Montana Department of
LABOR & INDUSTRY

2025

Montana Workers' Compensation and Occupational Disease Laws and Administrative Rules

Enclosed is the 2025 edition of the Montana Workers' Compensation and Occupational Disease Laws and Administrative Rules, better known as the "Blue Book."

It is recommended you keep previously issued statues (laws) sections, and administrative rules for reference since **the date of the incident determines which edition of the "Blue Book" you should use.**

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Chapter 71
Workers' Compensation

Part 1
General Provisions

39-71-101. Short title.

This chapter may be cited as the "Workers' Compensation Act".

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

39-71-102. Reference to plans.

Whenever compensation plan No. 1, 2, or 3 is referred to, such reference also includes all other sections which are applicable to the subject matter of such reference.

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

Cross-References

Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.
Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-103. Compensation provisions.

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

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

39-71-104. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 24, Ch. 96, L. 1915; re-en. Sec. 2964, R.C.M. 1921; re-en. Sec. 2964, R.C.M. 1935; R.C.M. 1947, 92-838.

39-71-105. *(Temporary)* Declaration of public policy.

For the purposes of interpreting and applying this chapter, the following is the public policy of this state:

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

(2) It is the intent of the legislature to assert that a conclusive presumption exists that recognizes that a holder of a current, valid independent contractor exemption certificate issued by the department is an independent contractor if the person is working under the independent contractor exemption certificate. The holder of an independent contractor exemption certificate waives the rights,

benefits, and obligations of this chapter unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3.

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

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

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

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

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

(b) for occupational disease or presumptive occupational disease claims, because of the nature of exposure, workers should not be required to provide notice to employers of the disease as required of injuries and that the requirements for filing of claims reflect consideration of when the worker knew or should have known that the worker's condition resulted from an occupational disease or a presumptive occupational disease. The legislature recognizes that occupational diseases in the workplace are caused by events occurring on more than a single day or work shift and that the legislature has the authority to define an occupational disease or a presumptive occupational disease and establish the causal connection to the workplace. (Void on occurrence of contingency–sec. 7, Ch. 158, L. 2019.)

39-71-105. *(Effective on occurrence of contingency)* **Declaration of public policy.**

For the purposes of interpreting and applying this chapter, the following is the public policy of this state:

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

(2) It is the intent of the legislature to assert that a conclusive presumption exists that recognizes that a holder of a current, valid independent contractor exemption certificate issued by the department is an independent contractor if the person is working under the independent contractor exemption

certificate. The holder of an independent contractor exemption certificate waives the rights, benefits, and obligations of this chapter unless the person has elected to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3.

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

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

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

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

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

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

History: En. Sec. 1, Ch. 464, L. 1987; amd. Sec. 1, Ch. 630, L. 1993; amd. Sec. 1, Ch. 103, L. 2005; amd. Sec. 9, Ch. 416, L. 2005; amd. Sec. 7, Ch. 448, L. 2005; amd. Sec. 1, Ch. 167, L. 2011; amd. Sec. 3, Ch. 158, L. 2019.

39-71-106. No liability for reporting violation.

A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of this chapter.

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

39-71-107. Insurers to act promptly on claims – in-state claims examiners – third-party agents – penalties.

(1) Pursuant to the public policy stated in 39-71-105, prompt claims handling practices are necessary to provide appropriate service to injured workers, to employers, and to providers who are the customers of the workers' compensation system.

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

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

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

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

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

(b) except for those medical benefits provided by a managed care organization or a preferred provider organization in Title 39, chapter 71, part 11, or paid pursuant to 39-71-704(5), an insurer whose agent neglects or fails to use the proper fee schedule may be assessed a penalty of not less than $200 or more than $1,000 for each bill that its agent reviews under a fee schedule other than the proper Montana fee schedule.

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

(6) An insurer shall provide to the claimant:

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

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

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

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

(7) An insurer shall:

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

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

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

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

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

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

History: En. Sec. 4, Ch. 243, L. 1995; amd. Sec. 3, Ch. 214, L. 2001; amd. Sec. 2, Ch. 103, L. 2005; amd. Sec. 2, Ch. 140, L. 2005; amd. Sec. 11, Ch. 416, L. 2005; amd. Sec. 1, Ch. 117, L. 2007; amd. Sec. 5, Ch. 112, L. 2009; amd. Sec. 1, Ch. 150, L. 2011; amd. Sec. 1, Ch. 123, L. 2015; amd. Sec. 5, Ch. 433, L. 2017.

39-71-108. False statement on employment questionnaire.

(1) A false statement made by an employee in an employer-provided written questionnaire calling for the disclosure of an employee's medical condition that is relevant to the essential functions of the job following a conditional offer of employment bars all wage-loss or medical benefits under this chapter if all of the following conditions are met:

(a) the employee knowingly or willfully, by omission or commission, makes a false representation regarding the employee's physical condition that is relevant to the essential functions of the job;

(b) the employer relies on the false representation and that reliance is a contributing factor in the hiring of the employee; and

(c) there is a causal connection between the falsely represented condition and the injury or occupational disease for which wage-loss or medical benefits are claimed.

(2) The employee has the right to petition the workers' compensation court after satisfying the mediation requirements of this chapter if the employee disagrees with a decision to terminate benefits or bar benefits as provided under subsection (1).

History: En. Sec. 1, Ch. 63, L. 2021.

39-71-109 through 39-71-115 reserved.

39-71-116. Definitions.

Definitions. Unless the context otherwise requires, in this chapter the following definitions apply:

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

(2) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act necessary to:
   (a) investigation, review, and settlement of claims;
   (b) payment of benefits;
   (c) setting of reserves;
   (d) furnishing of services and facilities; and
   (e) use of actuarial, audit, accounting, vocational rehabilitation, and legal services.

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

(4) "Beneficiary" means:
   (a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;
   (b) an unmarried child under 18 years of age;
   (c) an unmarried child under 22 years of age who is a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;
   (d) an invalid child over 18 years of age who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of injury;
   (e) a parent who is dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury if a beneficiary, as defined in subsections (4)(a) through (4)(d), does not exist; and
   (f) a brother or sister under 18 years of age if dependent, as defined in 26 U.S.C. 152, upon the decedent for support at the time of the injury but only until the age of 18 years and only when a beneficiary, as defined in subsections (4)(a) through (4)(e), does not exist.

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

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

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

(8) (a) "Claims examiner" means an individual who, as a paid employee of the department, of a plan No. 1, 2, or 3 insurer, or of an administrator licensed under Title 33, chapter 17, examines claims under chapter 71 to:
      (i) determine liability;
      (ii) apply the requirements of this title;
      (iii) settle workers' compensation or occupational disease claims; or
      (iv) determine survivor benefits.
   (b) the term does not include an adjuster as defined in 33-17-102.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the employer for the preceding calendar year or, if the employer has not operated a sufficient or any length of time during the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting

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

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

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

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

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

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

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

(30) "Prosthetic device" or "prosthesis" means an artificial substitute for a missing body part.

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

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

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

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

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

(b)(i) as used in this subsection (35), "disability" means a condition in which a worker's ability to engage in gainful employment is diminished as a result of physical restrictions resulting from an injury. The restrictions may be combined with factors, such as the worker's age, education, work history, and other factors that affect the worker's ability to engage in gainful employment.

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

(36) "Sole proprietor" means the person who has the exclusive legal right or title to or ownership of a business enterprise.

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

(38) "Temporary partial disability" means a physical condition resulting from an injury, as defined in 39-71-119, in which a worker, prior to maximum healing:
(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;
(b) returns to work in a modified or alternative employment; and
(c) suffers a partial wage loss.

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

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

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

(42) "Treating physician" means the person who, subject to the requirements of 39-71-1101, is primarily responsible for delivery and coordination of the worker's medical services for the treatment of a worker's compensable injury or occupational disease and is:
(a) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located;
(b) a chiropractor licensed by the state of Montana under Title 37, chapter 12;
(c) a physician assistant licensed by the state of Montana under Title 37, chapter 20;
(d) an osteopath licensed by the state of Montana under Title 37, chapter 3;
(e) a dentist licensed by the state of Montana under Title 37, chapter 4;
(f) for a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections (42)(a) through (42)(e) and (42)(h) who is licensed or certified in another state;
(g) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8; or
(h) a physical therapist licensed by the state of Montana under Title 37, chapter 11.

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

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

History: Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2853, R.C.M. 1921; re-en. Sec. 2853, R.C.M. 1935; Sec. 92-401, R.C.M. 1947; (1)En. 92-423.2 by Sec. 1, Ch. 445, L. 1973; Sec. 92-423.2, R.C.M. 1947; (2)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2865, R.C.M. 1921; amd. Sec. 4, Ch. 121, L. 1925; re-en. Sec. 2865, R.C.M. 1935; amd. Sec. 1, Ch. 92, L. 1969; amd. Sec. 1, Ch. 331, L. 1973; amd. Sec. 1, Ch. 269, L. 1974; amd. Sec. 1, Ch. 46, L. 1975; Sec. 92-413, R.C.M. 1947; (3)Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2888, R.C.M. 1921; re-en. Sec. 2888, R.C.M. 1935; Sec. 92-436, R.C.M. 1947; Ap. p. Sec. 12, Ch. 235, L. 1947; Sec. 92-1121.1, R.C.M. 1947; (4)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2869, R.C.M. 1921; re-en. Sec. 2869, R.C.M. 1935; amd. Sec. 2, Ch. 92, L. 1969; Sec. 92-417, R.C.M. 1947; (5)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2878, R.C.M. 1921; re-en. Sec. 2878, R.C.M. 1935; amd. Sec. 7, Ch. 23, L. 1975; Sec. 92-426, R.C.M. 1947; (6), (22)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2885, R.C.M. 1921; re-en. Sec. 2885, R.C.M. 1935; Sec. 92-433, R.C.M. 1947; (7)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2877, R.C.M. 1921; re-en. Sec. 2877, R.C.M. 1935; amd. Sec. 1, Ch. 33, L. 1974; Sec. 92-425, R.C.M.

1947; (8)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2887, R.C.M. 1921; re-en. Sec. 2887, R.C.M. 1935; amd. Sec. 7, Ch. 550, L. 1977; Sec. 92-435, R.C.M. 1947; (9)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2868, R.C.M. 1921; re-en. Sec. 2868, R.C.M. 1935; Sec. 92-416, R.C.M. 1947; (10)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2881, R.C.M. 1921; re-en. Sec. 2881, R.C.M. 1935; amd. Sec. 8, Ch. 23, L. 1975; Sec. 92-429, R.C.M. 1947; (11)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2884, R.C.M. 1921; re-en. Sec. 2884, R.C.M. 1935; amd. Sec. 9, Ch. 23, L. 1975; Sec. 92-432, R.C.M. 1947; (12)En. 92-440 by Sec. 1, Ch. 108, L. 1973; Sec. 92-440, R.C.M. 1947; (13)En. 92-441 by Sec. 1, Ch. 109, L. 1973; Sec. 92-441, R.C.M. 1947; (14)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2873, R.C.M. 1921; re-en. Sec. 2873, R.C.M. 1935; Sec. 92-421, R.C.M. 1947; (15)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2889, R.C.M. 1921; re-en. Sec. 2889, R.C.M. 1935; Sec. 92-437, R.C.M. 1947; (16)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2886, R.C.M. 1921; re-en. Sec. 2886, R.C.M,. 1935; Sec. 92-434, R.C.M. 1947; (17)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2860, R.C.M. 1921; re-en. Sec. 2860, R.C.M. 1935; Sec. 92-408, R.C.M. 1947; (18)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2861, R.C.M. 1921; re-en. Sec. 2861, R.C.M. 1935; Sec. 92-409, R.C.M. 1947; (19)En. 92-439 by Sec. 1, Ch. 107, L. 1973; Sec. 92-439, R.C.M. 1947; (20)En. 92-423.1 by Sec. 1, Ch. 444, L. 1973; Sec. 92-423.1, R.C.M. 1947; (21)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2876, R.C.M. 1921; re-en. Sec. 2876, R.C.M. 1935; Sec. 92-424, R.C.M. 1947; R.C.M. 1947, 92-401, 92-408, 92-409, 92-413, 92-416, 92-417, 92-421, 92-423.1, 92-423.2, 92-424, 92-425, 92-426, 92-429, 92-432, 92-433, 92-434, 92-435, 92-436, 92-437, 92-439, 92-440, 92-441, 92-1121.1(part); amd. Sec. 53, Ch. 397, L. 1979; amd. Sec. 1, Ch. 47, L. 1981; amd. Sec. 1, Ch. 349, L. 1981; amd. Sec. 1, Ch. 374, L. 1985; amd. Sec. 2, Ch. 464, L. 1987; amd. Sec. 7, Ch. 333, L. 1989; amd. Sec. 13, Ch. 613, L. 1989; amd. Sec. 6, Ch. 4, Sp. L. May 1990; amd. Sec. 1, Ch. 323, L. 1991; amd. Sec. 2, Ch. 480, L. 1991; amd. Sec. 1, Ch. 574, L. 1991; amd. Sec. 1, Ch. 555, L. 1993; amd. Sec. 1, Ch. 619, L. 1993; amd. Sec. 2, Ch. 628, L. 1993; amd. Sec. 1, Ch. 234, L. 1995; amd. Sec. 5, Ch. 243, L. 1995; amd. Sec. 1, Ch. 516, L. 1995; amd. Sec. 6, Ch. 276, L. 1997; amd. Sec. 1, Ch. 404, L. 1997; amd. Sec. 1, Ch. 500, L. 1997; amd. Sec. 72, Ch. 51, L. 1999; amd. Sec. 30, Ch. 224, L. 2003; amd. Sec. 5, Ch. 26, L. 2005; amd. Sec. 3, Ch. 140, L. 2005; amd. Secs. 12, 41, Ch. 416, L. 2005; amd. Sec. 20, Ch. 519, L. 2005; amd. Sec. 1, Ch. 359, L. 2007; amd. Sec. 2, Ch. 167, L. 2011; amd. Sec. 1, Ch. 197, L. 2021; amd. Sec. 1, Ch. 133, L. 2025; amd. Sec. 1, Ch. 157, L. 2025.

