULY 1, 2013 ~~(1) For claims arising on or after July 1, 2013, "treating physician" has the meaning provided by 39-71-116, MCA.~~

~~(2)~~(1) ~~The worker may select a treating physician.~~ Initial or repeated treatment in an emergency room or urgent care facility is not selection of a treating physician. ~~The selection of a treating physician should be made as soon as practicable. A worker may not avoid selection of a treating physician by repeatedly seeking care in an emergency room or urgent care facility. The worker should select a treating physician with due consideration for the type of injury or occupational disease suffered, as well as practical considerations such as the proximity and the availability of the physician to the worker.~~

~~(3) Any time after an insurer accepts liability for an injury or occupational disease, the insurer may recognize a treating physician selected by the injured worker. The treating physician is compensated at 100 percent of the fee schedule.~~

~~(4) After acceptance of liability, the insurer may formally approve the treating physician selected by the injured worker as a designated treating physician or may choose a different physician to be the designated treating physician. The designated treating physician is compensated at 110 percent of the fee schedule.~~

~~(a) The designated treating physician is responsible for coordination of all medical care, pursuant to 39-71-1101(2), MCA. The designated treating physician must agree to accept these responsibilities.~~

(b) remains the same but is renumbered (2).

(i) through (iii) remain the same but are renumbered (a) through (c).

~~(c) A health care provider who is referred by the designated treating physician is compensated at 90 percent of the fee schedule. These providers are not responsible for coordinating care or providing determinations as required by the designated treating physician.~~

~~(5) Treatment from a physician's assistant or an advanced practice nurse, when the treatment is under the direction of the treating physician, does not constitute a change of physician and does not require prior authorization pursuant to ARM 24.29.1517.~~

~~(6) Subject to 39-71-1101, MCA, ARM 24.29.1517, and any other applicable rule or statute, nothing in this rule prohibits the claimant from receiving treatment from more than one physician if required by the claimant's injury or occupational disease.~~

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

REASON: Reasonable necessity exists to strike (1) because it is not necessary to adopt a definition from the statutes which the rules implement and is duplicative of 39-71-1101, MCA. A portion of (2) is proposed to be stricken because it implies misfeasance on the part of injured workers and does not take into consideration the ability of insurers to designate a treating physician. Criteria for treating physician selection is unnecessary. Sections (3) and (4) are proposed to be repealed because they duplicate 39-71-1101, MCA. Reasonable necessity exists to strike (5) and (6) because it is not necessary to state in rule that treatment may be received from

multiple providers. Additionally, the rule artificially limits such treatment to physicians and duplicates 39-71-1101, MCA.

24.29.1513 DOCUMENTATION REQUIREMENTS (1) ~~When a treating physician, emergency room or similar urgent care facility sees the claimant for the first time (related to the claim), the provider must furnish to the insurer the initial report, the Medical Status Form (MSF), and the treatment bill (CMS 1500) within seven business days of the visit.~~ A treating physician or emergent or urgent care provider must provide the insurer the following documents within seven days of the first claim-related visit:

(a) initial report;

(b) Medical Status Form; and

(c) treatment bill (CMS 1500).

(2) ~~As soon as possible, upon completion of the initial diagnostic process, the treating physician must prepare a treatment plan and promptly furnish a copy to the insurer. Subsequent changes in the treatment plan must be documented and a copy of the amended treatment plan must be promptly furnished to the insurer.~~ The treating physician must prepare a treatment plan. The treatment plan must be provided to the insurer as soon as possible. The treating physician must provide any changes to the treatment plan to the insurer.

(3) To be eligible for payment ~~for subsequent visits~~, the provider must ~~furnish~~ provide to the insurer:

(a) ~~the treatment bill (~~CMS 1500~~)~~;

(b) functional improvement status with respect to the treatment plan; and

(c) applicable treatment notes ~~with the bill~~.

~~(4) Certain treatment plans may require services be obtained from a vendor that is outside the tradition of being a professional health care provider. Under that circumstance, the treating physician has the obligation to include the medical necessity for the service in the treatment plan and furnish functional improvement status as appropriate. The vendor, however, is responsible for furnishing documentation.~~

~~(a) The following are examples of services that are contemplated as falling within the meaning of this subsection:~~

~~(i) health club membership; and~~

~~(ii) home health care services.~~

(5) and (6) remain the same but are renumbered (4) and (5).

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

REASON: Sections (1) and (2) are proposed to be amended to simplify the language and improve readability. Section (3) is proposed to be updated to align with ARM 24.29.1515. Section (4) is proposed to be repealed because requirements for the treatment plan are set forth in the utilization and treatment guidelines. It is not necessary to reiterate that the provider seeking reimbursement must provide the billing information to the insurer.

24.29.1515 FUNCTIONAL IMPROVEMENT STATUS (1) remains the same.

~~(2) If there are any significant changes in the treatment plan, that fact must be noted and described.~~

AUTH: 39-71-203, MCA
IMP: 39-71-704, 39-71-1036, MCA

REASON: Reasonable necessity exists to strike (2) because it is duplicative of requirements set forth in ARM 24.29.1513. Reasonable necessity exists to update the implementation statutes to refer to the statute requiring the creation of the medical status form.

24.29.1523 MEDICAL EQUIPMENT AND SUPPLIES ~~FOR DATES OF SERVICE ON OR AFTER JULY 1, 2013~~ ~~(1) For both facility and professional services, reimbursement for DME dispensed through a medical provider is determined by the professional fee schedule in effect on the date of service, except for prescription medicines as provided by ARM 24.29.1529. On March 31 of each year, or as soon thereafter as is reasonably feasible, the professional fee schedule with updated HCPCS will be posted on the web site. If a RVU is not listed or if the RVU is listed as null, reimbursement is limited to a total amount that is determined by adding the cost of the item plus the lesser of either $30.00 or 30 percent of the cost of the item plus the freight cost. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.~~

~~(a) Copies of the instructions are available on the department web site or may be obtained at no charge from the Montana Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59604-8011.~~

(1) If the relative value unit is null or not listed on the fee schedule for durable medical equipment, reimbursement is the total of:

(a) item cost;

(b) shipping cost; and

(c) the lesser of $30 or 30% of the item cost.

(2) If a provider adds value to ~~DME~~ durable medical equipment (such as by complex assembly, modification, or special fabrication), then the provider may charge a reasonable fee for those services. ~~Merely unpacking~~ Unpacking an item ~~is not a "value-added" service~~ or simple fitting may not be billed. ~~While extensive~~ Extensive fitting of devices may be billed ~~for, simple fitting (such as adjusting the height of crutches) is not billable~~.

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

REASON: Reasonable necessity exists to amend the catchphrase because the language pertaining to other dates is proposed to be repealed. Reasonable necessity exists to rewrite (1) to clarify, simplify, and shorten the rule, as well as to strike duplicative text. Section (2) is amended for brevity and to define "DME" (durable medical equipment).

24.29.1534 PROFESSIONAL FEE SCHEDULE ~~FOR SERVICES PROVIDED ON OR AFTER JULY 1, 2013~~ (1) ~~The department adopts the professional fee schedule provided by this rule to determine the reimbursement amounts for medical services provided by a professional provider at a nonfacility or facility furnished on or after July 1, 2013.~~ An insurer must pay the fee schedule or the billed charge, whichever is less, for a service provided within the state of Montana. The fee schedules are available online at the ~~Employment Relations Division~~ department's web site and are updated as soon as is reasonably feasible relative to the effective dates of the medical codes as described below. All current and prior instruction sets for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the instruction sets for services provided starting July 1, 2013, through the present may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~ The fee schedules are comprised of the elements listed in 39-71-704, MCA, and the following:

(a) remains the same.

(b) modifiers, listed on the ~~ERD~~ department's website;

(c) through (e) remain the same.

(2) The conversion factors, the Current Procedural Terminology (CPT) codes, and the relative value unit (RVU)~~s~~ used depend on the date the medical service, procedure, or supply is provided. The reimbursement amount is generally determined by finding the proper CPT code in the Resource-Based Relative Value Scale (RBRVS) then multiplying the RVU for that code by the conversion factor. ~~For example, if the conversion factor is $5.00, and a procedure code has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is $15.00.~~

(3) Where a permitted procedure is not covered by these rules or uses a new code, the insurer must pay 75 percent of the usual and customary fee charged by the provider to nonworkers' compensation patients ~~unless the procedure is not allowed by these rules~~.

(4) remains the same.

(5) Professionals, including those who furnish services in a hospital, ~~CAH, ASC,~~ critical access hospital, ambulatory surgery center, or other facility setting must bill insurers using the CMS 1500, with the exception of ~~PT, OT, and ST~~ physical therapy, occupational therapy, and speech therapy services provided on an outpatient basis and billed on a UB04.

(6) remains the same.

(7) When billing the services listed below, the Montana unique code, MT001, must be used and a separate written report is required describing the services provided. The reimbursement rate for this code is 0.54 RVUs per 15 minutes with time documented by the provider. These requirements apply to the following services:

(a) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor; ~~or~~

(b) a report associated with nonphysician conferences required by the payor; ~~or~~

(c) through (10) remain the same.

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

REASON: Amendments are proposed to strike superfluous language and to define acronyms.

24.29.1538 CONVERSION FACTORS ~~FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008~~ ~~(1) This rule applies to services, supplies, and equipment provided on or after January 1, 2008.~~

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

(b) All prior conversion factors for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the conversion factors for services provided starting July 1, 2013, may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

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

(b) All prior conversion factors for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the conversion factors for services provided starting July 1, 2013, may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

~~(4) Up to the top five insurers or third-party administrators, ranked by premiums written in Montana providing group health insurance coverage through a group health plan as defined in 33-22-140, MCA, and who use the RBRVS to determine fees for covered services, must annually provide to the department their current standard conversion factors by July 1.~~

~~(5) The conversion factor amounts for professional services are calculated using the average rates for medical services paid by up to the top five insurers or third-party administrators providing group health insurance via a group health plan in Montana, based upon the amount of premium for that category of insurance reported to the office of the Montana insurance commissioner. The term "group health plan" has the same meaning as provided by 33-22-140, MCA. To be included in the conversion factor determination, the insurer or third-party administrator must occupy at least one percent of the market share for group health insurance policies as reported annually to the insurance commissioner.~~

~~(a) The department annually surveys up to the top five insurers to collect information on the rates (the RBRVS conversion factors) paid during the current year for professional health care services furnished in Montana.~~

~~(b) The department's conversion factors for the following year are set at no more than 110 percent of the surveyed average.~~

(3) The department will annually survey up to the top five insurers or third-party administrators providing group health plan coverage in Montana to collect information on the conversion factors paid during the current year for professional health care services in Montana. The term group health plan has the same meaning as provided in 33-22-140, MCA.

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

REASON: The rule is proposed to be amended to strike contact information of the department. The referenced reports are available on the department's website, and additional contact information, if needed, is also available on the website. Section (4) is proposed to be stricken because it is duplicative of (5). Section (5) is proposed to be stricken and replaced with new (3) for brevity and simplicity.

24.29.1601 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) remains the same.

~~(2) "Department" means the Department of Labor and Industry, Employment Relations Division.~~

(3) through (19) remain the same but are renumbered (2) through (18).

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

REASON: There is reasonable necessity to strike the definition of "department" because it is unnecessary to define in rule something already defined by controlling statute.

24.29.1611 UTILIZATION AND TREATMENT GUIDELINES (1) The department adopts the utilization and treatment guidelines provided by this rule to set forth the level and type of care for primary and secondary medical services. As provided by 39-71-704, MCA, there is a rebuttable presumption that the Montana Guidelines establish compensable medical treatment for primary and secondary medical services for the injured worker. The applicable utilization and treatment guidelines are available electronically ~~at the web site: http://www.mtguidelines.com; or a printed copy may be obtained for the cost of reproduction from the Employment Relations Division, Department of Labor and Industry, P.O. Box 8011, Helena, MT 59601-8011~~ on the department's website. The Montana Guidelines incorporated by reference apply as follows:

(a) and (b) remain the same.

~~(2) The Montana Guidelines consist of the following ten chapters and General Guideline Principles which are included at the beginning of each chapter:~~

~~(a) Low Back Pain;~~
~~(b) Shoulder Injury;~~
~~(c) Thoracic Outlet Syndrome;~~
~~(d) Lower Extremity;~~
~~(e) Chronic Pain Disorder;~~
~~(f) Cervical Spine Injury;~~
~~(g) Complex Regional Pain Syndrome;~~
~~(h) Mild Traumatic Brain Injury;~~
~~(i) Moderate/Severe Traumatic Brain Injury; and~~
~~(j) Cumulative Trauma Conditions.~~

~~(3)~~(2) The utilization and treatment guidelines adopted in (1) are to be read in conjunction with the Centers for Disease Control publications~~:~~,

~~(a)~~ "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, ~~2016~~ 2022."~~; and~~

~~(b) 2018 edition of "Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain."~~

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

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

REASON: Reasonable necessity exists to update (1) to guide users more generally to the department's website to access guidelines. Section (2) is proposed to be stricken, because the table of contents is also available on the website. Section (3) is proposed to be updated to reference the current guidelines.

24.29.1616 INCORPORATION BY REFERENCE AND UPDATES TO THE FORMULARY (1) through (3) remain the same.

(4) The formulary is available ~~from:~~ on the department's website and from

~~(a) the department's web site, at https://erd.dli.mt.gov/work-comp-claims, at no charge;~~

~~(b) the department at Employment Relations Division, Medical Regulations, P.O. Box 8011, Helena, MT 59624-8011, at the costs of reproduction and postage for a printed .pdf version; and~~

~~(c)~~ the vendor, via electronic access, at a subscription rate charged by the vendor, which may include supplemental information or materials that are not incorporated by reference. The vendor may be contacted ~~via the internet~~ at www.mcg.com/odg, and at ODG by MCG Health, 3006 Bee Caves Road, Suite A250, Austin, TX 78746.

(5) remains the same.

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

REASON: Reasonable necessity exists to amend (4) to eliminate incorrect titles and websites within the department. The information remains available from the department on its website.

24.29.1621 PRIOR AUTHORIZATION (1) Prior authorization must be obtained in cases where treatment(s) or procedure(s) are requested that:

(a) are not specifically addressed or recommended by the Montana Guidelines for a body part that is covered by a guideline or for body parts not covered by the Montana Guidelines;

(b) through (d) remain the same.

~~(2) For those body parts not covered by a guideline, the rule for prior authorization set out at ARM 24.29.1517 applies.~~

(2) Prior authorization is not required for emergency procedures.

(3) and (4) remain the same.

(5) All prior authorization requests~~, whether in written, e-mail, or facsimile (fax) form,~~ must be made at least 14 days prior to the date the service is scheduled ~~to be performed~~.

(a) Authorization is presumed to be given ~~by the insurer if there is no written denial sent by the insurer to the interested party within 14 days of the date the written prior authorization request was made~~ if not denied within 14 days.

(b) remains the same.

(c) ~~Nothing in this rule precludes verbal communication. However, all deadlines in this rule must be satisfied in written form.~~ A verbal request for authorization must be memorialized in writing to the insurer by the provider promptly. The memorialization must include all relevant details of the request and approval.

(6) and (7) remain the same.

~~(8) The provisions of this rule apply to medical services provided, or proposed to be provided, on or after July 1, 2011.~~

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

REASON: The rule is proposed to be amended to provide clarification as to the applicability of the rule. Additionally, the rule is amended to remove unnecessary verbiage.

24.29.1710 AUXILIARY REHABILITATION BENEFITS (1) remains the same.

~~(2) Travel and relocation expenses may be paid to a worker on the same schedule as reimbursed to state employees in the course of state business.~~

(3) through (5) remain the same but are renumbered (2) through (4).

~~(6)~~(5) The ~~division~~ department may order the insurer to pay such other reasonable and necessary auxiliary rehabilitation benefits as it deems appropriate.

AUTH: 39-71-203, MCA
IMP: 39-71-1025, MCA

REASON: Reasonable necessity exists to strike (2) because the timing of such reimbursement is not well defined for state employees, and as such, the rule lacks clarity. Reasonable necessity exists to amend (6) to reflect the change from the Division of Workers' Compensation to the department.

24.29.1725 INFORMATION TO BE INCLUDED IN THE REHABILITATION PLAN (1) and (1)(a) remain the same.

~~(b) the beginning and completion dates of the rehabilitation plan;~~

~~(c)~~(b) a projection of expenditures to be made pursuant to the plan~~. The plan should include an estimate of the amount of tuition, fees, books, and other reasonable retraining expenses needed to successfully complete the plan. The plan should also include~~ including the date the funds are needed and to whom the funds should be paid;

~~(d)~~(c) a description of the claimant's responsibilities under the plan~~. The plan should identify the responsibilities the claimant has agreed to undertake for successful completion of the plan. For example, the claimant agrees to attend classes and maintain a 2.0 grade point average, or the claimant agrees to timely register for classes, etc.~~;

~~(e)~~(d) a description of the insurer's responsibilities under the plan~~. The plan should identify the responsibilities the insurer has agreed to undertake for successful completion of the plan. For example, the insurer will pay rehabilitation benefits for a period of 70 weeks to begin on a specific date, etc.~~;

~~(f)~~(e) a description of the vocational rehabilitation provider's responsibilities~~. The plan should identify and list what actions or understandings the provider has agreed to undertake for successful completion of the plan. For example, the provider will continue to monitor the claimant's progress and provide further vocational rehabilitation services necessary to successfully complete the plan, etc.~~; and

(g) remains the same but is renumbered (f).

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

REASON: Reasonable necessity exists to strike (1)(b) and portions of (1)(c) because they duplicate 39-71-1006(1)(c), MCA. Amendments to (1)(d) through (f) are proposed to remove superfluous language.

24.29.1741 PAYMENT OF REHABILITATION EXPENSES ~~FOR CLAIMS~~ ARISING ON OR AFTER JULY 1, 1997 ~~(1) For claims arising on or after July 1, 1997, a disabled worker is entitled to receive payment for reasonable tuition, fees, books, and other reasonable and necessary retraining expenses, excluding travel and living expenses paid pursuant to the provisions of 39-71-1025, MCA.~~

~~(2) The insurer and claimant must agree to payment of tuition, fees, books and other reasonable and necessary retraining expenses. The expenses must be specified in the rehabilitation plan agreed upon between the insurer and claimant. The expenses must be paid directly by the insurer.~~

~~(3)~~(1) The insurer must pay for tuition ~~required for the agreed upon rehabilitation plan. The insurer must pay for~~, fees, books, supplies, and equipment which are a prerequisite for the retraining and required by the provider of the training. Unless otherwise agreed upon by the insurer and the claimant, the insurer is not responsible for f~~ees, books, supplies and/or equipment which are~~ optional~~,~~ expenses which are not required to complete the retraining plan. ~~For example, the purchase of student health insurance at a Montana university is an optional fee not required for enrollment, unless the claimant does not have health care insurance. If the claimant does not have health care insurance, the purchase of student health insurance is required. The payment of parking fees is required for enrollment at Montana universities.~~

~~(a) Supplies include, but are not limited to, pens, paper, notebooks, etc. and are limited to $25 for each term of training. For example, a term of training is a semester, quarter, etc.~~

~~(b) Equipment includes, but is not limited to, calculators, computer hardware and/or software, ergonomic furniture, tools, etc. The insurer may choose to rent or lease rather than purchase the equipment, if the insurer determines it is more cost effective to do so.~~

(4) remains the same but is renumbered (2).

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

REASON: Sections (1) and (2) are proposed to be stricken because they are duplicative of statutory requirements for the insurer to pay for rehabilitation benefits. Amendment to (3) is proposed to shorten and simplify the rule by eliminating non-substantive language.

24.29.2605 DEFINITIONS For the purposes of this subchapter, the following definitions apply:

(1) remains the same.

~~(2) "Certified" and "certification" mean the department has determined an individual has a permanent physical or mental impairment that constitutes a substantial obstacle to employment, based upon review of the SIF application, the medical evidence of impairment form, and rehabilitation evaluation, if applicable.~~

~~(3) "Department" means the Department of Labor and Industry.~~

~~(4) "Indemnity benefits" means any payment made by an insurer 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. The term does not include expense reimbursements for items such as meals, travel, or lodging.~~

~~(5) "Maximum medical improvement" means the same as provided by 39-71-116, MCA.~~

~~(6) "Permanent impairment" means a significant deviation, loss, or loss of use of any body structure or function in an individual, with respect to a health condition, disorder, or disease that has reached maximum medical improvement.~~

(7) remains the same but is renumbered (2).

~~(8)~~(3) "Referring agent" means a person or agency that assists an individual in preparing ~~an~~ a SIF application.

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

~~(10) "Treating physician" means the same as provided by 39-71-116, MCA.~~

AUTH: 39-71-203, 39-71-904, MCA
IMP: 39-71-116, 39-71-901, 39-71-905, MCA

REASON: Reasonable necessity exists to strike the definition of "certified" because it is duplicative of the definition of certificate, set forth at 39-71-901, MCA. The definition of "department" is proposed to be stricken because the term is defined statutorily for the workers' compensation act. The definitions of "maximum medical improvement," "indemnity benefits," and "treating physician" are proposed to be stricken because the terms are defined in 39-71-116, MCA. The definition of

"permanent impairment" is proposed to be stricken because it is defined statutorily within the definition of "permanent partial disability" in 39-71-116, MCA.