Cross-References

Rehabilitation benefits, 39-71-1006.

Managed care and preferred provider organizations, Title 39, ch. 71, part 11.

39-71-117. Employer defined.

(1) "Employer" means:

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

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

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

(d) subject to subsection (5), a religious corporation, religious organization, or religious trust receiving remuneration from nonmembers for:

(i) manufacturing or construction activities conducted by its members on or off the property owned or leased by the religious corporation, religious organization, or religious trust; or

(ii) agricultural labor and services performed off the property owned or leased by the religious corporation, religious organization, or religious trust; and

(e)an approved and authorized fiduciary, agent, or other person acting as fiscal agent under section 3504 of the Internal Revenue Code, 26 U.S.C. 3504, and 26 CFR 31.3504-1.

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

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

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

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

(b)the person, association, contractor, firm, limited liability company, limited liability partnership, or corporation furnishing employees or workers in this state to a motor carrier has obtained Montana workers' compensation insurance on the employees or workers in Montana both at the inception of employment and during all phases of the work performed.

(5) The definition of "employer" in subsection (1)(d) is limited to implementing the administrative purposes of this chapter and may not be interpreted or construed to create an employment relationship in any other context.

(6) (a)A fiscal agent that qualifies under subsection (1)(e) and that is designated as a payor, using federal, state, or local government funds, under 26 CFR 31.3504-1 is considered to be the employer for the purposes of the Workers' Compensation Act of those workers for whom the fiscal agent is making payments.

(b)the client of the fiscal agent, despite exercising control over the hiring, scheduling, and direction of the work tasks performed by the worker, is not the employer of that worker for the purposes of the Workers' Compensation Act.

History: En. 92-410.1 by Sec. 1, Ch. 154, L. 1973; R.C.M. 1947, 92-410.1(part); amd. Sec. 1, Ch. 480, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 2, Ch. 323, L. 1991; amd. Sec. 1, Ch. 813, L. 1991; amd. Sec. 1, Ch. 458, L. 1993; amd. Sec. 29, Ch. 308, L. 1995; amd. Sec. 18, Ch. 344, L. 1995; amd. Sec. 2, Ch. 516, L. 1995; amd. Sec. 1, Ch. 172, L. 1997; amd. Sec. 4, Ch. 214, L. 2001; amd. Sec. 8, Ch. 448, L. 2005; amd. Sec. 6, Ch. 112, L. 2009; amd. Sec. 1, Ch. 364, L. 2015; amd. Sec. 1, Ch. 89, L. 2017; amd. Sec. 1, Ch. 282, L. 2025.

39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency care provider defined – election of coverage.

(1) As used in this chapter, the term "employee" or "worker" means:

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

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

(c) a person who is receiving on-the-job vocational rehabilitation training or other on-the-job training under a state or federal vocational training program, whether or not under an appointment or contract of hire with an employer, as defined in 39-71-117, and, except as provided in subsection (7), whether or not receiving payment from a third party. However, this subsection (1)(c) does not apply to students enrolled in vocational training programs, as outlined in this subsection, while they are on the premises of a public school or community college.

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

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

(i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an impairment award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part 4, for a full-time employee at the time of the injury; and

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

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

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

(h) a person placed at a public or private entity's worksite pursuant to 53-4-704. The person is considered an employee for workers' compensation purposes only. The department of public health and human services shall provide workers' compensation coverage for recipients of cash assistance, as defined in 53-4-201, or for participants in the food stamp program, as defined in 53-2-902, who are placed at public or private worksites through an endorsement to the department of public health and human services' workers' compensation policy naming the public or private worksite entities as named insureds under the policy. The endorsement may cover only the entity's public assistance participants and may be only for the duration of

each participant's training while receiving cash assistance or while participating in the food stamp program under a written agreement between the department of public health and human services and each public or private entity. The department of public health and human services may not provide workers' compensation coverage for individuals who are covered for workers' compensation purposes by another state or federal employment training program. Premiums and benefits must be based upon the wage that a probationary employee is paid for work of a similar nature at the assigned worksite.

(i) subject to subsection (11), a member of a religious corporation, religious organization, or religious trust while performing services for the religious corporation, religious organization, or religious trust, as described in 39-71-117(1)(d); and

(j) a member of the army national guard or air national guard while performing state military duty as defined in 10-1-1003.

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

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

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

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

(d) performing temporary agricultural work for an employer if the person performing the work is otherwise exempt from the requirement to obtain workers' compensation coverage under 39-71-401(2)(r) with respect to a company that primarily performs agricultural work at a fixed business location or under 39-71-401(2)(d) and is not required to obtain an independent contractor's exemption certificate under 39-71-417 because the person does not regularly perform agricultural work away from the person's own fixed business location. For the purposes of this subsection, the term "agricultural" has the meaning provided in 15-1-101(1)(a).

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter a volunteer as defined in subsection (2)(b) or a volunteer firefighter as defined in 7-33-4510.

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

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

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

(d) all weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (4)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $900 a month and not more than 11/2 times the state's average weekly wage.

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

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

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

(d) for the purposes of an election under this subsection (5), all weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $200 a week and not more than 11/2 times the state's average weekly wage.

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

(7) (a) A student currently enrolled in an elementary, secondary, or postsecondary educational institution who is participating in work-based learning activities and who is paid wages by the educational institution or business partner is the employee of the entity that pays the student's wages for all purposes under this chapter.

(b) an elementary or secondary student who is not paid wages by the business partner or the educational institution in which the student is enrolled is a volunteer for whom coverage must be provided. The business partner and the educational institution shall mutually determine and agree in writing whether the business partner or the educational institution shall elect coverage for the student.

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

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

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

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

(d) a nonresident of Montana who does not meet the requirements of subsection (8)(b) and whose employer elects coverage with an insurer that allows an election for an employer whose:
(i) nonresident employees are hired in Montana;
(ii) nonresident employees' wages are paid in Montana;
(iii) nonresident employees are supervised in Montana; and
(iv) business records are maintained in Montana.

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

(10) (a) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee within the provisions of this chapter a volunteer emergency care provider who serves public safety through the ambulance service not otherwise covered by subsection (1)(g) or the paid or volunteer nontransporting medical unit. The ambulance service or nontransporting medical unit may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in this chapter.

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

(c) an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, may make a separate election to provide benefits as described in this subsection (10) to a member who is either a self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer emergency care provider pursuant to subsection (10)(a). When injured in the course and scope of employment as a volunteer emergency care provider, a member may instead of the benefits described in subsection (10)(b) be eligible for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080 hours a year. If the separate election is made as provided in this subsection (10), payroll information for those self-employed sole proprietors or partners must be reported and premiums must be assessed on the assumed weekly wage.

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

(e) an ambulance service not otherwise covered by subsection (1)(g) or a nontransporting medical unit, as defined in 50-6-302, that does not elect to purchase workers' compensation coverage for its volunteer emergency care providers under the provisions of this section shall annually notify its volunteer emergency care providers that coverage is not provided.

(f) (i) The term "volunteer emergency care provider" means a person who is licensed by the department as provided in Title 50, chapter 6, part 2, and who serves the public through an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county.
(ii) the term does not include a volunteer emergency care provider who serves an employer as defined in 7-33-4510.

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

(11) The definition of "employee" or "worker" in subsection (1)(i) is limited to implementing the administrative purposes of this chapter and may not be interpreted or construed to create an employment relationship in any other context.

History: En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2863, R.C.M. 1921; amd. Sec. 3, Ch. 121, L. 1925; amd. Sec. 1, Ch. 139, L. 1931; re-en. Sec. 2863, R.C.M. 1935; amd. Sec. 3, Ch. 88, L. 1945; amd. Sec. 1, Ch. 153, L. 1963; amd. Sec. 1, Ch. 308, L. 1971; amd. Sec. 1, Ch. 44, L. 1975; amd. Sec. 1, Ch. 281, L. 1977; R.C.M. 1947, 92-411; amd. Sec. 1, Ch. 21, L. 1981; amd. Sec. 2, Ch. 336, L. 1985; amd. Sec. 20, Ch. 670, L. 1985; amd. Sec. 96, Ch. 370, L. 1987; amd. Sec. 67, Ch. 464, L. 1987; amd. Sec. 25, Ch. 658, L. 1987; amd. Sec. 11, Ch. 333, L. 1989; amd. Sec. 1, Ch. 129, L. 1991; amd. Sec. 3, Ch. 323, L. 1991; amd. Sec. 2, Ch. 813, L. 1991; amd. Sec. 1, Ch. 154, L. 1993; amd. Sec. 8, Ch. 279, L. 1993; amd. Sec. 2, Ch. 458, L. 1993; amd. Sec. 1, Ch. 471, L. 1993; amd. Sec. 6, Ch. 561, L. 1993; amd. Sec. 1, Ch. 131, L. 1995; amd. Sec. 30, Ch. 308, L. 1995; amd. Sec. 19, Ch. 344, L. 1995; amd. Sec. 1, Ch. 424, L. 1995; amd. Sec. 3, Ch. 516, L. 1995; amd. Sec. 2, Ch. 172, L. 1997; amd. Sec. 2, Ch. 500, L. 1997; amd. Sec. 2, Ch. 515, L. 1997; amd. Sec. 1, Ch. 124, L. 1999; amd. Sec. 1, Ch. 238, L. 2001; amd. Sec. 3, Ch. 465, L. 2001; amd. Sec. 6, Ch. 26, L. 2005; amd. Sec. 7, Ch. 449, L. 2007; amd. Sec. 7, Ch. 112, L. 2009; amd. Sec. 1, Ch. 312, L. 2009; amd. Sec. 3, Ch. 167, L. 2011; amd. Sec. 8, Ch. 255, L. 2011; amd. Sec. 1, Ch. 262, L. 2011; amd. Sec. 3, Ch. 412, L. 2013; amd. Sec. 1, Ch. 330, L. 2015; amd. Sec. 2, Ch. 364, L. 2015; amd. Sec. 3, Ch. 95, L. 2017; amd. Sec. 2, Ch. 41, L. 2019; amd. Sec. 11, Ch. 220, L. 2019; amd. Sec. 7, Ch. 14, L. 2021; amd. Sec. 1, Ch. 136, L. 2021 ; amd. Sec. 3, Ch. 264, L. 2023; amd. Sec. 5, Ch. 415, L. 2025.

Cross-References

Independent contractor certification, 39-71-417.

39-71-119. Injury and accident defined.

(1) "Injury" or "injured" means:

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

(b) damage to prosthetic devices;

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

(d) death.

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

(a) an unexpected traumatic incident or unusual strain;

(b) identifiable by time and place of occurrence;

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

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

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

(a) emotional or mental stress; or

(b) a nonphysical stimulus or activity.

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

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

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

History: Ap. p. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2870, R.C.M. 1921; re-en. Sec. 2870, R.C.M. 1935; amd. Sec. 6, Ch. 162, L. 1961; amd. Sec. 6, Ch. 149, L. 1965; amd. Sec. 1, Ch. 270, L. 1967; amd. Sec. 1, Ch. 488, L. 1973; Sec. 92-418, R.C.M. 1947; Ap. p. Sec. 2, Ch. 488, L. 1973; Sec. 92-418.1, R.C.M. 1947; (3)En. Sec. 6, Ch. 96, L. 1915; re-en. Sec. 2864, R.C.M. 1921; re-en. Sec. 2864, R.C.M. 1935; Sec. 92-412, R.C.M. 1947; R.C.M. 1947, 92-412, 92-418, 92-418.1; amd. Sec. 3, Ch. 464, L. 1987; amd. Sec. 6, Ch. 243, L. 1995; amd. Sec. 2, Ch. 197, L. 2021.

39-71-120. Repealed.

Sec. 13, Ch. 448, L. 2005.

History: En. 92-438.1 by Sec. 1, Ch. 251, L. 1973; R.C.M. 1947, 92-438.1; amd. Sec. 5, Ch. 314, L. 1987; amd. Sec. 30, Ch. 500, L. 1995; amd. Sec. 11, Ch. 548, L. 1997.

39-71-121. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 2, Ch. 47, L. 1981.

39-71-122. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 3, Ch. 47, L. 1981.

39-71-123. Wages defined.

(1) "Wages" means all remuneration paid for services performed by an employee for an employer, or income provided for in subsection (1)(d). Wages include the cash value of all remuneration paid in any medium other than cash. The term includes but is not limited to:
   (a) monetary commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and periods of sickness;
   (b) backpay or any similar pay made for or in regard to previous service by the employee for the employer, other than retirement or pension benefits from a qualified plan;
   (c) tips or other gratuities received by the employee to the extent that tips or gratuities are documented by the employee to the employer for tax purposes;
   (d) income or payment in the form of a draw, wage, net profit, or money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration;
   (e) payments made to an employee on any basis other than time worked, including but not limited to piecework, an incentive plan, or profit-sharing arrangement;
   (f) board if it constitutes a part of the employee's remuneration and is based on its actual value; and
   (g) lodging, rent, or housing if it constitutes part of the employee's remuneration and is based on a value as set by administrative rule. The values set by administrative rule must address the general geographic proximity to available housing and may consider other reasonable factors that affect value.

(2) The term "wages" does not include any of the following:
   (a) employee expense reimbursements or allowances for meals, lodging, travel, subsistence, and other expenses, as set forth in department rules;
   (b) the amount of the payment made by the employer for employees, if the payment was made for:
      (i) retirement or pension pursuant to a qualified plan as defined under the provisions of the Internal Revenue Code;
      (ii) sickness or accident disability under a workers' compensation policy;
      (iii) medical or hospitalization expenses in connection with sickness or accident disability, including health insurance for the employee or the employee's immediate family;
      (iv) death, including life insurance for the employee or the employee's immediate family;

(c) vacation or sick leave benefits accrued but not paid;
(d) special monetary rewards for individual invention or discovery; or
(e) monetary and other benefits paid to a person as part of public assistance, as defined in 53-4-201.