24.29.2607 CERTIFICATION PROCESS ~~(1) A person with a permanent impairment that is a substantial obstacle to employment may apply for SIF certification. Application for SIF certification is voluntary on the part of the applicant.~~

~~(2)~~(1) Application for certification requires the following documentation:

(a) a completed SIF application form signed by the applicant~~, which includes:~~; and

~~(i) information regarding applicant's education, training, and job skills;~~

~~(ii) the applicant's employment history for the past ten years;~~

~~(iii) the applicant's assessment of the impact of applicant's permanent impairment on future employment; and~~

~~(iv) a description of any modifications to employment reasonably necessary to accommodate work restrictions; and~~

(b) ~~a completed SIF~~ medical evidence of permanent impairment ~~form~~ signed by a ~~treating~~ physician~~, which includes:~~ qualified to complete impairment ratings.

~~(i) an assessment of applicant's permanent impairment;~~

~~(ii) an assessment of the impact of applicant's permanent impairment on applicant's employability, including a description of permanent work-related restrictions and limitations;~~

~~(iii) copy of a treating physician's notes documenting applicant's permanent impairment and obstacles to employment, including any work restrictions, if available; and~~

~~(iv) evidence the applicant has achieved maximum medical improvement~~.

~~(3) The department shall review the application, the medical evidence of permanent impairment form, and other supporting documentation. The department shall evaluate whether the applicant qualifies for certification, in accordance with the requirements set forth by ARM 24.29.2610.~~

~~(4) The department encourages persons with a permanent impairment that is a substantial obstacle to obtaining employment or reemployment to apply for certification when a treating physician has not completed the medical evidence form. The department shall notify the applicant in writing when a medical evidence of form or other supporting information is needed to complete the certification process.~~

~~(5) The applicant may submit a signed release to the department that authorizes the department to contact, notify, and confer with a referring agent, a designated representative, or applicant's medical provider.~~

~~(6)~~(2) When the department approves an application, the department shall notify the applicant and referring agent, if applicable, and provide the applicant with ~~an~~ a letter of SIF certification ~~card~~.

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

~~(8)~~(4) When the department denies an application, the department shall issue an order ~~inform~~ informing the applicant and referring agent, if applicable~~, in writing of the reasons for denial~~.

~~(9) Upon the written petition of the applicant, the department shall reconsider the denial of an application, pursuant to the administrative review process outlined by ARM 24.29.206. The applicant shall submit the petition for administrative review~~

~~and any additional information for department consideration within six months following a denial.~~

~~(10) After an administrative review that affirms the denial of an application, the applicant may submit a written request to the department for a contested case hearing, pursuant to ARM 24.29.207.~~

AUTH: 39-71-203, 39-71-904, MCA
IMP: 39-71-905, MCA

REASON: Reasonable necessity exists to repeal (1) because it is duplicative of 39-71-901 and 39-71-905, MCA. Section (2) is proposed to be modified to specify that the SIF forms provided by the department must be filled out and executed. However, the details of the forms need not be set forth in administrative rules. Additionally, it is necessary to specify that a treating physician need not do the impairment rating. Instead it must be performed by someone qualified. Section (3) is proposed to be stricken because it duplicates 39-71-905, MCA. Section (4) is proposed to be repealed as unnecessary. Section (5) is proposed to be stricken because it sets forth a business process regarding the investigation to be performed by the department pursuant to statute. It need not be stated in rule that an applicant may voluntarily provide a release to the department. Section (6) is proposed to be updated to reflect change in business practice. Sections (9) and (10) are proposed to be stricken because the rule regarding administrative review is proposed to be repealed. A dispute of a departmental order is subject to a contested case proceeding and that need not be reiterated in this rule.

24.29.2610 CERTIFICATION REQUIREMENTS (1) The department shall grant SIF certification to an individual when all of the following requirements are met:

(a) The applicant ~~has documented the existence of a permanent physical or mental impairment that adversely impacts the applicant's employability, in accordance with ARM 24.29.2607~~ is a person with a disability. The applicant's ~~permanent impairment~~ disability may result from a congenital condition, trauma, or disease. The permanent impairment does not have to be caused by a work-related injury or occupational disease;

~~(b) The medical evidence of applicant's permanent impairment is not more than six months old at the time of application;~~

(c) remains the same but is renumbered (b).

~~(d)~~(c) A ~~treating~~ physician has provided written documentation that the applicant is permanently impaired; and

~~(e)~~(d) A ~~treating~~ physician has provided written documentation of employment restrictions or limitations due to the applicant's permanent impairment that demonstrates the impairment presents a substantial obstacle to employment or reemployment.

AUTH: 39-71-203, 39-71-904, MCA
IMP: 39-71-905, MCA

REASON: Subsection (1)(a) is proposed to be amended to utilize the definition set forth in 39-71-901, MCA. Subsection (1)(b) is proposed to be stricken because the impairment rating, typically permanent, is unlikely to be updated by a physician. Subsections (1)(d) and (e) remove "treating" because other physicians may provide valid documentation.

24.29.2614 REIMBURSEMENT PROCESS - SETTLEMENTS ~~(1) The department shall determine the right of an insurer to SIF reimbursement of medical and indemnity payments to an SIF-certified individual in accordance with the criteria outlined by this rule.~~

~~(2)~~(1) ~~An insurer shall send the following to the department to document~~ An insurer seeking reimbursement shall send proof of 104 weeks of insurer payments for medical and indemnity ~~after SIF has been notified of the insurer's intent to seek reimbursement~~ benefits to the department. Documents must include:

~~(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.~~

(a) claimant name and claim number;

(b) the insurer's representative's contact name, e-mail, and phone number;

(c) documentation of all medical and indemnity benefits paid; and

(d) medical notes from the first and last visit from the physician.

~~(3)~~(2) After an insurer's right to SIF reimbursement has been established, ~~the department recommends~~ the insurer shall request SIF reimbursement in writing at six-month intervals. Requests for reimbursement for benefits paid more than 18 months prior to the request will be denied.

~~(a) The department 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.~~

~~(b) The department 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)~~(3) Each reimbursement request must state the amount of reimbursement claimed for medical and indemnity payments and include ~~the following documentation for the six-month reimbursement period:~~ documentation required by the department. When an insurer voluntarily agrees to provide reserve data as coordinated with the department, the department recognizes that individual reserve information is recognized to be proprietary information not subject to disclosure. Aggregated claim reserve information for all case reserves reported to the department may be disclosed.

~~(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) 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) dates checks were issued;~~

~~(ii) provider names;~~

~~(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) copies of all medical bills with the corresponding explanations of benefits and directly related medical records.~~

~~(5)~~(4) The insurer shall notify the ~~SIF representative and the~~ department at the outset of settlement negotiations involving an injured individual who is SIF-certified. The insurer ~~shall~~ waives the right to SIF ~~contribution~~ reimbursement for the settlement by failing to notify the department at the outset of settlement negotiations.

~~(6) The insurer shall submit any negotiated settlement agreement to the SIF representative and the department for approval prior to final settlement.~~

~~(a)~~ Attorney fees must be itemized separately from medical and/or indemnity benefits when a settlement is submitted for department approval.

~~(7)~~(5) Disputes arising over payment or reimbursement between the department and the insurer may be resolved by the contested case hearing process, pursuant to ~~ARM 24.29.207~~ [NEW RULE II], at the written request of ~~the~~ either party.

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

REASON: Reasonable necessity exists to strike (1) because it is not substantive. Amendments to (2) are proposed to shorten and consolidate the rule for ease of use. Case reserve information will assist the department in generating reports to the legislature, and may be voluntarily produced. Section (3) is proposed to be amended to clarify that an insurer who fails to submit requests for reimbursement timely is not entitled to reimbursement. Subsections (3)(a) and (b) are proposed to be stricken because they duplicate statute. Section (4) is proposed to be shortened for ease of use and to further specify reporting on unpaid case reserves. Section (5) is proposed to be amended to clarify that the department must be notified of settlement negotiations and clarify the consequences for failing to do so. Section (6) is proposed to be stricken as duplicative of 39-71-920, MCA. Section (7) is amended because ARM 24.29.207 is proposed to be repealed. The dispute resolution process is redefined.

24.29.2831 ~~COLLECTION OF PENALTIES AND OTHER PAYMENTS~~ PENALTY CALCULATIONS FROM UNINSURED EMPLOYERS ~~(1) The department collects penalties from uninsured employers in the manner specified by 39-71-504, MCA. The department will assess a penalty on every uninsured employer of which it becomes aware, unless the department determines that the uninsured period is de minimis.~~

~~(2) The amount of the penalty assessed is $200.00, or twice the amount of the premium that the uninsured employer should have paid on the past three-year payroll while the employer was uninsured, whichever is greater.~~

~~(3)~~(1) ~~To the extent that the state compensation insurance fund (plan No. 3) has a multiple pricing of premium structure in effect during any period in which the employer was uninsured, the~~ The penalty ~~may be~~ is calculated using the highest tier (or pricing level) that could have been charged by the state fund during ~~that~~ the uninsured period.

~~(a) For good cause shown, the penalty will be calculated using the rate the state fund would have actually charged the employer during the uninsured period. The employer has the burden of proof of establishing what rate or rates would have been charged by the state fund during the uninsured period.~~

~~(b) The employer has the burden of proof of establishing good cause for use of the lower rate as provided in (3)(a).~~

~~(i) The employer's alleged financial inability to pay the cost of workers' compensation insurance premium during the uninsured period does not constitute "good cause" for the purposes of this rule.~~

~~(ii) The employer's alleged financial inability to pay the penalty imposed by this rule does not constitute "good cause" for the purposes of this rule.~~

~~(4) Amounts collected from an employer to reimburse the UEF for benefits paid must be deposited with the UEF. Any amount collected from an employer for future liability on a particular claim becomes an earmarked fund when there is an assignment agreement between the claimant and the UEF.~~

~~(5) An account balance is considered past due for the purposes of assessing a late fee if the payment is not received within 30 days after the original billing or notice of requirement of workers' compensation coverage.~~

AUTH: 39-71-203, MCA
IMP: 39-71-504, MCA

REASON: Reasonable necessity exists to repeal (1) and (2) because they duplicate 39-71-504, MCA. Reasonable necessity exists to amend (3) to simplify penalty provisions for purposes of clarity. An uninsured employer–by definition, an employer operating in violation of the Montana Workers' Compensation Act–is penalized based on the highest available rate which might have been charged by State Fund. An uninsured employer is not entitled to benefit from a reduced rate–essentially benefiting despite of its wrongdoing. Reasonable necessity exists to strike (4) because the first sentence is duplicative of requirements of 39-71-504, MCA. The second sentence merely sets forth terms which would exist in a written agreement between a claimant and the UEF; moreover, the UEF has not entered into such agreements. Reasonable necessity exists to strike (5) because it sets forth a

business process of establishing a due date for a penalty. Such due date is set forth in penalty and billing statements from the UEF and need not be defined in rule.

24.29.2841 CLAIMS FOR BENEFITS FOR INSOLVENT PERIOD

(1) remains the same.

~~(2) Effective July 1, 1987, 39-71-503, MCA was amended to remove the requirement that the UEF keep proper reserves and surpluses. Any claimant incurring an industrial injury or occupational disease in the course of employment with an uninsured employer on or after July 1, 1987, is eligible to apply for benefits by completing forms provided by the department. Upon receipt by the UEF of properly executed forms from a claimant, the department will initiate an investigation to determine whether the claimant meets eligibility requirements for benefits from the UEF. If the claimant is found to be eligible, the department will send a written notice to the employer advising of the employers' responsibilities under the law.~~

AUTH: 39-71-203, MCA
IMP: 39-71-503, MCA

REASON: Reasonable necessity exists to amend the catchphrase to clarify applicability of this rule to the insolvent period of the UEF. Reasonable necessity exists to strike (2) because it is duplicative of the UEF's general obligations under the Workers' Compensation Act. The department proposes to maintain (1) to continue to place the public on notice of the period during which the UEF was insolvent and will not, therefore, accept claims. Though infrequent, such claims continue to be filed on a periodic basis, and so the rule continues to serve its purpose.

24.29.2843 PAYMENT OF ~~ACCRUED~~ BENEFITS ~~(1) Although the purpose of the UEF is to pay claims as though the claimant's employer was properly insured, because the UEF does not have a stable source of funding, it is not always financially possible to pay every claim in full. Accordingly, the department has been granted the authority to make such payments as it deems appropriate, depending on available funds.~~

(1) The UEF pays benefits on a monthly basis.

(2) ~~Subject to ARM 24.29.2849, the~~ The UEF will pay compensation ~~benefits for losses~~ and medical benefits incurred prior to the time the claimant applied for benefits in a lump sum, during the month in which the UEF accepts liability for the claim. The lump sum payment for accrued compensation benefits will be paid from the positive fund balance, and treated as part of the month's claim for current benefits. If as a result of the inclusion of the accrued compensation benefits there is a proportionate reduction in benefits, there is no entitlement to retroactive reimbursement.

~~(3) The UEF will pay medical expenses incurred prior to the time the claimant applied for benefits in a lump sum, during the month in which the UEF accepts liability for the claim. The lump sum payment for accrued medical expenses will be paid from the positive fund balance, and treated as part of the month's claim for current benefits. If as a result of the inclusion of the accrued medical expenses~~

~~there is a proportionate reduction in medical benefits, there is no entitlement to retroactive reimbursement.~~

~~(4) The UEF pays current benefits in the manner described in ARM 24.29.2846.~~

(3) If the UEF is subject to a final order from a court of competent jurisdiction requiring it to pay benefits, the UEF will pay back-due benefits a month at a time, beginning with the first month of benefits. Back-due benefits are subject to the proportional reduction which would have occurred during the month they would have been paid. The UEF will also pay current monthly benefits as set forth in (2).

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-504, 39-71-510, MCA

REASON: Reasonable necessity exists to strike (1) because it merely restates 39-71-503(3)(a), MCA. Reasonable necessity exists to insert a new (1) because it incorporates the language of ARM 24.29.2811 which is proposed to be repealed. This consolidation assists readers by collocating rules regarding the payment of benefits. Reasonable necessity exists to strike (3) because, with the inclusion of three words, it can be accomplished in (2). In the interest of shortening rules, it is proposed to be stricken. Reasonable necessity exists to strike (4) because it is unnecessary to state that the specificity of ARM 24.29.2846 (or given the proposed repeal of the rule–the specificity of statute) and 24.29.2849 governs over this general rule. New proposed (3) incorporates relevant portions from ARM 24.29.2849, which is proposed to be repealed.

24.29.2853 RIGHTS OF THIRD-PARTY PROVIDERS AFTER THE UEF REACHES $100,000 MEDICAL BENEFIT EXPENDITURE LIMITATION--APPLICABILITY ~~(1) Providers of medical services, referred to in 39-71-508, MCA, as "third-party providers", who are directly affected by the UEF's invocation of the $100,000 aggregate expenditure limit for medical benefits have a right to bring a legal action against the uninsured employer for unpaid charges for medical services furnished to the injured worker as follows:~~

~~(a) The UEF's payment of the amount allowed by the fee schedule constitutes payment in full for the charges for a given medical service. After the UEF has reimbursed all services that fall within its aggregate expenditure limit, a medical provider may pursue the uninsured employer for the full amount of reasonable and customary charges incurred for services rendered that were not reimbursed. The UEF will notify a provider to which services a given reimbursement applies.~~

~~(b) The uninsured employer has liability only for medical services directly related to those conditions arising out of the industrial injury or occupational disease which the UEF accepted as a claim.~~

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

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-508, 39-71-510, 39-71-704, 39-71-727, 39-71-743, MCA

REASON: Reasonable necessity exists to strike (1) because it duplicates statute and sets forth a business process which need not be in rule.

24.29.3101 INTRODUCTION--APPLICABILITY--VOLUNTARY PAYMENTS

(1) Subchapter 31 addresses the reopening of medical benefits terminated by ~~operation of law~~ statute for certain claims that occurred on or after July 1, 2011.

~~(2) Subchapter 31 does not apply to claims to which any of the following circumstances apply:~~

~~(a) arising before July 1, 2011;~~

~~(b) in which the medical benefits have expressly been settled by means of a department or Workers' Compensation Court approved settlement or judgment;~~

~~(c) in which the insurer did not fully accept liability for the underlying accident or occupational disease; or~~

~~(d) arising on or after July 1, 2011, where the injury results in:~~

~~(i) permanent total disability; or~~

~~(ii) the fitting of a prosthesis which may need to be repaired or replaced.~~

~~(3) The department will apply the provisions of subchapter 31 to claims accepted by the Uninsured Employers' Fund.~~

~~(4) Informational instructions regarding the process for a party to petition to reopen medical benefits terminated by operation of law are available from the Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, and online at the department's web site. These instructions provide supplemental information about the reopening process and an explanation of how to submit a petition for reopening to the department.~~

~~(5)~~(2) Nothing in subchapter 31 prohibits an insurer from making voluntary payments for medical benefits that have terminated by ~~operation of law~~ statute. An insurer that makes a voluntary payment for a medical benefit that has been terminated by ~~operation of law~~ statute must advise the worker in writing that the payment for a medical benefit is made on a voluntary basis and does not create a legal obligation for the insurer to make payment for any other medical benefits.

AUTH: 39-71-203, MCA
IMP: 39-71-105, 39-71-107, 39-71-704, 39-71-717, MCA

REASON: Section (2) is proposed to be repealed because it duplicates provisions of 39-71-704 and 39-71-717, MCA. Section (3) is proposed to be repealed because it need not be stated in rule that this statute of general applicability applies to the UEF. Section (4) is proposed to be repealed because, while the department is happy to provide customer service to those in need of assistance, such need not be specified in rule.

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) "Accepted" means the petition has been evaluated by the department and was found to be eligible to be considered for medical review.~~

~~(2) "Additional information" means information other than a medical record, supplied by a worker or an insurer, and tendered as being relevant to the reopening of medical benefits.~~

~~(3) "Approved" means that after the medical review has been performed, medical benefits are reopened for not more than two years before being subject to a biennial review.~~

~~(4) "Denied" means that after the medical review has been performed, medical benefits are not reopened.~~

~~(5) "Department" means the Department of Labor and Industry.~~

(1) "Claim records" means documents related to the medical condition and work status of the worker. The records include but are not limited to notes and reports of health care providers, and any additional information relevant to the reopening of medical benefits. The term does not include medical billing records.

~~(6)~~(2) "Dismissed" means the petition ~~has been evaluated by the department and~~ was found ~~to be~~ ineligible ~~to be considered~~ for medical review or has been withdrawn at the injured worker's request.

~~(7) "Filed" means the status of a petition once it has been accepted by the department for medical review.~~

~~(8) "Joint petition" means a petition for reopening that has been signed by both the worker and the insurer, with agreed-to terms concerning the reopening of medical benefits.~~

~~(9) "Medical records" means documents related to the medical condition of the worker, and includes but is not limited to, notes, reports, and letters prepared by health care providers. The term does not include medical billing materials.~~

~~(10) "Medical review panel" means the department's medical director and two additional physicians selected from a pool of available physicians, who can review a petition for the reopening of medical benefits, as provided for in 39-71-717, MCA.~~

~~(11) "Periodic review" means the every-two-years consideration by the medical review panel or the medical director as to whether the recommendations previously made should be continued or changed.~~

~~(12)~~(3) "Petition" means the department-provided form upon which a party requests that medical benefits ~~which have been~~ terminated by ~~the operation of 39-71-704, MCA,~~ statute be reopened.

~~(13) "Physician" means a health care provider who takes part in a medical review panel under subchapter 31. A physician must be licensed in Montana in one or more of the following categories:~~

~~(a) medical doctor;~~

~~(b) osteopath;~~

~~(c) dentist;~~

~~(d) chiropractor;~~

~~(e) physician assistant; or~~

~~(f) advanced practice registered nurse.~~

~~(14) "Received" means a petition which has been delivered to the department, but has not yet been accepted and filed by the department.~~

~~(15)~~(4) "Reopened" means medical benefits ~~which had~~ terminated by ~~operation of law,~~ statute and which are now to be furnished by the insurer as recommended ~~by~~ in the medical report.

~~(16) "Report" means the written recommendations of the medical director or medical review panel concerning whether or not medical benefits should be reopened, and if reopened, to what extent those benefits should be furnished.~~

~~(17) "Returned" means the petition has been evaluated by the department and has been found to be incomplete.~~

~~(18) "Submission," as used in 39-71-717(8), MCA, means the same as being filed with the department.~~

~~(19) "Submit," as used in 39-71-717(6), MCA, means to deliver medical records or additional information to the department.~~

~~(20) "Work" means supplying labor or services for remuneration, although not necessarily in employment by another.~~

~~(21) "Worker" means the individual who suffered the workplace injury or occupational disease upon which basis a claim for benefits was made to the insurer.~~

~~(22) "Year" means 12 calendar months.~~

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

REASON: There is reasonable necessity to strike many of the definitions in this rule because they are duplicative or unnecessary.

24.29.3127 PERIODIC REVIEW OF CERTAIN REOPENED MEDICAL BENEFITS (1) The department's medical director shall biennially review claims where medical benefits have been reopened ~~and the recommended duration of the reopening is more than two years,~~ in order to determine whether the previous recommendations should be changed.

(2) The department shall request ~~that~~ the worker and the insurer deliver to the department ~~medical~~ claim records created since the prior medical review~~, as well as any additional information the party wants considered~~.

~~(a)~~ The department's request shall specify a deadline by which ~~those~~ claim records ~~and additional information~~ must be received by the department.

~~(b) Any medical records or other information submitted by a party which have not previously been provided to the other party must be sent to that other party at the same time the records or other information are delivered to the department.~~

(3) The biennial review will be based on the ~~materials~~ claim records previously submitted ~~by the parties at the time the original petition for reopening was considered,~~ and the records ~~and information~~ sent pursuant to (2). If a party does not timely send updated ~~medical~~ claim records ~~or additional information~~, the medical director shall base the review on the materials available.