(3) (a) Except as provided in subsection (3)(b), for compensation benefit purposes, the average actual earnings for the four pay periods immediately preceding the injury are the employee's wages, except that if the term of employment for the same employer is less than four pay periods, the employee's wages are the hourly rate times the number of hours in a week for which the employee was hired to work.
(b) for good cause shown, if the use of the last four pay periods does not accurately reflect the claimant's employment history with the employer, the wage may be calculated by dividing the total earnings for an additional period of time, not to exceed 1 year prior to the date of injury, by the number of weeks in that period, including periods of idleness or seasonal fluctuations.

(4) (a) For the purpose of calculating compensation benefits for an employee working concurrent employments, the average actual wages must be calculated as provided in subsection (3). As used in this subsection, "concurrent employment" means employment in which the employee was actually employed at the time of the injury and would have continued to be employed without a break in the term of employment if not for the injury.
(b) except as provided in 39-71-118(10)(c), the compensation benefits for a covered volunteer must be based on the average actual monetary wages in the volunteer's regular employment, except self-employment as a sole proprietor or partner who elected not to be covered, from which the volunteer is disabled by the injury incurred.
(c) the compensation benefits for an employee working at two or more concurrent remunerated employments must be based on the aggregate of average actual monetary wages of all employments, except for the wages earned by individuals while engaged in the employments outlined in 39-71-401(3)(a) who elected not to be covered, from which the employee is disabled by the injury incurred.

(5) For the purposes of calculating compensation benefits for an employee working for an employer, as provided in 39-71-117(1)(d), and for calculating premiums to be paid by that employer, the wages must be based upon all hours worked multiplied by the mean hourly wage by area, as published by the department in the edition of Montana Informational Wage Rates by Occupation, adopted annually by the department, that is in effect as of the date of injury or for the period in which the premium is due.

History: En. Sec. 4, Ch. 464, L. 1987; amd. Sec. 12, Ch. 333, L. 1989; amd. Sec. 2, Ch. 129, L. 1991; amd. Sec. 2, Ch. 261, L. 1991; amd. Sec. 2, Ch. 154, L. 1993; amd. Sec. 23, Ch. 619, L. 1993; amd. Sec. 2, Ch. 131, L. 1995; amd. Sec. 7, Ch. 243, L. 1995; amd. Sec. 29, Ch. 491, L. 1997; amd. Sec. 2, Ch. 124, L. 1999; amd. Sec. 2, Ch. 377, L. 1999; amd. Sec. 2, Ch. 238, L. 2001; amd. Sec. 4, Ch. 465, L. 2001; amd. Sec. 8, Ch. 112, L. 2009; amd. Sec. 9, Ch. 255, L. 2011; amd. Sec. 4, Ch. 412, L. 2013; amd. Sec. 1, Ch. 329, L. 2017.

39-71-124. Applicability of Workers' Compensation Act – exceptions.

Except as provided in 39-71-407, 39-71-601, and 39-71-603 [and as specified in 39-71-1401], this chapter applies to injuries and occupational diseases. (Bracketed language void on occurrence of contingency–sec. 7, Ch. 158, L. 2019.)

History: En. Sec. 1, Ch. 416, L. 2005; amd. Sec. 4, Ch. 158, L. 2019.

Part 2
Administrative Provisions

Part Cross-References
Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.

39-71-201. Workers' compensation administration fund.

(1) A workers' compensation administration fund is established out of which are to be paid upon lawful appropriation all costs of administering the Workers' Compensation Act, with the exception of the certification of independent contractors provided for in Title 39, chapter 71, part 4, the subsequent injury fund provided for in 39-71-907, and the uninsured employers' fund provided for in 39-71-503. The department may use the workers' compensation administration fund to reimburse premiums for high-quality work-based learning programs, as provided in 39-71-319. The department shall collect and deposit in the state treasury to the credit of the workers' compensation administration fund:
   (a) all fees and penalties provided in 39-71-107, 39-71-205, 39-71-223, 39-71-304, 39-71-306, 39-71-307, 39-71-315, 39-71-316, 39-71-401(6), 39-71-2204, 39-71-2205, and 39-71-2337; and
   (b) all fees paid by an assessment on paid losses, plus administrative fines and interest provided by this section.

(2) For the purposes of this section, paid losses include the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act without regard to the application of any deductible whether the employer or the insurer pays the losses:
   (a) total compensation benefits paid; and
   (b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

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

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

(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 4% of the paid losses paid in the preceding calendar year by or on behalf of the plan No. 1 employer. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) an employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 4% of the paid losses paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

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

(i) one installment due on July 1; or

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

(d) if an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund and may be used to pay the reimbursement of premiums required under 39-71-319.

(6) (a) compensation plan No. 3, the state fund, shall pay an assessment to fund administrative and regulatory costs attributable to claims arising before July 1, 1990. The assessment may be up to 4% of the paid losses paid in the preceding calendar year for claims arising before July 1, 1990. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the assessment for administrative and regulatory costs that is attributable to claims arising before July 1, 1990.

(b) the assessment must be paid in:

(i) one installment due on July 1; or

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

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

(7) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "workers' compensation regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed upon insured employers.

(b) the amount to be funded by the premium surcharge may be up to 4% of the paid losses paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and may be up to 4% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (7)(f). The amount to be funded must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or

plan No. 3 during the preceding calendar year. A single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

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

(d) the premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within 20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund and may be used to pay the reimbursement of premiums required under 39-71-319.

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

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

(8) By July 1, an insurer under compensation plan No. 2 that paid benefits in the preceding calendar year but that will not collect any premium for coverage in the following fiscal year shall pay an assessment of up to 4% of paid losses paid in the preceding calendar year. The department shall determine and notify the insurer by April 30 of each year of the amount that is due by July 1.

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

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

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state. Reimbursement of premiums required under 39-71-319 by the workers' compensation administration fund also is a debit on the fund.

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

(13) The department shall transfer funds to the workers' compensation court fund as provided by 3-9-105.

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

History: En. 92-116.1 by Sec. 1, Ch. 253, L. 1973; amd. Sec. 1, Ch. 318, L. 1975; amd. Sec. 28, Ch. 453, L. 1977; R.C.M. 1947, 92-116.1; amd. Sec. 18, Ch. 104, L. 1979; amd. Sec. 28, Ch. 557, L. 1987; amd. Sec. 14, Ch. 613, L. 1989; amd. Sec. 2, Ch. 558, L. 1991; amd. Sec. 2, Ch. 555, L. 1993; amd. Sec. 2, Ch. 514, L. 1995; amd. Secs. 1, 2, Ch. 385, L. 1997; amd. Secs. 3, 4, Ch. 377, L. 1999; amd. Sec. 51, Ch. 7, L. 2001; amd. Sec. 5, Ch. 214, L. 2001; amd. Sec. 3, Ch. 103, L. 2005; amd. Sec. 3, Ch. 133, L. 2005; amd. Sec. 13, Ch. 416, L. 2005; amd. Sec. 2, Ch. 117, L. 2007; amd. Sec. 15, Ch. 27, L. 2009; amd. Sec. 9, Ch. 112, L. 2009; amd. Sec. 1, Ch. 365, L. 2015; amd. Sec. 3, Ch. 400, L. 2019; amd. Sec. 2, Ch. 282, L. 2025; amd. Sec. 5, Ch. 688, L. 2025.

Cross-References

Collection and disposition of fines, penalties, forfeitures, and fees, 3-10-601.

39-71-202. Office of department.

The department shall keep its principal office in the capital of the state. It may rent or lease quarters for the conduct of its administrative duties.

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

39-71-203. Powers of department – rules.

(1) The department is hereby vested with full power, authority, and jurisdiction to do and perform any and all things that are necessary or convenient in the exercise of any power, authority, or jurisdiction conferred upon it under this chapter.
(2) The department may adopt rules to carry out the provisions of this chapter.

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

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

39-71-204. Hearings – rules of evidence – appeal, rescission, alteration, or amendment by department of its orders, decisions, or awards – effect – appeal.

(1) The statutory and common-law rules of evidence do not apply to a hearing before the department under this chapter. A petition for a hearing before the department must be filed within 2 years after benefits are denied.
(2) A hearing under this chapter may be conducted by telephone or by video conference.
(3) The department has continuing jurisdiction over all its orders, decisions, and awards and may, at any time, upon notice, and after opportunity to be heard is given to the parties in interest, rescind, alter, or amend any order, decision, or award made by it upon good cause.
(4) Any order, decision, or award rescinding, altering, or amending a prior order, decision, or award has the same effect as original orders or awards.
(5) If a party is aggrieved by a department order, the party may appeal the dispute to the workers' compensation judge.

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

39-71-205. Department authorized to charge certain fees – disposition of.

(1) The department shall have power and authority to charge and collect a fee for copies of papers and records, including certified copies of documents and orders filed in its office, sufficient to recover the cost of the material and the time expended, as fixed by the department.
(2) The department shall have power and authority to fix and collect reasonable charges for publications issued under its authority.
(3) The fees charged and collected under this section shall be paid monthly into the treasury of the state to the credit of the state special revenue fund and shall be accompanied by detailed statement thereof.

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

39-71-206. Legal advisers of department and state fund – investigative and prosecution services.

(1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.
(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of this chapter.

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

Cross-References

Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-207. Repealed.

Sec. 4, Ch. 239, L. 1989.

History: En. 92-121 by Sec. 1, Ch. 332, L. 1973; R.C.M. 1947, 92-121; amd. Sec. 51, Ch. 613, L. 1989.

39-71-208. Blank forms, minutes, and records.

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

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

39-71-209. Publication of reports and bulletins authorized.

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

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

39-71-210. Repealed.

Sec. 3, Ch. 370, L. 1989.

History: En. Sec. 25, Ch. 96, L. 1915; re-en. Sec. 2968, R.C.M. 1921; re-en. Sec. 2968, R.C.M. 1935; amd. Sec. 50, Ch. 23, L. 1975; R.C.M. 1947, 92-842; amd. Sec. 2, Ch. 103, L. 1979; amd. Sec. 64, Ch. 613, L. 1989.

39-71-211. Fraud detection and prevention unit – expenditure accounting.

(1) The state fund shall establish a fraud prevention and detection unit. The unit is responsible for developing detection and prevention procedures, providing detection services, and providing training in the prevention and detection of fraudulent conduct under this chapter that is subject to prosecution under Title 45. The unit shall refer all cases of suspected fraudulent conduct to the workers' compensation fraud investigation and prosecution office established in 2-15-2015.
(2) The state fund shall expend money to investigate fraud pursuant to this section and shall separately account for money expended.

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

Cross-References

Fraud, 28-2-404 through 28-2-406.

39-71-212 through 39-71-220 reserved.

39-71-221. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-844 by Sec. 1, Ch. 25, L. 1975; R.C.M. 1947, 92-844; amd. Sec. 64, Ch. 613, L. 1989.

39-71-222. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-845 by Sec. 2, Ch. 25, L. 1975; R.C.M. 1947, 92-845; amd. Sec. 64, Ch. 613, L. 1989.

39-71-223. Certified copies of public records – fees.

(1) The department shall, on demand, furnish a certified copy of any public record to a person who has a right to inspect it, if the record is of a nature permitting such copying, or shall furnish reasonable opportunity to inspect or copy.
(2) The department may establish fees reasonably calculated to reimburse the department for its actual cost in making such records available.

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

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Public participation in governmental operations, Title 2, ch. 3.
Adoption and publication of rules, Title 2, ch. 4, part 3.

39-71-224. Records exempt from disclosure -- separation of exempt material from nonexempt.

(1) In assuring that the right of individual privacy so essential to the well-being of a free society shall not be infringed without the showing of a compelling state interest, the following public records of the department are exempt from disclosure:
   (a) information of a personal nature such as personal, medical, or similar information if the public disclosure thereof would constitute an unreasonable invasion of privacy, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy.
   (b) any public records or information, the disclosure of which is prohibited by federal law or regulations.
(2) If any public record of the department contains material which is not exempt under subsection (1) of this section, as well as material which is exempt from disclosure, the department shall separate the exempt and nonexempt and make the nonexempt material available for examination.

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

39-71-225. Workers' compensation database system.

(1) The department shall develop a workers' compensation database system to generate management information about Montana's workers' compensation system. The database system must be used to collect and compile information from insurers, employers, health care providers, claimants, claims examiners, rehabilitation providers, and the legal profession.
(2) Data collected must be used to provide:
   (a) management information to the legislative and executive branches for the purpose of making policy and management decisions, including but not limited to:
      (i) performance information to enable the state to enact remedial efforts to ensure quality, control abuse, and enhance cost control;
      (ii) information on medical, indemnity, and rehabilitation costs, utilization, and trends;
      (iii) information on litigation and attorney involvement for the purpose of identifying trends, problem areas, and the costs of legal involvement;
   (b) current and prior claim information to any insurer that is at risk on a claim, or that is alleged to be at risk in any administrative or judicial proceeding, to determine claims liability or for fraud investigation. The department may release information only upon written request by the insurer and may disclose only the claimant's name, claimant's identification number, prior claim number, date of injury, body part involved, and name and address of the insurer and claims examiner on each claim filed. Information obtained by an insurer pursuant to this section must remain confidential and may not be disclosed to a third party except to the extent necessary for determining claim liability or for fraud investigation.
   (c) current and prior claim information to law enforcement agencies for purposes of fraud investigation or prosecution; and

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

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

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

(a)avoidance of duplication and inconsistency;

(b)reasonable availability of data elements;

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

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

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

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

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

(h)compatibility with electronic data reporting;

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

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

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

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

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

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

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

39-71-226. Renumbered 39-71-2370.

Sec. 11, Ch. 26, L. 2005.

Part 3
Miscellaneous Provisions

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-301. Certificates and certified copies as evidence.

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

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

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

Cross-References

Suspension of license for violation of certain labor laws, 18-2-432.

Grounds for disciplinary action as grounds for license denial – conditions to new licenses, 37-1-137.

39-71-302. Repealed.

Sec. 12, Ch. 103, L. 2005.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3009, R.C.M. 1921; re-en. Sec. 3009, R.C.M. 1935; amd. Sec. 11, Ch. 235, L. 1947; amd. Sec. 1, Ch. 146, L. 1971; amd. Sec. 5, Ch. 443, L. 1973; R.C.M. 1947, 92-1121; amd. Sec. 54, Ch. 397, L. 1979; amd. Sec. 8, Ch. 333, L. 1989.