(4) For parties which filed a joint petition for reopening and did not deliver ~~medical~~ claim records to the department with the initial petition:

(a) if ~~they~~ the insurer agrees medical benefits should remain open until the next review, medical records are not required ~~to be submitted~~ for periodic review and the department will acknowledge the continued concurrence for reopened medical benefits;

(b) if ~~they do~~ the insurer does not agree medical benefits should remain open until the next biennial review, they must notify the department and the other party

within 14 days of notice of the review that they believe benefits should not continue and submit claim records. The medical director will ~~then~~ conduct a review as set forth in ~~ARM 24.29.3114, except the date the petition is filed is the date of notification of dispute~~ [NEW RULE VII].

~~(5) The prior report and recommendation regarding medical benefits is presumed to be correct. A previous recommendation may be changed only if it is based on the updated medical records and information sent to the department.~~

~~(6)~~(5) Following the medical director's review, if the medical director believes there is reason to change the prior recommendation, the medical director shall:

(a) in cases where the original review was made by a medical review panel, convene a new medical review panel to review the updated ~~medical~~ claim records ~~and information~~; or

(b) in cases where the original review was made solely by the medical director, ~~issue a report and make recommendations as provided by (7)~~ only the medical director will review the updated claim records.

~~(7)~~(6) Following completion of the periodic review, the medical director shall issue a report and make recommendations ~~with respect to continuing the reopening of medical benefits~~.

~~(8) A party disagreeing with the medical director's report and recommendations may bring the dispute to the Workers' Compensation Court after following the mediation requirements provided by law.~~

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

REASON: The rule is proposed to be updated to recognize the new proposed definition of "claim record." Subsection (2)(b) is unnecessary because the rule need not state the general requirement that parties share information with each other. Sections (5) and (8) are proposed to be repealed as duplicative of 39-71-717(10), MCA.

24.29.3802 ATTORNEY FEE REGULATION ~~(1) This rule is promulgated under the authority of 39-71-203, 39-71-613, and 39-71-2905, MCA, to implement regulation of the fees charged to claimants by attorneys in workers' compensation cases as provided in 39-71-613, MCA.~~

~~(2)~~(1) An attorney representing a claimant on a workers' compensation claim shall submit to the department within 30 days of undertaking representation of the claimant~~, in accordance with 39-71-613, MCA,~~ on forms supplied by the department, a contract of employment stating specifically the terms of the fee arrangement. An attorney substituting for another attorney previously representing a claimant must submit a new contract conforming with this rule within 30 days of undertaking representation of the claimant. The contract of employment shall be signed by the claimant and the attorney, and must be approved by the ~~administrator of the division of workers' compensation or the administrator's designee~~ department. The ~~administrator or the administrator's designee~~ department shall return the contract to the attorney along with a notification that the contract has been approved or disapproved.

~~(3)~~(2) Except as provided in ~~(7)~~(6), an attorney representing a claimant on a workers' compensation claim who plans to utilize a contingent percentage fee arrangement to establish the fee with the claimant, may not charge a fee above the following amounts:

(a) remains the same.

(b) For cases that go to a hearing before the workers' compensation judge or the supreme court, 25% of the amount of additional compensation payments the claimant receives from an order of the workers' compensation judge or the supreme court due to the efforts of the attorney. However, a settlement approved by the workers' compensation judge which could have been submitted to the department for approval is subject to the limits set forth in (a).

~~(4)~~(3) The fee schedule set forth in ~~(3)~~(2) does not preclude the use of other attorney fee arrangements, such as the use of a fee system based on time at a reasonable hourly rate ~~not exceeding $100.00 per hour~~, but the total fee charged may not exceed the schedule set forth in ~~(3)~~(2) except as provided in ~~(7)~~(6). When such fee arrangement is utilized, the contract of employment shall specifically set forth the fee arrangement, such as the amount charged per hour.

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

(b) If a variance requested under ~~(7)(a)~~(6)(a) is not approved, an attorney may request that the administrator or the administrator's designee review the matter and issue an order of determination pursuant to procedures set forth in ~~ARM 24.29.201, et seq.~~ [NEW RULE II].

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

~~(10) The department retains its authority to regulate the attorney fee amount in any workers' compensation case according to the factors set forth in 39-71-613, MCA, and (7)(a) of this rule even though the contract of employment fully complies with 39-71-613, MCA, and this rule.~~

(11) and (12) remain the same but are renumbered (9) and (10).

AUTH: 39-71-203, MCA
IMP: 39-71-225, 39-71-613, 39-71-2905, MCA

REASON: There is reasonable necessity to amend (2) to clarify reference to the department. Section (3) is proposed to be updated to disincentivize unnecessary petitions to the workers' compensation court for settlement approval, avoiding the less costly departmental approval process. Section (4) is proposed to be updated to remove the hourly fee cap. The cap is unnecessary because, whatever the fee, it cannot exceed the contingency limitation, and is reasonably restricted based on the Montana Rules of Professional Conduct. Section (7) is proposed to be amended to reflect the proposed repeal of ARM 24.29.201. Section (10) is proposed to be repealed as it is duplicative of statute.

24.29.4303 DEFINITIONS For the purpose of this subchapter, the following definitions apply, unless the context of the rule clearly indicates otherwise:

(1) remains the same.

~~(2) "Data base system" means the electronic repository for workers' compensation data established by 39-71-225, MCA.~~

~~(3)~~(2) "Electronic data interchange", or "EDI" means ~~the intercompany exchange of standard business documents in a machine readable and standardized form~~ computer-to-computer exchange of business information in a standard and structured format.

~~(4) "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, or in settlement of a dispute over initial compensability of the claim. The term does not include expense reimbursements for items such as meals, travel or lodging.~~

~~(5) "Indemnity claim" means a workers' compensation or occupational disease claim where indemnity benefits in addition to medical benefits are being paid or are likely to be paid in the future.~~

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

~~(7) "Plan 1" or "Plan 1 self-insurer" means an employer that has been properly bound by the provisions of Title 39, chapter 71, part 21, MCA.~~

~~(8) "Plan 2" or "Plan 2 private insurer" means an insurer that provides workers' compensation insurance pursuant to the provisions of Title 39, chapter 71, part 22, MCA.~~

~~(9) "Plan 3" or "state fund" means the state compensation insurance fund, established by Title 39, chapter 71, part 23, MCA.~~

(10) through (12) remain the same but are renumbered (4) through (6).

~~(13) "UEF" means the Uninsured Employers' Fund, established by 39-71-503, MCA~~.

(14) remains the same but is renumbered (7).

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: There is reasonable necessity to strike (2) because it defines a term already defined by statute at 39-71-225, MCA. Section (3) is proposed to be modernized to increase readability. There is reasonable necessity to strike (4), (5), (7), (8), (9), and (13) because they set forth terms of general applicability used throughout the Workers' Compensation Act and these rules and need not be further defined here.

24.29.4307 CLAIM FILE RECORDS MAINTENANCE AND RETENTION

~~(1) All insurers shall maintain their respective claim files. Upon request by the department, insurers shall provide to the department, in whole or part according to the request, a copy of the claim file, other than documents protected by the attorney-client privilege or attorney work-product doctrine. The copies must be provided at no cost to the department. If information is maintained by computer, "hard copy" information must be available upon request. Insurers shall submit requested copies of file information within 30 days of the department's request.~~

~~(2) All insurers shall retain complete copies of the claim file for the life of the claim or as long as liability or potential liability exists for the claim. The department is not responsible for maintaining a duplicate of any document pertaining to a claim.~~

~~(3)~~(1) Claim files must include, but need not be limited to, all of the following which exist in relation to the claim:

(a) the department's form first report of injury and occupational disease~~, Montana form ERD-991~~ or department-approved equivalent;

(b) through (h) remain the same.

~~(4) For the purposes of this rule, an insurer may maintain claim file documents either as an "original" or as a "duplicate", as those terms are used in the Montana Rules of Evidence. However, nothing in this rule affects the legal standards concerning the admissibility of an original versus a duplicate.~~

(2) Copies of insurer files must be provided to the department at no cost.

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: Reasonable necessity exists to strike (1) because it is duplicative of requirements set forth in 39-71-107 and 39-71-304, MCA, with regard to the maintenance and production of records. Reasonable necessity exists to strike (2) because it is duplicative of requirements set forth at 39-71-107(3), MCA. Section (4) is duplicative of 39-71-107(3), MCA. Additionally, it comments on legal standards for admissibility of evidence. New (2) is transferred from current (1) to improve the logical order of the rule.

24.29.4314 ~~ELECTRONIC~~ REPORTING (1) Reporting parties who report electronically~~, whether voluntarily or when required by 39-71-225, MCA,~~ shall sign a written agreement with the department.

(a) The reporting parties may designate another entity, approved by the department, to serve as their reporting agent. ~~The written agreement will provide the effective date to send and receive the electronic reports, the acceptable data to be sent and received, the method of transmission to be used, and other pertinent agreements between the parties.~~

~~(2)~~(b) Electronic reporting for workers' compensation claims and insurance coverage information must be reported using a department-supported IAIABC ~~product, using the IAIABC flat file format. The department will not accept electronic reports submitted in any other formats after the transition to the IAIABC product is complete~~ standard.

(2) Reporting parties not required to report electronically may submit on hard copy forms approved by, or provided by at a cost to the reporting party, the department.

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: Reasonable necessity exists to amend (1) because it is not necessary to insert a cross reference in a rule implementing a statute. Reasonable necessity exists to strike provisions and renumber to eliminate duplicative and unnecessary language and because the file format previously noted is no longer used. Because the transition to the IAIABC product is long-ago complete, it is no longer necessary

to refer to a transition period in the rule. Reasonable necessity exists to adopt a new (2) to incorporate the necessary repealed language from ARM 24.29.4311.

24.29.4321 INSURER REPORTING REQUIREMENTS--INJURIES AND OCCUPATIONAL DISEASES (1) All insurers and the UEF are required to submit a first report of injury or occupational disease to the department within 30 days of the report to the insurer of the ~~accident~~ injury or of an occupational disease.

(2) through (5) remain the same.

~~(6) The department may impose penalties as specified in 39-71-307, MCA, for failure to comply with these reporting requirements.~~

AUTH: 39-71-203, MCA
IMP: 39-71-225, 39-71-307, MCA

REASON: Section (1) is proposed to be amended to harmonize its requirements with 39-71-307, MCA. Reasonable necessity exists to strike (6) because it is not necessary to state in rule what is explicit in statute.

24.29.4332 CLAIMANT LEGAL FEES AND COSTS REPORTING REQUIREMENTS (1) through (6)(b)(iv) remain the same.

(v) documented long-distance telephone expenses; ~~and~~

(vi) documented postage expenses~~.~~; and

(vii) the amount of attorney fees received pursuant to a settlement.

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: The rule is proposed to be amended to clarify that the amount of fees paid as a result of a settlement must be reported to the department.

24.29.4336 IN-HOUSE COUNSEL COST ALLOCATION (1) Insurers that use the services of in-house counsel for assistance in handling Montana indemnity claims shall report the cost of that legal assistance. ~~If the insurer does not separately track and report in-house legal costs on a per-claim basis, the insurer shall report the cost allocation information required by this rule.~~

(2) ~~The purpose of this cost allocation rule is to obtain a figure that reasonably reflects the per-claim cost of having in-house counsel. The~~ If the insurer does not separately track in-house legal costs on a per claim basis, the insurer shall report annually upon request by the department:

(a) and (b) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: Reasonable necessity exists to modify this rule to simplify it by setting forth the principal rule of reporting followed by the exception, rather than combining the exception in (1).

24.29.4339 VERIFICATION OF CONSULTANT AND LEGAL FEE REPORTING ~~(1) For the sole purpose of verifying the accuracy of the data reported, the department may periodically verify a consultant's billing documents used in the preparation and reporting of the information required by ARM 24.29.4332 and 24.29.4335.~~

~~(2)~~(1) For the ~~sole~~ purpose of verifying the accuracy of the data reported, the department may periodically verify ~~the amount of an attorney's billing~~ data reported pursuant to ARM 24.29.4332 and 24.29.4335. Documents protected by the attorney-client privilege or attorney work-product doctrine are not subject to verification.

~~(3)~~(2) At least 14 days' advance notice ~~of the time and place of the verification~~ will be given to the reporting party. A reporting party is responsible for full cooperation with the department.

AUTH: 39-71-203, MCA
IMP: 39-71-225, 39-71-304, MCA

REASON: Sections (1) and (2) are proposed to be consolidated to simplify and shorten the rule. Section (3) is updated to remove superfluous verbiage.

5. The proposed new rules are as follows:

NEW RULE I UEF PENALTY DISPUTES (1) A UEF penalty determination is final 15 days from the date it is sent to a party.

(2) A party disputing a UEF penalty determination must request a redetermination within 15 days of the date the determination is sent.

(3) A party disputing a UEF penalty redetermination must request mediation within 15 days of the date the redetermination was sent. Requested mediation must be completed pursuant to ARM Title 24, chapter 28.

(4) If mediation does not fully resolve the dispute, a party may request a hearing in accordance with Title 2, chapter 4, part 6, MCA. Requests for hearing must be received by the department within ten days from the date the mediator's report is sent. Failure to request a hearing means the original UEF penalty determination becomes final.

(5) Any party aggrieved by the order following hearing may petition the Workers' Compensation Court for judicial review, pursuant to Title 2, chapter 4, part 7, MCA.

(6) This rule governs procedures for disputes solely regarding penalties issued by the UEF. It does not apply to disputes for reimbursement regarding benefits paid by the UEF.

AUTH: 2-4-201, 39-71-203, MCA
IMP: 39-71-504, 39-71-506, 39-71-541, 39-71-2401, MCA

REASON: Reasonable necessity exists to adopt this rule to provide clarity and consistency with UEF penalty determinations. Previously, UEF penalty appeals

have been governed by the general rules of workers' compensation appeals. However, penalties are different in kind from the variety of workers' compensation orders issued by the department. Further, UEF penalties are increasingly issued simultaneous with other findings by the department. As such, this rule seeks to align, to the extent feasible, the appellate timelines from other programs of the department–in particular, wage and hour, prevailing wage, and independent contractor. This alignment will assist parties by providing a single route and timeline for appeal, so that no party seeking appeal is unaware of such process.

NEW RULE II ORDERS AND APPEALS (1) On request of any party or on its own, the department may issue an order on a dispute concerning workers' compensation. Any order issued must be in writing and signed by a department employee.

(2) A party aggrieved by an order which is not subject to a more specific appellate review procedure:

(a) may request reconsideration 30 days after the order was sent. A party who requested reconsideration may request a contested case hearing ten days after notice of the results of reconsideration are sent; or

(b) may, in the alternative to reconsideration, request a contested case hearing within 30 days of the date the order was sent.

(3) A party seeking judicial review of a final order of the department after a contested case hearing must file a petition with the Workers' Compensation Court within 30 days after the final order was sent.

(4) "Sent" for purposes of this rule means mailed, delivered by personal service, or transmitted electronically if electronic service has been consented to by the party.

AUTH: 2-4-201, 39-71-203, MCA
IMP: 2-4-201, 39-71-203, 39-71-2401, MCA

REASON: There is reasonable necessity to adopt this rule in place of those being repealed. This rule sets forth a streamlined and consolidated procedure for resolving disputes regarding departmental orders involving workers' compensation, but outside of disputes involving benefits.

NEW RULE III RENEWAL (1) A self-insured employer or employer group must renew each year. The renewal application must be submitted to the department 60 days before the renewal date.

(2) A renewal applicant must:

(a) submit all required documents; and

(b) be in compliance with laws governing plan No. 1 employers and groups.

(3) A self-insured employer or employer group not renewing shall elect to be bound by plan No. 2 or 3 on the effective date of the termination of permission to self-insure.

AUTH: 39-71-203, MCA
IMP: 39-71-2104, MCA

REASON: This new rule is proposed to replace ARM 24.29.623 to simplify, clarify, and consolidate requirements for renewals, without the need to list every document the department may need in rule. The renewal form utilized by the department for many years sets forth the requirements.

NEW RULE IV DESCRIPTION OF BENEFITS PAID FOR PURPOSES OF ASSESSMENT (1) Compensation benefits paid include periodic and lump-sum payments for:

(a) permanent total disability;

(b) permanent partial disability;

(c) temporary total disability;

(d) temporary partial disability;

(e) loss of hearing, whether under the Workers' Compensation or Occupational Disease Act for occupational diseases that occurred prior to July 1, 2005;

(f) rehabilitation benefits (biweekly compensation paid to claimants);

(g) death benefits;

(h) disfigurement payments;

(i) SIF cases, to the extent paid by the insurer and not reimbursed by the SIF;

(j) settlement amounts paid pursuant to 39-71-741, MCA, except to the extent any portion of the settlement is reported as being medical benefits paid;

(k) benefits paid pursuant to 39-71-608, MCA; and

(l) settlement amounts paid pursuant to 39-71-405, MCA.

(2) Medical benefits paid include payments for:

(a) medical and dental treatment;

(b) prescription drugs;

(c) prosthetics and orthotics;

(d) other durable medical goods;

(e) hospital care;

(f) domiciliary care;

(g) diagnostic examinations for the purpose of determining what treatment is necessary;

(h) medical benefits paid pursuant to 39-71-615, MCA; and

(i) hearing loss treatment, whether under the Workers' Compensation or Occupational Disease Act for occupational diseases that occurred prior to July 1, 2005.

(3) Miscellaneous expense costs are not included in the calculation of the administration fund assessment. Miscellaneous expense costs are all workers' compensation or occupational disease costs incurred by an insurer other than compensation or medical benefits paid. These costs include, but are not limited to:

(a) rehabilitation services provided by a licensed rehabilitation provider or the Department of Public Health and Human Services;

(b) rehabilitation expenses, such as books and tuition, or auxiliary rehabilitation benefits, such as relocation expenses;

(c) administrative costs for the processing of claims, such as the costs of investigating or adjusting the claim;

(d) independent medical examinations requested by the insurer, where the purpose of the examination(s) is not for the diagnosis or treatment of the claimant's condition;

(e) matching payments to a catastrophically injured worker's family; and

(f) various other miscellaneous costs that do not constitute a compensation benefit or medical benefit provided to the claimant or beneficiary.

(4) Benefits paid include any amount paid by the insurer or the employer, regardless of any deductible paid by the employer or reimbursements to the insurer from reinsurance or excess insurance other than by the claimant. Copayments actually made by the claimant are not considered to be "benefits paid" for the purposes of this rule.

(5) The department may inspect the insurer's records to determine whether the insurer is properly reporting compensation paid and medical benefits paid.

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-306, 39-71-915, 39-71-1049, 50-71-128, MCA

REASON: There is reasonable necessity to adopt this new rule in place of those being repealed to clarify, simplify, and streamline the processes and procedures relating to reporting benefits related to assessment.

NEW RULE V ASSESSMENT OVERPAYMENTS AND UNDERPAYMENTS

(1) For the purposes of this rule an employer is also the insurer's policyholder.

(2) Each plan No. 2 insurer and the plan No. 3 insurer is responsible for correctly calculating the amount of the authorized premium surcharge for assessments that the insurer is to collect from each of its insured employers using the rates 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.

(3) Insurers may address over-collections or overpayments in the following manner:

(a) Any over-collection of the premium surcharge(s) from a policyholder by the insurer may be refunded by the insurer or applied to premium or future surcharge payments due from the policyholder to the insurer. An accounting of the payment shall be provided by the insurer to the policyholder.

(b) If a surcharge remittance from an insurer to the department is later determined to include an overpayment, the insurer may deduct the amount overpaid from the next surcharge remittance due from the insurer to the department. The insurer shall maintain records documenting any surcharge amounts refunded to its policyholders.

(4) Each plan No. 2 insurer and the plan No. 3 insurer shall maintain reasonable records showing the total amount of premium and premium surcharge collected from each policyholder. The department may inspect those records.

AUTH: 39-71-203, MCA

IMP: 39-71-201, 39-71-306, 39-71-915, 39-71-1049, 50-71-128, MCA

REASON: Reasonable necessity exists to adopt this rule as a streamlined, clarified version of ARM 24.29.956.

NEW RULE VI MANAGED CARE ORGANIZATION APPLICATION AND RENEWAL (1) In addition to statutory requirements, applicants for recognition as a managed care organization must electronically submit:

(a) an application fee of $1,500;

(b) the proposed organizational structure and contact information;

(c) evidence that the applicant can meet the financial obligations of the contract, including capital, insurance, and business plan; and

(d) the managed care plan.

(2) Applications are reviewed for completeness. The department may request more information. Applications will be approved or denied on the information received.

(3) Certification is valid for two years. Renewal applications must be submitted at least 60 days before expiration. There is no renewal fee.

(4) Applications and renewals are public documents. If an applicant believes part of its applications is a trade secret, it must mark the information as confidential. The applicant will be notified if the information is requested. The applicant is responsible for defending any action to release the information.

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: Reasonable necessity exists to repeal all existing managed care organization rules and consolidate them into this new rule. Some of the existing rules have language that is duplicative of what is in statute, and many of the rules document the department's business process in significant detail for managing the program, which is unnecessary. Some of the rules created red tape that need not be in place as part of approving managed care organizations.

NEW RULE VII PETITION TO REOPEN MEDICAL BENEFITS (1) A party wishing to reopen medical benefits terminated by statute must submit a petition to reopen to the department on the form provided by the department. A claim may go through the petition process, including initial petition and biennial reviews, one time.

(2) The department will provide notice of the petition to reopen to the insurer. The parties must provide claim records to the department and the other party within 14 days of the notice. Records not received in that time will not be considered.