39-71-303. Repealed.

Sec. 12, Ch. 103, L. 2005.

History: En. Sec. 11, Ch. 96, L. 1915; re-en. Sec. 2904, R.C.M. 1921; re-en. Sec. 2904, R.C.M. 1935; amd. Sec. 14, Ch. 23, L. 1975; R.C.M. 1947, 92-607(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 3, Ch. 172, L. 1997.

39-71-304. Books, records, and payrolls to be open to inspection – penalty for refusal – subpoenas.

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

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

History: En. Sec. 19, Ch. 96, L. 1915; re-en. Sec. 2946, R.C.M. 1921; re-en. Sec. 2946, R.C.M. 1935; amd. Sec. 166, Ch. 147, L. 1963; amd. Sec. 33, Ch. 23, L. 1975; R.C.M. 1947, 92-820; amd. Sec. 3, Ch. 103, L. 1979; amd. Sec. 55, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 3, Ch. 555, L. 1993; amd. Sec. 10, Ch. 442, L. 1999; amd. Sec. 6, Ch. 214, L. 2001.

39-71-305. Repealed.

Sec. 16, Ch. 103, L. 1979.

History: En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2930, R.C.M. 1921; re-en. Sec. 2930, R.C.M. 1935; amd. Sec. 20, Ch. 23, L. 1975; R.C.M. 1947, 92-804.

39-71-306. Insurers to file summary reports of benefits paid for injuries and miscellaneous expenses and statements of medical expenditures.

(1) By January 15 of each year, each insurer shall file with the department:
   (a) summary reports of benefits for all compensation payments made during the previous calendar year to injured workers or their beneficiaries or dependents;
   (b) statements showing the amounts expended during the previous calendar year for all medical services for injured workers; and
   (c) statements showing all miscellaneous amounts, other than compensation and medical expenditures, paid during the previous calendar year to or on behalf of injured workers or their beneficiaries or dependents and not otherwise reported as an expenditure for the workers' compensation administration assessment provided for in 39-71-201.

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

History: En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2932, R.C.M. 1921; re-en. Sec. 2932, R.C.M. 1935; amd. Sec. 21, Ch. 23, L. 1975; R.C.M. 1947, 92-806; amd. Sec. 56, Ch. 397, L. 1979; amd. Sec. 17, Ch. 613, L. 1989; amd. Sec. 3, Ch. 558, L. 1991; amd. Sec. 7, Ch. 214, L. 2001; amd. Sec. 2, Ch. 69, L. 2005; amd. Sec. 3, Ch. 282, L. 2025.

Cross-References

Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.

39-71-307. Employers and insurers to file reports – penalty.

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

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

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

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

39-71-308. Repealed.

Sec. 12, Ch. 103, L. 2005.

History: En. Sec. 3, Ch. 96, L. 1915; amd. Sec. 1, Ch. 100, L. 1919; amd. Sec. 1, Ch. 196, L. 1921; re-en. Sec. 2840, R.C.M. 1921; re-en. Sec. 2840, R.C.M. 1935; amd. Sec. 1, Ch. 410, L. 1971; amd. Sec. 6, Ch. 23, L. 1975; R.C.M. 1947, 92-206(part); amd. Sec. 3, Ch. 21, L. 1981; amd. Sec. 19, Ch. 613, L. 1989.

39-71-309. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. 92-706.1 by Sec. 1, Ch. 252, L. 1973; amd. Sec. 1, Ch. 43, L. 1975; amd. Sec. 1, Ch. 189, L. 1975; R.C.M. 1947, 92-706.1(2); amd. Sec. 57, Ch. 397, L. 1979.

39-71-310 through 39-71-314 reserved.

39-71-315. Prohibited actions – penalty.

(1) The following actions by a health care provider constitute violations and are subject to the penalty in subsection (2):
   (a) failing to certify the provision of the services or treatment for which compensation is claimed under this chapter; or
   (b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

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

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

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

39-71-316. Filing true claim – obtaining benefits through deception or other fraudulent means.

(1) A person filing a claim under this chapter, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.

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

subsection includes but is not limited to a person who is receiving temporary total disability benefits, permanent total disability benefits, or rehabilitation benefits while working without the knowledge and concurrence of the insurer.

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

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

(b) the department shall:

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

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

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

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

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

39-71-317. Employer not to terminate worker for filing claim – preference – jurisdiction over dispute.

(1) An employer may not use as grounds for terminating a worker the filing of a claim under this chapter. The district court has exclusive jurisdiction over disputes concerning the grounds for termination under this section.

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

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

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

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

39-71-318. Repealed.

Sec. 12, Ch. 103, L. 2005.

History: En. Sec. 1, Ch. 558, L. 1991; amd. Sec. 5, Ch. 516, L. 1995; amd. Sec. 7, Ch. 276, L. 1997.

39-71-319. State to reimburse certain premium costs for learning programs – rulemaking.

(1) (a)Subject to subsection (1)(b), the department of labor and industry shall reimburse a private employer who has hired a student enrolled in a high-quality work-based learning opportunity for the added costs of the employer's workers' compensation premium because of employing that student.

(b)the reimbursement is subject to available funds and an affirmation by the employer or another indication that the employer adheres to safe working conditions and that the first 2 hours, at a minimum, of the student's employment were devoted to safety instruction through a safety training program that is specific to the student's employment. The department may use funds in the workers' compensation administration fund provided for in 39-71-201 to reimburse the premiums under subsection (1)(a).

(2) The rules must provide the parameters of the program, the application process, and other components necessary to determine premium payments. The rules must describe the attributes of qualified high-quality work-based learning opportunities and provide for a declaration made under penalty of perjury by the employer of the student that the requested reimbursement is only for the increased premium costs due to the student employment.

(3) This section does not apply to a private secondary or postsecondary institution that employs students in work-study programs.

(4) For the purposes of this section, a high-quality work-based learning opportunity:

(a)is a term-limited educational program registered with the department; and

(b)uses on-the-job training to develop marketable skills.

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

History: En. Sec. 1, Ch. 400, L. 2019.

39-71-320. Certification program for claims examiners – purpose – rulemaking – advisory committee – continuing education – fee.

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

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

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

(b)requiring continuing education for certified claims examiners;

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

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

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

(a)minimum qualifications;

(b)examination;

(c)2-year certification and renewal;

(d)continuing education requirements;

(e)a process by which a claims examiner who is newly hired or is in training may perform specified claims functions prior to becoming certified under this section; and

(f) a grace period of 12 months in which to take the examination for all noncertified individuals who were working as a claims examiner as of January 1, 2019.

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

(5) The department shall maintain:

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

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

(i) documentation of current and historical certifications;

(ii) beginning and ending dates of certifications; and

(iii) continuing education records.

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

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

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

(a) initial certification, including examination;

(b) certification renewal;

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

(d) specialized training offered by the department.

History: En. Sec. 2, Ch. 125, L. 2009; amd. Sec. 6, Ch. 167, L. 2011; amd. Sec. 1, Ch. 371, L. 2019.

39-71-321 through 39-71-324 reserved.

39-71-325. Claim summary and actuarial documentation for impaired insurer.

(1) An insurer becomes impaired if the insurer:

(a) becomes insolvent;

(b) is placed in receivership or administration;

(c) declares bankruptcy; or

(d) seeks protection from its creditors.

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

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

Part 4
Coverage, Liability, and Subrogation

Part Cross-References
Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119

39-71-401. Employments covered and exemptions – elections – notice.

(1) Except as provided in subsection (2), the Workers' Compensation Act applies to all employers and to all employees. An employer who has any employee in service under any appointment or contract of hire, expressed or implied, oral or written, shall elect to be bound by the provisions of compensation plan No. 1, 2, or 3 unless the provisions of 39-71-442 apply. Each employee whose employer is bound by the Workers' Compensation Act is subject to and bound by the compensation plan that has been elected by the employer.

(2) Unless the employer elects coverage for these employments under this chapter and an insurer allows an election, the Workers' Compensation Act does not apply to any of the following:
(a) household or domestic employment;
(b) casual employment;
(c) employment of a dependent member of an employer's family for whom an exemption may be claimed by the employer under the federal Internal Revenue Code;
(d) employment of sole proprietors, working members of a partnership, working members of a limited liability partnership, or working members of a member-managed limited liability company, except as provided in subsection (3);
(e) employment of a real estate, securities, or insurance salesperson paid solely by commission and without a guarantee of minimum earnings;
(f) employment as a direct seller as defined by 26 U.S.C. 3508;
(g) employment for which a rule of liability for injury, occupational disease, or death is provided under the laws of the United States;
(h) employment of a person performing services in return for aid or sustenance only, except employment of a volunteer under 67-2-105;
(i) employment with a railroad engaged in interstate commerce, except that railroad construction work is included in and subject to the provisions of this chapter;
(j) employment as an official, including a timer, referee, umpire, or judge, at an amateur athletic event;
(k) employment of a person performing services as a newspaper carrier or freelance correspondent if the person performing the services or a parent or guardian of the person performing the services in the case of a minor has acknowledged in writing that the person performing the services and the services are not covered. As used in this subsection (2)(k):

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

(ii) "newspaper carrier":

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) the officer or manager either:

(A) owns 10% or more of the number of shares of stock in the corporation or owns 10% or more of the limited liability company; or

(B) owns less than 10% of the number of shares of stock in the corporation or limited liability company if the officer's or manager's shares when aggregated with the shares owned by a person or persons listed in subsection (2)(r)(iv) total 10% or more of the number of shares in the corporation or limited liability company; or

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

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

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

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

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

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

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

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

(z) a musician performing under a written contract.

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

(ii) application fees or renewal fees for independent contractor exemption certificates must be deposited in the state special revenue account established in 39-71-417 and must be used to offset the certification administration costs.

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

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

(i) a sole proprietor;

(ii) a working member of a partnership;

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

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

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

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

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

(ii) if the employer has elected to be bound by the provisions of compensation plan No. 2 or 3, by delivering the notice to the board of directors of the corporation or to the management organization of the manager-managed limited liability company and to the insurer.

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

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

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

History: (1), (2)(a) thru (f)En. 92-202.1 by Sec. 1, Ch. 492, L. 1973; amd. Sec. 1, Ch. 550, L. 1977; Sec. 92-202.1, R.C.M. 1947; (2)(g)En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2931, R.C.M. 1921; re-en. Sec. 2931, R.C.M. 1935; Sec. 92-805, R.C.M. 1947; R.C.M. 1947, 92-202.1, 92-805; amd. Sec. 58, Ch. 397, L. 1979; amd. Sec. 1, Ch. 470, L. 1983; amd. Sec. 1, Ch. 94, L. 1985; amd. Sec. 1, Ch. 100, L. 1985; amd. Sec. 3, Ch. 336, L. 1985; amd. Sec. 1, Ch. 148, L. 1987; amd. Sec. 1, Ch. 290, L. 1987; amd. Sec. 6, Ch. 314, L. 1987; amd. Sec. 10, Ch. 464, L. 1987; amd. Sec. 2, Ch. 526, L. 1987; amd. Sec. 1, Ch. 33, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 39, Ch. 16, L. 1991; amd. Sec. 2, Ch. 573, L. 1991; amd. Sec. 4, Ch. 555, L. 1993; amd. Sec. 3, Ch. 48, L. 1995; amd. Sec. 2, Ch. 95, L. 1995; amd. Sec. 1, Ch. 112, L. 1995; amd. Sec. 1, Ch. 142, L. 1995; amd. Sec. 6, Ch. 516, L. 1995; amd. Sec. 4, Ch. 172, L. 1997; amd. Sec. 4, Ch. 310, L. 1997; amd. Sec. 1, Ch. 386, L. 1997; amd. Sec. 30, Ch. 491, L. 1997; amd. Sec. 12, Ch. 548, L. 1997; amd. Sec. 14, Ch. 442, L. 1999; amd. Sec. 1, Ch. 14, L. 2001; amd. Sec. 1, Ch. 43, L. 2001; amd. Sec. 2, Ch. 339, L. 2001; amd. Sec. 3, Ch. 83, L. 2003; amd. Sec. 1, Ch. 193, L. 2003; amd. Sec. 7, Ch. 26, L. 2005; amd. Sec. 4, Ch. 133, L. 2005; amd. Sec. 9, Ch. 448, L. 2005; amd. Sec. 1, Ch. 179, L. 2007; amd. Sec. 1, Ch. 288, L. 2007; amd. Sec. 1, Ch. 234, L. 2009; amd. Sec. 1, Ch. 450, L. 2009; amd. Sec. 1, Ch. 200, L. 2011; amd. Sec. 5, Ch. 412, L. 2013; amd. Sec. 2, Ch. 315, L. 2015 ; amd. Sec. 1, Ch. 293, L. 2023; amd. Sec. 18, Ch. 644, L. 2025.

Cross-References

Regulation of real estate brokers and salespersons, Title 37, ch. 51.
Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.
Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-402. Extraterritorial applicability and reciprocity of coverage – agreements with other states – rulemaking.

(1) (a)In the absence of an agreement under subsection (2), if a worker employed in this state who is subject to the provisions of this chapter temporarily leaves this state incidental to that employment and receives an injury arising out of and in the course of employment, the provisions of this chapter apply to the worker as though the worker were injured within this state.

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

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

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

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

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

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

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

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

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

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

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

(f) after an agreement has been entered into pursuant to this subsection (2) a certificate from an authorized officer of the workers' compensation department or similar agency of another state certifying that an employer of the other state is bound by the Workers' Compensation Act of the state and that its act will be applied to employees of the employer while engaged in work in the state of Montana is prima facie evidence that:

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

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

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

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

Cross-References

Governor – sole official organ of communication, 2-15-201.

39-71-403. Plan three exclusive for state agencies – election of plan by public corporations – financing of self-insurance fund – exemption for university system – definitions – rulemaking.

(1) (a) Except as provided in subsection (5), if a state agency is the employer, the terms, conditions, and provisions of compensation plan No. 3, state fund, are exclusive, compulsory, and obligatory upon both employer and employee. Any sums necessary to be paid under the provisions of this chapter by a state agency are considered to be ordinary and necessary expenses of the agency. The agency shall pay the sums into the state fund at the time and in the manner provided for in this chapter, notwithstanding that the state agency may have failed to anticipate the ordinary and necessary expense in a budget, estimate of expenses, appropriations, ordinances, or otherwise.

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

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

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

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

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

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

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

(ii) the bonds and notes:

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

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

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

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

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

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

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

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

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

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

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

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

(B) the judicial branch; and

(C) the legislative branch.

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

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

Cross-References

Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.
Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-404. Repealed.

Sec. 16, Ch. 103, L. 1979.

History: En. Sec. 3, Ch. 96, L. 1915; amd. Sec. 1, Ch. 100, L. 1919; amd. Sec. 1, Ch. 196, L. 1921; re-en. Sec. 2840, R.C.M. 1921; re-en. Sec. 2840, R.C.M. 1935; amd. Sec. 1, Ch. 410, L. 1971; amd. Sec. 6, Ch. 23, L. 1975; R.C.M. 1947, 92-206(part).

39-71-405. Liability of employer who contracts work out.

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

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

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

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

Cross-References

Independent contractor certification, 39-71-417.

39-71-406. Deduction from wages of any part of premium a misdemeanor.

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

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

Cross-References

Penalty for misdemeanor, 46-18-212.

39-71-407. *(Temporary)* **Liability of insurers – limitations.**

(Temporary) Liability of insurers – limitations.

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

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

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

(b) engaged in an unpaid social or recreational activity, regardless of whether the employer pays for any portion of the activity or whether the activity occurs at the worksite of the employer. The exclusion from coverage of this subsection (2)(b) does not apply to an employee who, at the time of injury, is on paid time while participating in a social or recreational activity and whose presence at the activity is required or requested by the employer. For the purposes of this subsection (2)(b):

(i) "requested" means the employer asked the employee to assume duties for the activity so that the employee's presence is not completely voluntary and optional and the injury occurred in the performance of those duties; and

(ii) "social or recreational activity" means an activity that is generally undertaken by individuals for exercise, relaxation, pleasure, or voluntary or optional preparation related to the employment.

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

(i) a claimed injury has occurred; or

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

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

(c) objective medical findings are sufficient for a presumptive occupational disease as defined in 39-71-1401 but may be overcome by a preponderance of the evidence.

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

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

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

(b) a payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular job site is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(c) as provided in this subsection (4), whether the employer furnishes the transportation or the employee receives reimbursement for costs of travel, gas, oil, or lodging is not dispositive of whether the employee is covered by this chapter.

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

(b)for the purposes of this subsection (5), if an employee fails or refuses to take a drug test after the accident and if the testing procedures comply with federal drug testing statutes and administrative regulations applicable to private sector employers and employees as provided in Title 39, chapter 2, there is a presumption that the major contributing cause of the accident was the employee's use of drugs not prescribed by a physician.

(6) (a)An employee who has received written certification, as defined in 16-12-502, from a physician for the use of marijuana for a debilitating medical condition and who is otherwise eligible for benefits payable under this chapter is subject to the limitations of subsections (6)(b) through (6)(d).

(b)an employee is not eligible for benefits otherwise payable under this chapter if the employee's use of marijuana for a debilitating medical condition, as defined in 16-12-102, is the major contributing cause of the injury or occupational disease.

(c)nothing in this chapter may be construed to require an insurer to reimburse any person for costs associated with the use of marijuana for a debilitating medical condition, as defined in 16-12-102.

(d)in an accepted liability claim, the benefits payable under this chapter may not be increased or enhanced due to a worker's use of marijuana for a debilitating medical condition, as defined in 16-12-102. An insurer remains liable for those benefits that the worker would qualify for absent the worker's use of marijuana for a debilitating medical condition.

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

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

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

(10) Except for cases of presumptive occupational disease as provided in 39-71-1401 and 39-71-1402, an employee is not eligible for benefits payable under this chapter unless the entitlement to benefits is established by objective medical findings that contain sufficient factual and historical information concerning the relationship of the worker's condition to the original injury.

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

(b)the provisions of subsection (11)(a) apply to presumptive occupational disease if the employee is diagnosed and meets the conditions of 39-71-1401 and 39-71-1402.

(12) An insurer is liable for an occupational disease only if the occupational disease:
(a) is established by objective medical findings; and
(b) arises out of or is contracted in the course and scope of employment. An occupational disease is considered to arise out of or be contracted in the course and scope of employment if the events occurring on more than a single day or work shift are the major contributing cause of the occupational disease in relation to other factors contributing to the occupational disease. For the purposes of this subsection (12), an occupational disease is not the same as a presumptive occupational disease.

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

(14) When there is more than one insurer and only one employer at the time that the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:
(a) the time that the occupational disease or presumptive occupational disease was first diagnosed by a health care provider; or
(b) the time that the employee knew or should have known that the condition was the result of an occupational disease or a presumptive occupational disease.

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

(16) As used in this section, "major contributing cause" means a cause that is the leading cause contributing to the result when compared to all other contributing causes. (Void on occurrence of contingency–sec. 7, Ch. 158, L. 2019.)

39-71-407. (Effective on occurrence of contingency) Liability of insurers – limitations.

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

(2) An injury does not arise out of and in the course of employment when the employee is:
(a) on a paid or unpaid break, is not at a worksite of the employer, and is not performing any specific tasks for the employer during the break; or
(b) engaged in an unpaid social or recreational activity, regardless of whether the employer pays for any portion of the activity or whether the activity occurs at the worksite of the employer. The exclusion from coverage of this subsection (2)(b) does not apply to an employee who, at the time of injury, is on paid time while participating in a social or recreational activity and whose presence at the activity is required or requested by the employer. For the purposes of this subsection (2)(b):

(i) "requested" means the employer asked the employee to assume duties for the activity so that the employee's presence is not completely voluntary and optional and the injury occurred in the performance of those duties; and

(ii) "social or recreational activity" means an activity that is generally undertaken by individuals for exercise, relaxation, pleasure, or voluntary or optional preparation related to the employment.

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

(i) a claimed injury has occurred; or

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

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

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

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

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

(b) a payment made to an employee under a collective bargaining agreement, personnel policy manual, or employee handbook or any other document provided to the employee that is not wages but is designated as an incentive to work at a particular job site is not a reimbursement for the costs of travel, gas, oil, or lodging, and the employee is not covered under this chapter while traveling.

(c) as provided in this subsection (4), whether the employer furnishes the transportation or the employee receives reimbursement for costs of travel, gas, oil, or lodging is not dispositive of whether the employee is covered by this chapter.

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

(b) for the purposes of this subsection (5), if an employee fails or refuses to take a drug test after the accident and if the testing procedures comply with federal drug testing statutes and administrative regulations applicable to private sector employers and employees as provided in Title 39, chapter 2, there is a presumption that the major contributing cause of the accident was the employee's use of drugs not prescribed by a physician.

(6) (a) An employee who has received written certification, as defined in 16-12-502, from a physician for the use of marijuana for a debilitating medical condition and who is otherwise eligible for benefits payable under this chapter is subject to the limitations of subsections (6)(b) through (6)(d).

(b) an employee is not eligible for benefits otherwise payable under this chapter if the employee's use of marijuana for a debilitating medical condition, as defined in 16-12-102, is the major contributing cause of the injury or occupational disease.

(c) nothing in this chapter may be construed to require an insurer to reimburse any person for costs associated with the use of marijuana for a debilitating medical condition, as defined in 16-12-102.

(d) in an accepted liability claim, the benefits payable under this chapter may not be increased or enhanced due to a worker's use of marijuana for a debilitating medical condition, as defined in 16-12-102. An insurer remains liable for those benefits that the worker would qualify for absent the worker's use of marijuana for a debilitating medical condition.

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

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

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

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

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

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

(a) is established by objective medical findings; and

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

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

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

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

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

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

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

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2911, R.C.M. 1921; re-en. Sec. 2911, R.C.M. 1935; amd. Sec. 1, Ch. 70, L. 1967; amd. Sec. 17, Ch. 23, L. 1975; amd. Sec. 8, Ch. 550, L. 1977; R.C.M. 1947, 92-614(1); amd. Sec. 11, Ch. 464, L. 1987; amd. Sec. 1, Ch. 184, L. 1989; amd. Sec. 26, Ch. 619, L. 1993; amd. Sec. 8, Ch. 243, L. 1995; amd. Sec. 1, Ch. 435, L. 2003; amd. Sec. 6, Ch. 103, L. 2005; amd. Sec. 20, Ch. 416, L. 2005; amd. Sec. 8, Ch. 167, L. 2011; amd. Sec. 4, Ch. 315, L. 2011; amd. Sec. 5, Ch. 158, L. 2019; amd. Sec. 2, Ch. 555, L. 2021; amd. Sec. 67, Ch. 576, L. 2021; amd. Sec. 1, Ch. 84, L. 2023; amd. Sec. 1, Ch. 266, L. 2025.

39-71-408. Liability as first lien in case of bankruptcy or failure.

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

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

Cross-References

Liens generally, Title 71, ch. 3, part 1.

39-71-409. Waivers by employee invalid.

(1) An agreement by an employee to waive any rights under this chapter is not valid.

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

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

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

39-71-410. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 3, Ch. 96, L. 1915; re-en. Sec. 2842, R.C.M. 1921; re-en. Sec. 2842, R.C.M. 1935; amd. Sec. 1, Ch. 95, L. 1963; amd. Sec. 1, Ch. 145, L. 1971; amd. Sec. 1, Ch. 95, L. 1974; R.C.M. 1947, 92-208; amd. Sec. 60, Ch. 197, L. 1979.

39-71-411. Provisions of chapter exclusive remedy – nonliability of insured employer.

For all employments covered under the Workers' Compensation Act or for which an election has been made for coverage under this chapter, the provisions of this chapter are exclusive. Except as provided in part 5 of this chapter for uninsured employers and except as otherwise provided in the Workers' Compensation Act, an employer is not subject to any liability whatever for the death of or personal injury to an employee covered by the Workers' Compensation Act or for any claims for contribution or indemnity asserted by a third person from whom damages are sought on account of the injuries

or death. The Workers' Compensation Act binds the employee and, in case of death, binds the employee's personal representative and all persons having any right or claim to compensation for the employee's injury or death, as well as the employer and the servants and employees of the employer and those conducting the employer's business during liquidation, bankruptcy, or insolvency.

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

Cross-References

Liability of railroad or mining company to employee injured by coemployee, 39-2-703, 39-2-704.

39-71-412. Liability of third party other than employer or fellow employee -- additional cause of action.

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

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

39-71-413. Liability of employer or fellow employee for intentional and deliberate acts – additional cause of action – intentional injury defined.

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

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

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

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

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

Cross-References

Liability of railroad or mining company to employee injured by coemployee, 39-2-703, 39-2-704.

39-71-414. Subrogation.

(1) If an action is prosecuted as provided for in 39-71-412 or 39-71-413 and except as otherwise provided in this section, the insurer is entitled to subrogation for all compensation and benefits paid or to be paid under the Workers' Compensation Act. The insurer's right of subrogation is a first lien on the claim, judgment, or recovery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39-71-416. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. Sec. 2, Ch. 243, L. 1995.

39-71-417. Independent contractor certification.

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

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

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

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

(i) a sole proprietor;

(ii) a working member of a partnership;

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

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

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

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

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

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

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

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

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

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

(i) the applicant's name and address;

(ii) the applicant's social security number;

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

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

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

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

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

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

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

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

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

(c) for the purposes of the Workers' Compensation Act, a person is working under an independent contractor exemption certificate if:
(i) the person is performing work in the trade, business, occupation, or profession listed on the person's independent contractor exemption certificate; and
(ii) the hiring agent and the person holding the independent contractor exemption certificate do not have a written or an oral agreement that the independent contractor exemption certificate holder's status with respect to that hiring agent is that of an employee.
(d) a person without an independent contractor exemption certificate is rebuttably presumed to be an independent contractor when:
(i) the person represents to a hiring entity or individual in writing that the person has an independent contractor exemption certificate;
(ii) the person provides the hiring entity or individual a forged or otherwise fraudulent independent contractor exemption certificate; or
(iii) the person's independent contractor exemption certificate expires while the person is working under the contract and prior to full performance of the contract, for a period not to exceed 120 days following the expiration of the certificate.
(e) the department shall utilize the considerations set forth in subsections (4)(a)(i) and (4)(a)(ii) for any evaluation conducted under subsection (7)(d).

(8) Once issued, an independent contractor exemption certificate remains in effect for 2 years unless:
(a) suspended or revoked pursuant to 39-71-418; or
(b) canceled by the independent contractor.

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

History: En. Sec. 1, Ch. 448, L. 2005; amd. Sec. 4, Ch. 117, L. 2007; amd. Sec. 2, Ch. 340, L. 2007; amd. Sec. 1, Ch. 120, L. 2009; amd. Sec. 2, Ch. 200, L. 2011 ; amd. Sec. 1, Ch. 224, L. 2023.

39-71-418. Suspension or Revocation of Independent Contractor Exemption Certificate.

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

(2) The department may revoke an independent contractor exemption certificate after determining that the certificate holder:
(a) made misrepresentations in the application affidavit or certificate renewal form;
(b) altered or amended the application form, the renewal application form, other supporting documentation required by the department, or the independent contractor exemption certificate;
(c) failed to cooperate with the department in providing information relevant to the continued validity of the holder's certificate; or
(d) does not have an independently established business as required by 39-71-417(4).

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

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

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

39-71-419. Independent contractor violations – penalty.

(1) A person may not:
(a) perform work as an independent contractor without first:
(i) obtaining from the department an independent contractor exemption certificate unless the individual is not required to obtain an independent contractor exemption certificate pursuant to 39-71-417(1)(a); or
(ii) electing to be bound personally and individually by the provisions of compensation plan No. 1, 2, or 3;
(b) perform work as an independent contractor when the department has suspended, revoked, or denied the independent contractor's exemption certificate;
(c) transfer to another person or allow another person to use an independent contractor exemption certificate that was not issued to that person;
(d) alter or falsify an independent contractor exemption certificate; or
(e) misrepresent the person's status as an independent contractor. A person who falsely claimed, either in writing or through credible evidence, to have an independent contractor certification may not be considered to be an employee solely based on not actually having an independent contractor exemption certificate. The burden of proof that an independent contractor is certified rests with the independent contractor and not the hiring entity.