(3) An insurer may dispute the presumption that a petition to reopen relates to a compensable claim. The dispute must be made within 14 days of the notice of the petition to reopen from the department.

(4) The petition to reopen may be reviewed solely by the department's medical director upon a mutual, irrevocable agreement from the injured worker and the insurer. The medical director will issue a report explaining the rationale for the decision pursuant to statutory criteria.

(5) If the injured worker and insurer agree to reopen medical benefits, they may submit a joint petition to reopen. The petition to reopen form must be completed, but claim records need not be provided. The reopened benefits are subject to biennial review.

(6) Any other petition to reopen will be reviewed by a three-member panel. Each panel member must prepare a report evaluating the statutory reopening criteria. The medical director will issue a report on behalf of the panel explaining the rationale for the decision.

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

REASON: This new rule is proposed to simplify the rules surrounding petitions to reopen medical benefits. It is proposed to replace ARM 24.29.3107, 24.29.3111, 24.29.3114, 24.29.3117, 24.29.3121, and 24.29.3124, and sets forth in rule existing business processes.

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

24.29.205 ISSUING ORDERS

AUTH: 2-4-201, 39-71-203, 39-72-203, MCA
IMP: 2-4-201, 2-4-202, 39-71-116, 39-71-120, 39-71-415, 39-72-203, MCA

REASON: There is reasonable necessity to repeal this rule in favor of simplification, shortening, and clarification of the appeal and procedural rules of the department pertaining to workers' compensation, set forth in NEW RULES I and II.

24.29.206 ADMINISTRATIVE REVIEW

AUTH: 2-4-201, 39-71-203, 39-72-202, MCA
IMP: 39-71-204, 39-72-402, MCA

REASON: There is reasonable necessity to repeal this rule because, while the department is willing to engage in informal processes to resolve disputes at the lowest level, these processes and the discussions had need not be subject to administrative rule.

24.29.207 CONTESTED CASES

AUTH: 2-4-201, 39-71-203, MCA
IMP: Title 2, chapter 4, part 6, 33-16-1012, 39-71-204, 39-71-415, 39-71-704, 39-71-2401, 39-71-2905, MCA

REASON: There is reasonable necessity to repeal this rule in favor of simplification, shortening, and clarification of the appeal and procedural rules of the department pertaining to workers' compensation, set forth in NEW RULES I and II.

24.29.213 PROCEDURE FOR ISSUING WORKERS' COMPENSATION DETERMINATIONS REGARDING EMPLOYMENT STATUS, INCLUDING THAT OF INDEPENDENT CONTRACTOR

AUTH: 39-71-203, MCA
IMP: 39-71-120, 39-71-415, MCA

REASON: There is reasonable necessity to repeal this rule in favor of simplification, shortening, and clarification of the appeal and procedural rules of the department pertaining to workers' compensation, set forth in NEW RULES I and II.

24.29.215 TIME LIMITS

AUTH: 39-71-203, 39-72-203, MCA
IMP: Title 2, chapter 6, 2-4-702, MCA

REASON: There is reasonable necessity to repeal this rule in favor of simplification, shortening, and clarification of the appeal and procedural rules of the department pertaining to workers' compensation, set forth in NEW RULES I and II.

24.29.608 ELECTION TO BE BOUND BY COMPENSATION PLAN NO. 1--ELIGIBILITY

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA

REASON: There is reasonable necessity to repeal this rule because it duplicates the statutes it implements.

24.29.610 WHEN SECURITY REQUIRED

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2106, MCA

REASON: This rule is proposed to be repealed because 39-71-2106, MCA, is sufficient on its own without further clarification by this rule.

24.29.622 PERMISSION TO SELF-INSURE

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA

REASON: There is reasonable necessity to repeal this rule because its substance is found within 39-71-2101 and 39-71-2105, MCA.

24.29.623 RENEWAL REQUIRED

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2104, MCA

REASON: There is reasonable necessity to repeal this rule in favor of NEW RULE III, which is simpler and encapsulates current requirements.

24.29.627 RIGHT TO REVIEW

AUTH: 39-71-203, MCA
IMP: 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2107, 39-71-2108, 39-71-2905, MCA

REASON: This rule is proposed to be repealed because a specified right to appeal need not exist where a general applicable right exists. Additionally, changes to the cross-referenced rule are being proposed.

24.29.704 WHO MUST BE BOUND

AUTH: 39-71-203, MCA
IMP: 39-71-401, MCA

REASON: Reasonable necessity exists to repeal this rule because it is duplicative of statute, which sets forth requirements for coverage.

24.29.709 SECURITY DEPOSITS FOR PLAN NO. 2 INSURERS--REPORTS

AUTH: 39-71-203, MCA
IMP: 39-71-2215, MCA

REASON: Reasonable necessity exists to repeal this rule because 39-71-2215, MCA, was repealed by House Bill 199 (2021). As such, the authority to require security deposits for plan No. 2 insurers has been repealed. Additionally, it is unnecessary to receive the reporting of (5) and (6) by this rule because the department receives similar information from the Commissioner of Securities and Insurance. This removes approximately 300 insurer reports that range from 3 to 15 pages each sent annually to the department, saving insurer and department resources.

24.29.713 EVIDENCE OF INSURANCE COVERAGE

AUTH: 39-71-203, MCA
IMP: 39-71-304, 39-71-401, 39-71-402, 39-71-2201, 39-71-2336, MCA

REASON: Reasonable necessity exists to repeal this rule because it is duplicative of the authority of the department to request records of employers pursuant to 39-71-304, MCA.

24.29.804 EXAMINERS AND THIRD-PARTY ADMINISTRATORS IN MONTANA

AUTH: 39-71-107, 39-71-203, MCA
IMP: 39-71-105, 39-71-107, 39-71-320, MCA

REASON: Reasonable necessity exists to repeal this rule. Section (1) is duplicative of 39-71-107(2), MCA. Section (2) duplicates 39-71-107(3), MCA. Section (3) sets forth the common definition of "settled claim," which is apparent based on the requirement of the department to approve settlement agreements. Section (4) duplicates 39-71-107(4)(a), MCA. Section (5) sets forth a standard ability of an agent to communicate on behalf of its principal, and need not be restated in rule. Section (6) duplicates 39-71-107(4)(b), MCA.

24.29.851 MAINTENANCE OF CERTIFICATION DOCUMENTATION

AUTH: 39-71-203, 39-71-320, MCA
IMP: 39-71-105, 39-71-320, MCA

REASON: Reasonable necessity exists to repeal this rule because it is not necessary to state that records may be stored electronically–the normal means of storage at this time.

24.29.902 DEFINITIONS

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

REASON: There is reasonable necessity to repeal this rule because it is substantially duplicative of statute and defines terms for which definitions are not necessary.

24.29.907 BILLING AND PAYMENT OF THE ADMINISTRATION FUND ASSESSMENT

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-408, MCA

REASON: There is reasonable necessity to repeal this rule because it sets forth business process which need not be in rule.

24.29.929 ASSESSMENTS OTHER THAN THE ADMINISTRATION FUND ASSESSMENT

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

REASON: There is reasonable necessity to repeal this rule because it merely sets forth business practice which need not be in rule.

24.29.954 CALCULATION OF AMOUNT OF ADMINISTRATION FUND ASSESSMENT

AUTH: 39-71-203, MCA
IMP: 39-71-201, 39-71-203, 39-71-209, MCA

REASON: There is reasonable necessity to repeal this rule because it primarily defines terms which need not be defined in rule and sets forth business processes.

24.29.956 COMPUTATION AND COLLECTION OF THE ADMINISTRATION FUND AND SAFETY FUND ASSESSMENT PREMIUM SURCHARGE RATE FOR PLAN NO. 2 AND NO. 3

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

REASON: There is reasonable necessity to repeal this rule in favor of shortening and simplifying and removing business processes from rule.

24.29.962 COMPUTATION OF THE SUBSEQUENT INJURY FUND ASSESSMENT SURCHARGE

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

REASON: There is reasonable necessity to repeal this rule in favor of shortening, simplifying, and reducing business process in rule.

24.29.971 FAILURE OF INSURER TO TIMELY REPORT PAID LOSSES--DEPARTMENT ESTIMATE OF PAID LOSSES--RECALCULATION OF ASSESSMENT AND PREMIUM SURCHARGE--PENALTY

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

REASON: There is reasonable necessity to repeal this rule in favor of shortening, simplifying, and reducing business process in rule.

24.29.1401 INITIAL LIABILITY

AUTH: 39-71-203, MCA
IMP: 39-71-510, 39-71-704, 39-71-743, MCA

REASON: Reasonable necessity exists to repeal this rule. Reasonable necessity exists to strike (1) because it is reasonably clear from 39-71-743(3), MCA that, while payment becomes the responsibility of the insurer after a claim is accepted, responsibility does not transition until such acceptance. Reasonable necessity exists to strike (2) because it is duplicative of 39-71-743(3), MCA. Reasonable necessity exists to strike (3) because it is duplicative of 39-71-704(11) and 39-71-743(3), MCA. Reasonable necessity exists to strike (3)(a) because it is not necessary to state in rule that statutory provisions supersede rule. Reasonable necessity exists to strike (4) because it is not necessary to state in rule that treatment unrelated to a claim or for which benefits are no longer payable are the responsibility of the individual seeking treatment.

24.29.1501 PURPOSE

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

REASON: There is reasonable necessity to repeal this rule because it sets forth general policy. While not inaccurate, these purpose provisions are unnecessary in administrative rule.

24.29.1510 SELECTION OF PHYSICIAN FOR CLAIMS ARISING FROM JULY 1, 1993 THROUGH JUNE 30, 2013

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

REASON: There is reasonable necessity to repeal this rule. Reasonable necessity exists to strike (1) because it is unnecessary to adopt a definition from the statute which creates this rule. Sections (2) and (3) substantially repeat statute, and relevant portions of (3) are proposed to transition to ARM 24.29.1621. Reasonable necessity exists to strike (4) because it is not necessary to state in rule that treatment may be received from multiple providers. Additionally, the rule artificially limits such treatment to physicians and duplicates 39-71-1101, MCA.

24.29.1517 PRIOR AUTHORIZATION FOR CERTAIN SERVICES

AUTH: 39-71-203, MCA
IMP: 39-71-704, 39-71-743, MCA

REASON: There is reasonable necessity to repeal this rule because it is proposed to be consolidated into ARM 24.29.1621. The department believes it is confusing to have multiple rules and rule locations to refer the public to when questions arise with regard to prior authorization.

24.29.1522 MEDICAL EQUIPMENT AND SUPPLIES PROVIDED BY A NONFACILITY FOR DATES OF SERVICE FROM JANUARY 1, 2008 THROUGH JUNE 30, 2013

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

REASON: Reasonable necessity exists to repeal this rule because it is solely applicable to services provided more than ten years ago. Section (1) additionally implies that the rule applies to durable medical equipment provided after January 1, 2008, but it is no longer applicable.