(2) An employer may not:
(a) require an employee through coercion, misrepresentation, or fraudulent means to adopt independent contractor status to avoid the employer's obligations to provide workers' compensation coverage; or
(b) exert control to a degree that causes the independent contractor to violate the provisions of 39-71-417(4).

(3) (a) In addition to any other penalty or sanction provided in this chapter, a person or employer who violates a provision of this section is subject to a fine to be assessed by the department of up to $5,000 for each violation as follows:
(i) up to $1,000 for the first violation, of which up to $1,000 may be waived if the person or employer completes a department-directed education program;
(ii) up to $2,500 for the second violation;
(iii) up to $5,000 for the third violation;
(iv) $5,000 for the fourth and each subsequent violation. In addition to the fine, the department shall suspend or revoke the person's independent contractor exemption certificate and report the person to the workers' compensation fraud investigation and prosecution office provided for in 2-15-2015.
(b) the department shall deposit the fines in the uninsured employers' fund. The lien provisions of 39-71-506 apply to any assessed fines.

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

History: En. Sec. 3, Ch. 448, L. 2005; amd. Sec. 2, Ch. 345, L. 2021 ; amd. Sec. 2, Ch. 505, L. 2023.

39-71-420 reserved.

39-71-421. Financial incentives to institute safety programs.

Insurers may provide financial incentives to an employer who implements a formal safety program. An insurer may provide to an employer a premium discount that reflects the degree of risk diminished by the implemented safety program.

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

39-71-422 through 39-71-425 reserved.

39-71-426. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. Sec. 1, Ch. 388, L. 1989; amd. Sec. 5, Ch. 480, L. 1991.

39-71-427. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. Sec. 2, Ch. 388, L. 1989.

39-71-428. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. Sec. 3, Ch. 388, L. 1989.

39-71-429 and 39-71-430 reserved.

39-71-431. Repealed.

Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 12, Ch. 613, L. 1989; amd. Sec. 5, Ch. 323, L. 1991.

39-71-432. Definitions.

As used in 39-71-433, the following definitions apply:

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

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

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

39-71-433. Group purchase of workers' compensation insurance.

(1) Two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.
(2) A group formed under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state, except that the state fund, as defined in 39-71-2312, has the right to refuse coverage of a group and its plan of operation but may not refuse coverage to an individual employer. Under an individual policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.
(3) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.
(4) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, the eligibility requirements to join the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management.

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

39-71-434. Deductible insurance policy provision for medical benefits.

(1) In order to lower the amount an employer is required to pay to obtain workers' compensation insurance coverage under this chapter, a workers' compensation policy issued by the state compensation insurance fund under plan No. 3 or by a private insurer under plan No. 2 must offer a deductible for the medical, hospital, and related services allowed under 39-71-704. The medical deductible must be offered in amounts of at least $500.
(2) If the insured employer chooses to accept a medical deductible, the insured employer is liable for the amount of the deductible for the medical benefits paid for each otherwise compensable claim of work injury suffered by an employee.
(3) The insured employer shall contract with the insurer to have the insurer pay the entire cost of the covered medical benefits directly to the provider of medical or related services and then seek reimbursement from the insured employer for the deductible amount. The insurer is entitled to reimbursement only for medical, hospital, and related services allowed under 39-71-704, up to the amount of the deductible.
(4) If an insured employer who has contracted with an insurer for a medical deductible does not pay the medical deductible amount to the insurer through reimbursement, the amount paid by the insurer on the claim may be included as benefits paid in a determination of the insured employer's rate.
(5) If an insured employer chooses to accept a medical deductible, then for purposes of computing rates and rating plans, all medical losses incurred must be reported to the insurer without regard to the application of any medical deductible regardless of whether the employer or the insurer pays the losses.

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

39-71-435. Workers' compensation and employers' liability insurance – optional deductibles.

(1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).
(2) The advisory organization designated under 33-16-1023 may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).
(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:
   (a) claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.
   (b) premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.
   (c) premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.
   (d) recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.
   (e) the policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.
   (f) the insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.
   (g) failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.
   (h) losses subject to the deductiblemust be reported and recorded as losses for purposes of calculating rates for a policyholder on the same basis as losses under policies providing first dollar coverage.
(4) The state compensation insurance fund, plan No. 3, may adopt the plan filed by the designated advisory organization or adopt an optional deductible plan that meets the requirements of this section.
(5) For purposes of 39-71-201, 39-71-915, and 50-71-128, liability for assessments must be ascertained without regard to application of any deductible,whether the employer or the insurer pays the losses. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible.

History: En. Sec. 8,Ch. 619, L. 1993; amd. Sec. 24, Ch. 186, L. 1995; amd. Sec. 9, Ch. 214, L. 2001; amd. Sec. 2, Ch. 365, L. 2015.

39-71-436 through 39-71-440 reserved.

39-71-441. Tribal employment coverage.

The department may, as provided in Title 18, chapter 11, enter into an agreement with a tribal government to recognize, with the same effect as the exclusive remedy and benefits under plans No. 1, 2, and 3, tribal workers' compensation plans or self-insured plans that the department determines provide adequate coverage to persons who are:
(1) Employed by an enrolled tribal member or by an association, business, corporation, or other entity at least 51% of which is owned by one or more enrolled tribal members; and

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

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

39-71-442. Employer option for extraterritorial coverage.

(1) Notwithstanding 39-71-118(8)(a), an employee of an employer in this state who is employed by the employer to work solely in North Dakota, and who is required by the laws of that state to be covered for workers' compensation purposes while working in that state, is not considered to be an employee in this state covered under Title 39, chapter 71, during any time that the employer maintains workers' compensation coverage for the employee in North Dakota. For purposes of this section, "work solely in North Dakota" means the employee does not perform job duties in Montana and coverage is required by the state of North Dakota. Travel that is commuting to and from a job site in North Dakota from a location in Montana does not constitute performing job duties in Montana even if the employer pays for all or a portion of the costs of travel or if the worker is paid for the travel time.

(2) A plan No. 1, 2, or 3 insurer providing coverage to the employer under this chapter may require proof of coverage in North Dakota and records of work in North Dakota. An insurer may use a verification of employment form, developed by the department, to request an attestation by the employer regarding the employees working solely in North Dakota.

(3) (a)this section does not exempt an employee from coverage under this chapter when the employee's usual job duties begin in this state and the employee is otherwise covered under 39-71-407(4)(a).

(b)this section exempts an employee from coverage under this chapter when the employee is engaged in travel while commuting as provided in subsection (1).

History: En. Sec. 1, Ch. 315, L. 2015.

Part 5
Uninsured Employers

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-501. Definition of uninsured employer.

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

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

39-71-502. Repealed.

Sec. 22, Ch. 377, L. 1999.

History: En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(part); amd. Sec. 13, Ch. 464, L. 1987; amd. Sec. 9, Ch. 276, L. 1997.

39-71-503. Uninsured employers' fund – purpose and administration of fund – maintaining balance for administrative costs – appropriation.

(1) There is created an uninsured employers' fund in the state special revenue account to pay:
   (a) to an injured employee of an uninsured employer the same benefits the employee would have received if the employer had been properly enrolled under compensation plan No. 1, 2, or 3, except as provided in subsection (3);
   (b) the costs of investigating and prosecuting workers' compensation fraud under 2-15-2015; and
   (c) the expenses incurred by the department in administering the uninsured employers' fund.

(2) The department may refer to the workers' compensation fraud office, established in 2-15-2015, cases involving:
   (a) false or fraudulent claims for benefits; and
   (b) criminal violations of 45-7-501.

(3) (a) Except as provided in subsection (3)(b), surpluses and reserves may not be kept for the fund. The department shall make payments that it considers appropriate as funds become available from time to time. The payment of weekly disability benefits takes precedence over the payment of medical benefits. Lump-sum payments of future projected benefits, including impairment awards, may not be made from the fund. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.
   (b) the department shall maintain at least a 3-month balance based on projected budget costs for administration of the fund. The balance for administrative costs may be used by the department only in administering the fund.
   (c) the maximum aggregate medical benefits expenditure that may be made from the fund may not exceed $100,000 for any single claim regardless of whether the claim arises from an injury or an occupational disease.

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

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

Cross-References

Investments, Title 17, ch. 6, part 2.

39-71-504. Funding of fund – option for agreement between department and injured employee.

The fund is funded in the following manner:

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

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

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

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

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

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

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

39-71-505. Applicability of other provisions of chapter to fund.

All appropriate provisions in the Workers' Compensation Act apply to the fund in the same manner as they apply to compensation plans No. 1, 2, and 3.

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

Cross-References

Compensation plan No. 1, Title 39, ch. 71, part 21.
Compensation plan No. 2, Title 39, ch. 71, part 22.
Compensation plan No. 3, Title 39, ch. 71, part 23.

39-71-506. Lien for payment of unpaid penalties, fees, and interest – levy and execution.

(1) (a) If, upon demand of the department, an uninsured employer refuses to make the payments to the fund that are provided for in 39-71-504(1)(a), (1)(c), and (2), the unpaid penalties, fees, and interest have the effect of a judgment against the employer at the time the payments become due. After issuing an order to the uninsured employer requiring payment of penalties, fees, and interest and after the due process requirements of 39-71-2401(2) and (3) are satisfied, the department may issue a certificate setting forth the amount of payment due and direct the clerk of the district court of any county in the state to enter the certificate as a judgment on the docket pursuant to 25-9-301. From the time the judgment is entered on the docket, it becomes a lien upon all real property of the uninsured employer. The department may enforce the judgment at any time within 10 years of creation of the lien.

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

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

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

39-71-507. Department to order uninsured employer to cease operations – noncompliance with order a misdemeanor – coordination of remedies.

(1) When the department discovers an uninsured employer, it shall order the employer to cease operations until the employer has elected to be bound by a compensation plan.
(2) When the department discovers a person, business, or other entity functioning as a prime contractor that has subcontracted for the services of an uninsured employer, it shall order the person, business, or other entity functioning as a prime contractor to cause all operations performed by the uninsured employer to cease at worksites controlled by the prime contractor until the uninsured employer has elected to be bound by a compensation plan. If after 3 business days following the order by the department the person, business, or other entity functioning as a prime contractor has not complied with the order, the department may order the prime contractor to cease all operations at the affected worksites.
(3) An employer who does not comply with the department's order to cease operations is guilty of a misdemeanor. Each day of violation is a separate offense. The county attorney may prosecute a criminal action under this subsection in the county in which the violation occurs. Prosecution under this subsection does not bar the department from enforcing its order by a civil action.
(4) A person, business, or other entity functioning as a prime contractor that does not comply with the department's order to cease all operations is guilty of a misdemeanor. Each day of violation is a separate offense. The county attorney may prosecute a criminal action under this subsection in the county in which the violation occurs. Prosecution under this subsection does not bar the department from enforcing its order by a civil action. In addition, the department may assess a penalty against the person, business, or other entity functioning as a prime contractor of not more than $1,000 per day for each day of violation.
(5) The department may institute and maintain in the name of the state, through the attorney general or the county attorney of the county in which the violation occurs, an action for an injunction order or other civil remedy in district court to enforce its order to cease operations.
(6) The remedies provided in 39-71-506 and subsections (3) through (5) of this section are not mutually exclusive and may be pursued concurrently

History: En. 92-212 by Sec. 4, Ch. 550, L. 1977; R.C.M. 1947, 92-212(6); amd. Sec. 1, Ch. 586, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 11, Ch. 516, L. 1995 ; amd. Sec. 3, Ch. 505, L. 2023.

Cross-References

Misdemeanor defined, 45-2-101.
Penalty when no penalty specified, 46-18-212.

39-71-508. Coordination of remedies – limitation of liability of employee to third-party providers – rights of third-party providers.

(1) An employee who suffers an injury arising out of and in the course of employment while working for an uninsured employer, as defined in 39-71-501, or an employee's beneficiaries in injuries resulting in death may pursue all remedies concurrently, including but not limited to:
(a) a claim for benefits from the uninsured employers' fund;
(b) a damage action against the employer in accordance with 39-71-509;
(c) an independent action against an employer as provided in 39-71-515; or
(d) any other civil remedy provided by law.
(2) An employee who is entitled to recover under this part is not liable to any third-party provider for services provided to the employee that are not reimbursed by the uninsured employers' fund.

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

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

39-71-509. Action against uninsured employer -limitation of employer's defenses.

If an injured employee or the employee's beneficiaries bring an action to recover damages for personal injuries sustained or for death resulting from personal injuries sustained, it is not a defense for the employer that the:

(1) Employee was negligent unless the negligence was willful;
(2) Injury was caused by the negligence of a fellow employee; or
(3) Employee had assumed the risks inherent in, incident to, or arising out of the employee's employment or arising from the failure of the employer to provide and maintain a reasonably safe place to work or reasonably safe tools or appliances.

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

39-71-510. Limitation on benefit entitlement under fund.

(1) Notwithstanding the provisions of 39-71-407, 39-71-503, and subsection (2) of this section, injured employees or an employee's beneficiaries who pursue a claim for benefits from the uninsured employers' fund are not granted an entitlement by this state for full workers' compensation benefits from the fund. Benefits from the fund must be paid in accordance with the money in the fund. If the department determines at any time that the money in the fund is not adequate to fully pay all claims, the department may make appropriate proportionate reductions in benefits to all claimants. The reductions do not entitle claimants to retroactive reimbursements in the future.
(2) The maximum medical benefits entitlement for any single claim against the fund is limited to an aggregate amount of $100,000.

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

39-71-511. Setoffs to claim against fund.

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

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

39-71-512 through 39-71-514 reserved.

39-71-515. Independent cause of action.

(1) An injured employee or the employee's beneficiaries have an independent cause of action against an uninsured employer for failure to be enrolled in a compensation plan as required by this chapter.
(2) In an action described in subsection (1), prima facie liability of the uninsured employer exists if the claimant proves, by a preponderance of the evidence, that:

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

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

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

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

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

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

Cross-References

Costs and attorney fees, Title 25, ch. 10.