24.29.1526 DISALLOWED PROCEDURES

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

REASON: There is reasonable necessity to repeal this rule. The procedures listed here were not generally accepted by the medical community at the time of adoption. However, the rule was adopted prior to adoption of the Utilization and Treatment Guidelines. Those guidelines better address procedures which may not be permissible, and when they might nonetheless be considered. Repeal of this rule avoids ambiguity and conflict within the rule and avoids a blanket prohibition where it is not necessary.

24.29.1533 NONFACILITY FEE SCHEDULE FOR SERVICES PROVIDED FROM JANUARY 1, 2008 THROUGH JUNE 30, 2013

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

REASON: Reasonable necessity exists to repeal this rule because it is no longer necessary due to the passage of time because it applies solely to services provided on or before June 30, 2013. Section (1) implies its applicability to any claim after January 1, 2008, but it is not applicable.

24.29.1701 REHABILITATION PROVIDER DESIGNATION

AUTH: 39-71-203, MCA
IMP: 39-71-1014, 39-71-1015, 39-71-1023, MCA

REASON: There is reasonable necessity to repeal this rule because it implements two statutes which have been repealed, 39-71-1015 and 39-71-1023, MCA. The rule is no longer necessary in light of amendments to 39-71-1014, MCA and part 10 of the Workers' Compensation Act.

24.29.1705 LOCAL JOB POOL AREA DEFINITION

AUTH: 39-71-203, MCA
IMP: 39-71-1011, 39-71-1012, MCA

REASON: Reasonable necessity exists to repeal this rule because it defines a term which was repealed from 39-71-1011, MCA, in 1991, and 39-71-1012, MCA has been repealed.

24.29.1761 DISPUTES OVER REHABILITATION EXPENSES

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

REASON: There is reasonable necessity to repeal this rule because all disputes regarding workers' compensation benefits may be appealed to the workers' compensation court, following mediation, pursuant to 39-71-2905, MCA. The rule is not necessary.

24.29.2002 STANDARDS FOR DIAGNOSIS FOR SERVICES PROVIDED ON OR BEFORE JUNE 30, 2011

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

REASON: Reasonable necessity exists to repeal this rule because it has become obsolete through the passage of time due to its applicability solely to services provided on or before June 30, 2011.

24.29.2003 WORKERS' COMPENSATION DOES PAY FOR CERTAIN SERVICES PROVIDED ON OR BEFORE JUNE 30, 2011

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

REASON: Reasonable necessity exists to repeal this rule because it has become obsolete through the passage of time due to its applicability solely to services provided on or before June 30, 2011.

24.29.2301 PURPOSE

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2303 DEFINITIONS

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2311 SELECTION OF MANAGED CARE ORGANIZATION AND TREATING PHYSICIAN WITHIN A MANAGED CARE ORGANIZATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2321 PRELIMINARY APPLICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-224, 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2323 TIME, PLACE, AND MANNER OF PROVIDING SERVICES

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2326 AREAS SERVED BY THE MANAGED CARE ORGANIZATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2329 STRUCTURE OF ORGANIZATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2331 CONTENTS OF THE MANAGED CARE PLAN

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2336 FINANCIAL ABILITY OF ORGANIZATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2339 APPROVAL OF PRELIMINARY APPLICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2341 FINAL APPLICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-224, 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2346 ORIGINAL CERTIFICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE.

24.29.2351 REPORTING REQUIREMENTS

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-224, 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2356 DEPARTMENT MAY INSPECT OR AUDIT

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2361 APPLICATION TO RENEW CERTIFICATION, NOTICE OF INTENT NOT TO RENEW CERTIFICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2366 RENEWAL CERTIFICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2371 APPLICATION TO MODIFY PLAN

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2373 ADDITION AND TERMINATION OF MEMBERS

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2376 REVOCATION OR SUSPENSION OF CERTIFICATION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2379 DISPUTE RESOLUTION

AUTH: 39-71-203, 39-71-1103, 39-71-1105, MCA
IMP: 39-71-1103, 39-71-1105, MCA

REASON: See reason statement for NEW RULE VI.

24.29.2602 INTRODUCTION

AUTH: 39-71-203, 39-71-904, MCA
IMP: 39-71-901, 39-71-905, 39-71-907, 39-71-908, MCA

REASON: Reasonable necessity exists to strike (1) through (4) and (6) because they are duplicative of statute. Section (5) is proposed to be incorporated into ARM 24.29.2614.

24.29.2701 PAYMENT OF SILICOSIS BENEFITS

AUTH: 39-73-102, MCA
IMP: 39-73-104, 39-73-107, 39-73-108, 39-73-109, 39-73-111, MCA, and Chap. 142, L. of 1999

REASON: Reasonable necessity exists to repeal this rule because it merely duplicates the statutes it implements.

24.29.2811 MONTHLY PAYMENTS--UEF

AUTH: 39-71-203, MCA
IMP: 39-71-503, MCA

REASON: Reasonable necessity exists to repeal this rule because it is proposed to be included in ARM 24.29.2843, so as to simplify the rules by collocating payment requirements.

24.29.2839 COMPROMISE OF PENALTIES ASSESSED

AUTH: 39-71-203, MCA
IMP: 39-71-506, MCA

REASON: Reasonable necessity exists to repeal this rule because it duplicates 39-71-506(2), MCA.

24.29.2846 PRIORITY OF PAYMENT OF CURRENT BENEFITS

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-504, 39-71-510, MCA

REASON: Reasonable necessity exists to repeal this rule. Section (1) restates 39-71-503(3)(a), MCA. Section (2) because it restates 39-71-510, MCA. Section (3) states the necessary conclusion of 39-71-503 and 39-71-510, MCA. Section (4) is unnecessary because such earmarked funds do not exist, and would be subject to a specified settlement agreement, which would govern.

24.29.2849 PAYMENT OF CLAIMS WHERE LIABILITY IS DISPUTED

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-504, 39-71-510, MCA

REASON: Reasonable necessity exists to repeal this rule. Section (1) sets forth general policy and is not substantive. Sections (2) through (4) are proposed to be incorporated into ARM 24.29.2843 in a more concise manner. Section (5) is unnecessary because the UEF is not an insurer and is not subject to the provisions of the Workers' Compensation Act regarding unreasonable conduct by insurers. *See Pekus v. UEF*, 2003 MTWCC 33. Section (6) is unnecessary because it sets forth business process, which need not be in rule. Section (7) sets forth business process with regard to settlement agreements. Reasonable necessity exists to strike (8) because it cross-references a rule proposed to be repealed.

24.29.2851 LIMITATION ON EXPENDITURES FOR MEDICAL BENEFITS PAYABLE BY THE UEF--APPLICABILITY

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-510, 39-71-704, 39-71-727, MCA

REASON: Reasonable necessity exists to repeal this rule because it is duplicative of the statutes it purports to implement.

24.29.2855 RIGHTS OF THIRD-PARTY PROVIDERS UPON THE UEF'S PROPORTIONATE REDUCTION IN BENEFIT PAYMENTS--APPLICABILITY

AUTH: 39-71-203, MCA
IMP: 39-71-503, 39-71-508, 39-71-510, 39-71-704, 39-71-727, 39-71-743, MCA

REASON: Reasonable necessity exists to repeal this rule because it is duplicative of 39-71-508(3), MCA, which permits providers to pursue a cause of action against uninsured employers when costs of services are not paid by the UEF.

24.29.3107 TIMELINES AND EXPLANATION OF STATUS CLASSIFICATIONS OF A PETITION

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

REASON: See the general statement of reasonable necessity.

24.29.3111 PETITION FOR REOPENING

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

REASON: Reasonable necessity exists to repeal this rule because its substance is more concisely included within NEW RULE VII.

24.29.3114 SUBMISSION OF MEDICAL RECORDS AND ADDITIONAL INFORMATION--EFFECT OF FAILURE TO SUBMIT MEDICAL RECORDS OR ADDITIONAL INFORMATION

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

REASON: See the general statement of reasonable necessity.

24.29.3117 JOINT PETITION FOR REOPENING

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

REASON: See the general statement of reasonable necessity.

24.29.3121 REVIEW BY MEDICAL DIRECTOR--CONSENT OF BOTH PARTIES

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

REASON: See the general statement of reasonable necessity.

24.29.3124 REVIEW BY MEDICAL REVIEW PANEL--REPORT AND RECOMMENDATIONS

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

REASON: See the general statement of reasonable necessity.

24.29.4301 PURPOSE

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: There is reasonable necessity to repeal this rule because it is not substantive.

24.29.4311 FORMS USED FOR REPORTING

AUTH: 39-71-203, MCA
IMP: 39-71-205, 39-71-208, 39-71-225, MCA

REASON: Reasonable necessity exists to repeal this rule because its substance is more simply set forth in ARM 24.29.4314. Repeal is in the interest of simplifying, clarifying, and shortening the Administrative Rules of Montana.

24.29.4317 REPORTS PRODUCED BY THE DEPARTMENT

AUTH: 39-71-203, MCA
IMP: 39-71-205, 39-71-209, 39-71-224, 39-71-225, MCA

REASON: Reasonable necessity exists to repeal this rule because it is duplicative of 39-71-205 and 39-71-225, MCA. To the extent it goes beyond those statutes, it merely sets forth business process and procedures when reviewing and responding to requests for public records and implicates constitutional and statutory provisions for public record requests. The rule is unnecessary.

24.29.4322 TRANSITIONAL RULE FOR INJURY AND OCCUPATIONAL DISEASE INFORMATION REPORTING REQUIREMENTS

AUTH: 39-71-203, MCA
IMP: 39-71-225, MCA

REASON: Reasonable necessity exists to repeal this rule because, while necessary initially, nearly thirty years have passed since transition occurred. As such, the rule has become obsolete.

24.29.4329 VERIFICATION AND ADDITIONAL INFORMATION

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-225, 39-71-304, MCA

REASON: Reasonable necessity exists to repeal this rule because 39-71-107, MCA, requires insurers to provide information to the department on request. As a result, this rule is duplicative of statute.

7. Concerned persons may present their data, views, or arguments at the hearing. Written data, views, or arguments may also be submitted at dli.mt.gov/rules or P.O. Box 1728, Helena, Montana 59624. Comments must be received no later than 5:00 p.m., April 5, 2024.

8. An electronic copy of this notice of public hearing is available at dli.mt.gov/rules and sosmt.gov/ARM/register.

9. The agency maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by the agency. Persons wishing to have their name added to the list may sign up at dli.mt.gov/rules or by sending a letter to P.O. Box 1728, Helena, Montana 59624 and indicating the program or programs about which they wish to receive notices.

10. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

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

12. Department staff has been designated to preside over and conduct this hearing.

/s/ QUINLAN L. O'CONNOR
Quinlan L. O'Connor
Rule Reviewer

/s/ SARAH SWANSON
Sarah Swanson, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State February 27, 2024.