39-71-516. District court venue and jurisdiction for independent cause of action.

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

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

Cross-References

Venue generally, Title 25, ch. 2.
Attachment, Title 27, ch. 18.
Injunctions, Title 27, ch. 19.
Receivership, Title 27, ch. 20.

39-71-517. Requirement to serve papers.

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

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

39-71-518. Setoffs against remaining liability.

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

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

39-71-519. Settlement.

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

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

39-71-520. Time limit to appeal to mediation – petitioning workers' compensation court – failure to settle or petition.

(1) A dispute concerning uninsured employers' fund benefits must be appealed to mediation within 90 days from the date of the determination by the department or the determination is considered final.

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

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

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

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

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

39-71-521. Burden of proof – insurance coverage.

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

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

(b) either:

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

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

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

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

39-71-522. Inspection of construction sites – public policy – penalty.

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

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

(3) Upon presentation of proper credentials, department employees must be admitted to a construction site to:
(a)gather information relating to compliance with the coverage requirements of this chapter; and
(b)when appropriate, issue a notice of violation to a person who is in violation of 39-71-419.

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

(5) A person who purposely or knowingly restricts the access to a construction site by a credentialed department employee or who obstructs the employee in the performance of the employee's duties under this section commits the offense of obstruction of a public servant as provided in 45-7-302.

(6) As used in this section, the following definitions apply:
(a)"Construction permit" means any permit that can be issued pursuant to Title 50, chapter 60, and includes:
(i) a boiler permit;
(ii) a building permit;
(iii)an electrical permit;
(iv)an elevator permit;
(v) a mechanical permit; or
(vi)a plumbing permit.
(b)"Construction site" means any parcel of real property where work is being performed for which a construction permit is required or has been issued.

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

39-71-523 and 39-71-524 reserved.

39-71-525. Confidentiality of records – exception for use by public employees.

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

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

39-71-526 through 39-71-530 reserved.

39-71-531. Repealed.

Sec. 9, Ch. 172, L. 1997; Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 1, Ch. 467, L. 1993.

39-71-532. Repealed.

Sec. 9, Ch. 172, L. 1997; Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 2, Ch. 467, L. 1993; amd. Sec. 46, Ch. 18, L. 1995.

39-71-533. Repealed.

Sec. 9, Ch. 172, L. 1997; Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 3, Ch. 467, L. 1993.

39-71-534. Repealed.

Sec. 9, Ch. 172, L. 1997; Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 4, Ch. 467, L. 1993.

39-71-535. Collection of penalties, claim costs, late fees, and interest – liability for payment of collection costs.

(1) If the department is unable to collect penalties, claim costs, late fees, or interest assessed pursuant to the provisions of this part, the department may assign the debt to a collection service or transfer the debt to the department of revenue pursuant to Title 17, chapter 4, part 1.

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

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

(ii) all money collected by a collection service must be paid to the department, except that the collection service may retain those collection costs or, if the total debt is not collected, that portion of collection costs that are approved by the department.

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

39-71-536 through 39-71-540 reserved.

39-71-541. Uninsured employer as party to benefits disputes – indemnification by uninsured employer for benefits paid – lien for payment – levy and execution.

(1) An uninsured employer or an employer alleged to be uninsured is a party to all disputes concerning any benefits for which the employer may become obligated to indemnify the department pursuant to 39-71-504(1)(b).

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

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

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

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

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

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

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

Part 6
Claims for Benefits

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-601. Statute of limitation on presentment of claim – waiver.

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

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

(a) lack of knowledge of disability;

(b) latent injury; or

(c) equitable estoppel.

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

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

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

39-71-602. Statute of limitation not to apply during minority or mental incompetency unless guardian appointed.

No limitation of time as provided in 39-71-601 or in this chapter, known as the Workers' Compensation Act, shall run as against any injured worker who is mentally incompetent and without a guardian or an injured minor under 18 years of age who may be without a parent or guardian. A guardian in either case may be appointed by any court of competent jurisdiction, in which event the period of limitations as provided for in 39-71-601 shall begin to run on the date of appointment of such guardian or when such minor arrives at 18 years of age, whichever date is earlier.

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

Cross-References

Person under disability – statute of limitations extended, 27-2-401.
Persons under disability – guardianship and conservatorship, Title 72, ch. 5.

39-71-603. Notice of injuries other than death to be submitted within 30 days – exception.

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

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

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

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

39-71-604. Application for compensation – disclosure and communication without prior notice of health care information.

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

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

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

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

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

39-71-605. Examination of employee by physician – effect of refusal to submit to examination – report and testimony of physician – cost.

(1) (a)Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, the employee shall, upon the written request of the insurer, submit from time to time to examination by a physician, psychologist, or panel that must be provided and paid for by the insurer and shall likewise submit to examination from time to time by any physician, psychologist, or panel selected by the department or as ordered by the workers' compensation judge.

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

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

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

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

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

39-71-606. Insurer to accept or deny claim within 30 days of receipt — notice of benefits and entitlements to claimants — notice of denial — notice of reopening — notice to employer — employer's right to loss information.

(1) Each insurer under any plan for the payment of workers' compensation benefits shall, within 30 days of receipt of a claim for compensation signed by the claimant or the claimant's representative, either accept or deny the claim and, if denied, shall inform the claimant and the department in writing of the denial.

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

(b)the department may provide information to claimants regarding nonstatutory programs or benefits offered to injured workers or the families of injured workers by a nonprofit organization. The department may not provide the contact information of an injured worker to such an organization without the express consent of the injured worker.

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

(4) (a)When requested by an employer that an insurer currently insures or has insured in the immediately preceding 5 years or when requested by the employer's designated insurance producer, an insurer shall provide the loss information listed in subsection (4)(b) within 10 days of the request.

(b)loss information provided under this subsection (4) must include for the period requested:

(i) all date of injury or occupational disease data for the employer's claims;

(ii) payment data on the employer's closed claims; and

(iii)payment data and loss reserve amounts on the employer's open claims, including all compensation benefits that are ongoing and are being charged against that employer's account.

(c)the information provided under this subsection (4) is confidential insurance information. The information may be used by the employer for internal management purposes or for procuring insurance products but may not be disclosed for any other purpose without the express written consent of the insurer.

(5) Failure of an insurer to comply with the time limitations required in subsections (1) and (3) does not constitute an acceptance of a claim as a matter of law. However, an insurer who fails to comply with 39-71-608 or subsections (1) and (3) of this section may be assessed a penalty under 39-71-2907 if a claim is determined to be compensable by the workers' compensation court.

History: En. Sec. 1, Ch. 477, L. 1973; amd. Sec. 1, Ch. 173, L. 1974; R.C.M. 1947, 92-615(part); amd. Sec. 1, Ch. 122, L. 1981; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 22, Ch. 619, L. 1993; amd. Sec. 13, Ch. 630, L. 1993; amd. Sec. 11, Ch. 276, L. 1997; amd. Sec. 2, Ch. 267, L. 2015; amd. Sec. 1, Ch. 79, L. 2021.

39-71-607. Suspension of payments by insurer pending receipt of medical information.

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

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

39-71-608. Payments within 30 days by insurer without admission of liability or waiver of defense authorized – notice – limitations on payments over 90 days.

(1) An insurer may, after written notice to the claimant and the department, make payment of compensation benefits within 30 days of receipt of a claim for compensation without the payments being construed as an admission of liability or a waiver of any right of defense.
(2) An insurer may not make payments pursuant to this section for more than 90 days without:
(a)written consent of the claimant; or
(b)approval of the department.

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

39-71-609. Denial of claim after payments made or termination of all benefits or reduction to partial benefits by insurer – 14-day notice required – criteria for conversion of benefits - claimant released to full duty.

(1) Except as provided in subsections (2) and (3), if an insurer determines to deny a claim on which payments have been made under 39-71-608 during a time of further investigation or, after a claim has been accepted, terminates all biweekly compensation benefits, it may do so only after 14 days' written notice to the claimant, the claimant's authorized representative, if any, and the department. For injuries occurring prior to July 1, 1987, an insurer shall give 14 days' written notice to the claimant before reducing benefits from total to partial. However, if an insurer has knowledge that a claimant has returned to work, compensation benefits may be terminated as of the time the claimant returned to work.
(2) Temporary total disability benefits may be terminated on the date that the worker has been released to return to work in some capacity. Unless the claimant is found, at maximum healing, to be without a permanent physical impairment from the injury, the insurer, prior to converting temporary total disability benefits or temporary partial disability benefits to permanent partial disability benefits:
(a)must have a physician's determination that the claimant has reached medical stability;
(b)must have a physician's determination of the claimant's physical restrictions resulting from the industrial injury;
(c)must have a physician's determination, based on the physician's knowledge of the claimant's job analysis prepared by a rehabilitation provider, that the claimant can return to work, with or without restrictions, on the job on which the claimant was injured or on another job for which the claimant is suited by age, education, work experience, and physical condition;
(d)shall give notice to the claimant of the insurer's receipt of the report of the physician's determinations required pursuant to subsections (2)(a) through (2)(c). The notice must be attached to a copy of the report.
(3) Notwithstanding subsections (1) and (2), when a claimant is released to full duty prior to or on reaching maximum medical improvement, temporary total disability benefits may be terminated as of the time the claimant returned to work or after 14 days' written notice, whichever is earlier.

History: En. Sec. 1, Ch. 477, L. 1973; amd. Sec. 1, Ch. 173, L. 1974; R.C.M. 1947, 92-615(part); amd. Sec. 8, Ch. 103, L. 1979; amd. Sec. 5, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 243, L. 1995; amd. Sec. 1, Ch. 174, L. 2001; amd. Sec. 1, Ch. 112, L. 2025.

39-71-610. Termination of benefits by insurer – department order to pay disputed benefits prior to hearing or mediation – limitation on order – right of reimbursement.

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

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

39-71-611. Costs and attorney fees payable on denial of claim or termination of benefits later found compensable – barring of attorney fees under common fund and other doctrines.

(1) The insurer shall pay reasonable costs and attorney fees as established by the workers' compensation court if:
   (a) the insurer denies liability for a claim for compensation or terminates compensation benefits;
   (b) the claim is later adjudged compensable by the workers' compensation court; and
   (c) in the case of attorney fees, the workers' compensation court determines that the insurer's actions in denying liability or terminating benefits were unreasonable.

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

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

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

Cross-References

Attorney fees, Title 25, ch. 10, part 3.

39-71-612. Costs and attorney fees that may be assessed against insurer by workers' compensation judge – barring of attorney fees under common fund or other doctrines.

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

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

(3) A finding of unreasonableness against an insurer made under this section does not constitute a finding that the insurer acted in bad faith or violated the unfair trade practices provisions of Title 33, chapter 18.
(4) Attorney fees may be awarded only under the provisions of subsections (1) and (2) and may not be awarded under the common fund doctrine or any other action or doctrine in law or equity.

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

Cross-References
Attorney fees, Title 25, ch. 10, part 3.

39-71-613. Regulation of attorney fees – forfeiture of fee for noncompliance – return of fee when claimant received benefits through fraud or deception.

(1) When an attorney represents or acts on behalf of a claimant or any other party on any workers' compensation claim, the attorney shall submit to the department a contract of employment, on a form provided by the department, stating specifically the terms of the fee arrangement between the attorney and the claimant.
(2) The department may regulate the amount of the attorney fees in any workers' compensation case. In regulating the amount of the fees, the department shall consider:
(a) the benefits the claimant gained due to the efforts of the attorney;
(b) the time the attorney was required to spend on the case;
(c) the complexity of the case; and
(d) any other relevant matter the department may consider appropriate.
(3) An attorney who violates a provision of this section, a rule adopted under this section, or an order fixing attorney fees under this section forfeits the right to any fees that the attorney collected or was entitled to collect.
(4) If, after an attorney receives attorney fees and costs assessed against an insurer, the claimant is convicted of having obtained benefits through fraud or deception, the attorney fees and costs for obtaining the benefits must be returned to the insurer by the attorney.
(5) (a) A dispute concerning the forfeiture or return of attorney fees is considered a dispute for which the workers' compensation court has original jurisdiction and is not subject to mediation or a contested case hearing.
(b) the parties to a dispute referred to in subsection (5)(a) may voluntarily request a mediator appointed by the department and proceed to nonbinding mediation.

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

Cross-References
Attorney fees, Title 25, ch. 10, part 3.

39-71-614. Calculation of attorney fees – limitation.

(1) The amount of an attorney's fee assessed against an insurer under 39-71-611 or 39-71-612 must be based exclusively on the time spent by the attorney in representing the claimant on the issues brought to hearing. The attorney must document the time spent, but the judge is not bound by the documentation submitted.

(2) The judge shall determine a reasonable attorney fee and assess costs. The hourly rate applied to the time spent must be based on the attorney's customary and current hourly rate for legal work performed in this state, subject to a maximum established by the department.
(3) This section does not restrict a claimant and an attorney from entering into a contingency fee arrangement under which the attorney receives a percentage of the amount of compensation payments received by the claimant because of the efforts of the attorney. However, an amount equal to any fee and costs assessed against an insurer under 39-71-611 or 39-71-612 and this section must be deducted from the fee an attorney is entitled to from the claimant under a contingency fee arrangement.

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

39-71-615. Payment of medical claims without acceptance of liability.

(1) An insurer may pay a medical claim that is based upon the report of a nonwage loss injury or occupational disease without the payments being construed as an acceptance of liability for the claim.
(2) An insurer shall, within 10 days of making payment under subsection (1), notify the worker of the payment of the medical claim without acceptance of liability.
(3) Upon written request by a worker for the payment of indemnity benefits or for a determination of liability, the insurer shall investigate the claim to determine liability for the injury or occupational disease under 39-71-606 or 39-71-608.

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

Part 7
Compensation and Benefits Generally

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.
Workers' compensation exempt from medical services lien, 71-3-1118.

39-71-701. Compensation for temporary total disability – exception.

(1) Subject to the limitation in 39-71-736 and subsection (4) of this section, a worker is eligible for temporary total disability benefits:
   (a) when the worker suffers a total loss of wages as a result of an injury and until the worker reaches maximum healing; or
   (b) until the worker has been released to return to the employment in which the worker was engaged at the time of the injury or to employment with similar physical requirements.
(2) The determination of temporary total disability must be supported by a preponderance of objective medical findings.
(3) Weekly compensation benefits for injury producing temporary total disability are 66 2/3% of the wages received at the time of the injury. The maximum weekly compensation benefits may not exceed the state's average weekly wage at the time of injury. Temporary total disability benefits must be paid for the duration of the worker's temporary disability. The weekly benefit amount may not be adjusted for cost of living as provided in 39-71-702(5).

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

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

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

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

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

39-71-702. Compensation for permanent total disability.

(1) If a worker is no longer temporarily totally disabled and is permanently totally disabled, as defined in 39-71-116, the worker is eligible for permanent total disability benefits. Permanent total disability benefits must be paid for the duration of the worker's permanent total disability, subject to 39-71-710.

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

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

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

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

(6) A worker may not receive both wages and permanent total disability benefits without the written consent of the insurer. A worker who receives both wages and permanent total disability benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.
(7) If the claimant is awarded social security benefits, the insurer may, upon notification of the claimant's receipt of social security benefits, suspend biweekly compensation benefits for a period sufficient to recover any resulting overpayment of benefits. This subsection does not prevent a claimant and insurer from agreeing to a repayment plan.

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

39-71-703. Compensation for permanent partial disability.

(1) If an injured worker suffers a permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the worker is entitled to a permanent partial disability award if that worker:
  (a)has an actual wage loss as a result of the injury; and
  (b)has a permanent impairment rating as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease that:
    (i) is not based exclusively on complaints of pain;
    (ii) is established by objective medical findings; and
    (iii)is more than zero.
(2) When a worker receives a Class 2 or greater class of impairment as converted to the whole person, as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition, and has no actual wage loss as a result of the compensable injury or occupational disease, the worker is eligible to receive payment for an impairment award only.
(3) The permanent partial disability award must be arrived at by multiplying the percentage arrived at through the calculation provided in subsection (5) by 400 weeks.
(4) A permanent partial disability award granted an injured worker may not exceed a permanent partial disability rating of 100%.
(5) The percentage to be used in subsection (4) must be determined by adding all of the following applicable percentages to the whole person impairment rating:
  (a)if the claimant is 40 years of age or younger at the time of injury, 0%; if the claimant is over 40 years of age at the time of injury, 1%;
  (b) for a worker who has completed less than 12 years of education, 1%; for a worker who has completed 12 years ormore of education or who has received a high school equivalency diploma, 0%;
  (c) if a worker has no actual wage loss as a result of the industrial injury, 0%; if a worker has an actual wage loss of $2 or less an hour as a result of the industrial injury, 10%; if a worker has an actual wage loss of more than $2 an hour as a result of the industrial injury, 20%.Wage loss benefits must be based on the difference between the actual wages received at the time of injury and the wages that the worker earns or is qualified to earn after the worker reaches maximum healing.

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

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

(7) An undisputed impairment award may be paid biweekly or in a lump sum at the discretion of theworker. Lump sums paid for impairments are not subject to the requirements of 39-71-741, except that lump-sum payments for benefits not accrued may be reduced to present value at the rate established by the department pursuant to 39-71-741(5).

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

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

(10) As used in this section:

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

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

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

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

History: En. 92-703.1 bySec. 1,Ch. 155, L. 1973; amd. Sec. 1, Ch. 241, L. 1975; amd. Sec. 1, Ch. 278, L. 1975; R.C.M. 1947, 92-703.1; amd. Sec. 23, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 6, Ch. 9, Sp. L. June 1989; amd. Sec. 4, Ch. 574, L. 1991; amd. Sec. 13, Ch. 243, L. 1995; amd. Sec. 182, Ch. 42, L. 1997; amd. Sec. 12, Ch. 276, L. 1997; amd. Sec. 4, Ch. 464, L. 2003; amd. Sec. 8, Ch. 103, L. 2005; amd. Sec. 1, Ch. 36, L. 2011; amd. Sec. 9, Ch. 167, L. 2011; amd. Sec. 17, Ch. 55, L. 2015.

39-71-704. Payment of medical, hospital, and related services – fee schedules and hospital rates – fee limitation.

(1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

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

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

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

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

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

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

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

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

(D) travel for unauthorized treatment or disallowed procedures.

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

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

(f) (i) the benefits provided for in this section terminate 60 months from the date of injury or diagnosis of an occupational disease. A worker may request reopening of medical benefits that were terminated under this subsection (1)(f) as provided in 39-71-717.

(ii) subsection (1)(f)(i) does not apply to a worker who is permanently totally disabled as a result of a compensable injury or occupational disease or for the repair or replacement of a prosthesis furnished as a direct result of a compensable injury or occupational disease.

(g) notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

(ii) when necessary to monitor the status of a prosthetic device; or

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable under this subsection (1)(g) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

(h) notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) (a) The department shall annually establish a schedule of fees for medical services that are necessary for the treatment of injured workers. Regardless of the date of injury, payment for medical services is based on the fee schedule rates in this section in effect on the date on which the medical service is provided. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

(b)(i) the department may not set the rate for medical services at a rate greater than 10% above the average of the conversion factors used by up to the top five insurers or third-party administrators providing group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.

(ii) the insurers or third-party administrators included under subsection (2)(b)(i) shall provide their standard conversion rates to the department.

(iii) the department may use the conversion rates only for the purpose of determining average conversion rates under this subsection (2).

(iv) the department shall maintain the confidentiality of the conversion rates.

(c) the fee schedule rates established in subsection (2)(b), when adopted, must be based on the following standards as adopted by the centers for medicare and medicaid services, regardless of where services are provided:

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

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

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

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

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

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

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

(d) the department may establish additional codes and coding standards for use by providers when billing for medical services under this section.

(3) (a) The department shall establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. There is a rebuttable presumption that the adopted utilization and treatment guidelines establish compensable medical treatment for an injured worker.

(b)(i) the department may adopt a drug formulary as part of its utilization and treatment guidelines. To implement this section, the department may annually adopt by rule an evidence-based commercial or other evidence-based drug formulary as part of its utilization and treatment guidelines.

(ii) if the department adopts a commercial drug formulary, the formulary automatically includes all of the changes and updates furnished by the commercial vendor that are made during the year. This process is independent of the provisions of 2-4-307.

(iii) if the department adopts a drug formulary, the department shall, by rule, provide for:

(A) an appropriate transition of treatment, if the treatment began prior to the adoption of a drug formulary, to treatment that is consistent with the application of the formulary; and

(B) a timely and responsive dispute resolution process for disputes related to use of the formulary.

(c) an insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.

(d) the department, in consultation with health care providers with relevant experience and education, shall provide for an annual review of the evidence-based utilization and treatment guidelines to consider amendments or changes to the guidelines.

(4) The department shall hire a medical director. The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to subsection (3) prior to mediation under 39-71-2401.

(5) For services available in Montana, insurers may pay facilities located outside Montana according to the workers' compensation fee schedule of the state where the medical service is performed.

(6) (a) an insurer shall make payments at the fee schedule rate within 30 days of receipt of medical bills for which a claim has been accepted and for which no other disputes exist. Disputes must be defined by the department by rule.

(b) any unpaid balance under this subsection (6) accrues interest at 12% a year or 1% a month or a fraction of a month. If the charge is not paid within 30 days, interest on the unpaid balance accrues from the date of receipt of the original billing.

(7) Once a determination has been made regarding the correct reimbursement amount, any overpayment made to a health care provider must be reimbursed to the insurer within 30 days of the determination. Any reimbursement amount remaining unpaid after 30 days accrues interest at 12% a year or 1% a month or a fraction of a month. Interest on the reimbursement amount remaining unpaid accrues from the date of receipt of the determination of the correct reimbursement amount.

(8) For a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the usual and customary charge.

(9) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(10) After mediation pursuant to department rules, an unresolved dispute between an insurer and a health care provider regarding the amount of a fee for medical services may be brought before the workers' compensation court.

(11) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(b) "visit", as used in this subsection (11), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(c) a worker is not responsible for the cost of a subsequent visit pursuant to subsection (11)(a) if the visit is for treatment requested by an insurer.

History: En. 92-706.1 by Sec. 1, Ch. 252, L. 1973; amd. Sec. 1, Ch. 43, L. 1975; amd. Sec. 1, Ch. 189, L. 1975; R.C.M. 1947, 92-706.1(1); amd. Sec. 1, Ch. 90, L. 1981; amd. Sec. 2, Ch. 422, L. 1985; amd. Sec. 25, Ch. 464, L. 1987; amd. Sec. 4, Ch. 333, L. 1989; amd. Secs. 23, 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 9, Sp. L. June 1989; amd. Sec. 1, Ch. 131, L. 1991; amd. Sec. 6, Ch. 558, L. 1991; amd. Sec. 5, Ch. 574, L. 1991; amd. Sec. 3, Ch. 628, L. 1993; amd. Sec. 1, Ch. 308, L. 1997; amd. Sec. 8, Ch. 310, L. 1997; amd. Sec. 19, Ch. 442, L. 1999; amd. Sec. 1, Ch. 138, L. 2001; amd. Sec. 3, Ch. 192, L. 2001; amd. Sec. 1, Ch. 377, L. 2003; amd. Sec. 5, Ch. 69, L. 2005; amd. Sec. 5, Ch. 345, L. 2005; amd. Sec. 3, Ch. 330, L. 2007; amd. Sec. 16, Ch. 112, L. 2009; amd. Sec. 10, Ch. 167, L. 2011; amd. Sec. 2, Ch. 123, L. 2015; amd. Sec. 6, Ch. 433, L. 2017

Cross-References

Catastrophically Injured Worker's Travel Assistance Act, Title 39, Ch. 71, part 40

39-71-705. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 8, Ch. 100, L. 1919; amd. Sec. 5, Ch. 196, L. 1921; re-en. Sec. 2920, R.C.M. 1921; amd. Sec. 16, Ch. 121, L. 1925; amd. Sec. 16, Ch. 177, L. 1929; re-en. Sec. 2920, R.C.M. 1935; amd. Sec. 5, Ch. 213, L. 1945; amd. Sec. 5, Ch. 230, L. 1947; amd. Sec. 6, Ch. 7, L. 1949; amd. Sec. 5, Ch. 48, L. 1951; amd. Sec. 5, Ch. 38, L. 1953; amd. Sec. 6, Ch. 253, L. 1955; amd. Sec. 7, Ch. 234, L. 1957; amd. Sec. 5, Ch. 162, L. 1961; amd. Sec. 5, Ch. 149, L. 1965; amd. Sec. 5, Ch. 207, L. 1967; amd. Sec. 1, Ch. 140, L. 1971; amd. Sec. 1, Ch. 204, L. 1973; amd. Sec. 2, Ch. 386, L. 1975; R.C.M. 1947, 92-709(part).

39-71-706. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: (1), (2), (4)En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 8, Ch. 100, L. 1919; amd. Sec. 5, Ch. 196, L. 1921; re-en. Sec. 2920, R.C.M. 1921; amd. Sec. 16, Ch. 121, L. 1925; amd. Sec. 16, Ch. 177, L. 1929; re-en. Sec. 2920, R.C.M. 1935; amd. Sec. 5, Ch. 213, L. 1945; amd. Sec. 5, Ch. 230, L. 1947; amd. Sec. 6, Ch. 7, L. 1949; amd. Sec. 5, Ch. 48, L. 1951; amd. Sec. 5, Ch. 38, L. 1953; amd. Sec. 6, Ch. 253, L. 1955; amd. Sec. 7, Ch. 234, L. 1957; amd. Sec. 5, Ch. 162, L. 1961; amd. Sec. 5, Ch. 149, L. 1965; amd. Sec. 5, Ch. 207, L. 1967; amd. Sec. 1, Ch. 140, L. 1971; amd. Sec. 1, Ch. 204, L. 1973; amd. Sec. 2, Ch. 386, L. 1975; Sec. 92-709, R.C.M. 1947; (3)En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2922, R.C.M. 1921; re-en. Sec. 2922, R.C.M. 1935; Sec. 92-711, R.C.M. 1947; R.C.M. 1947, 92-709(part), 92-711.

39-71-707. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 8, Ch. 100, L. 1919; amd. Sec. 5, Ch. 196, L. 1921; re-en. Sec. 2920, R.C.M. 1921; amd. Sec. 16, Ch. 121, L. 1925; amd. Sec. 16, Ch. 177, L. 1929; re-en. Sec. 2920, R.C.M. 1935; amd. Sec. 5, Ch. 213, L. 1945; amd. Sec. 5, Ch. 230, L. 1947; amd. Sec. 6, Ch. 7, L. 1949; amd. Sec. 5, Ch. 48, L. 1951; amd. Sec. 5, Ch. 38, L. 1953; amd. Sec. 6, Ch. 253, L. 1955; amd. Sec. 7, Ch. 234, L. 1957; amd. Sec. 5, Ch. 162, L. 1961; amd. Sec. 5, Ch. 149, L. 1965; amd. Sec. 5, Ch. 207, L. 1967; amd. Sec. 1, Ch. 140, L. 1971; amd. Sec. 1, Ch. 204, L. 1973; amd. Sec. 2, Ch. 386, L. 1975; R.C.M. 1947, 92-709(part).

39-71-708. Compensation for disfigurement.

(1) Injured workers who suffer serious face, head, or neck disfigurement may be entitled to benefits not to exceed $2,500, in addition to benefits payable under 39-71-703.
(2) A payment under this section may not be in lieu of the separate benefit of medical and hospital services or of any benefits paid under 39-71-701 for temporary total disability.

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 8, Ch. 100, L. 1919; amd. Sec. 5, Ch. 196, L. 1921; re-en. Sec. 2920, R.C.M. 1921; amd. Sec. 16, Ch. 121, L. 1925; amd. Sec. 16, Ch. 177, L. 1929; re-en. Sec. 2920, R.C.M. 1935; amd. Sec. 5, Ch. 213, L. 1945; amd. Sec. 5, Ch. 230, L. 1947; amd. Sec. 6, Ch. 7, L. 1949; amd. Sec. 5, Ch. 48, L. 1951; amd. Sec. 5, Ch. 38, L. 1953; amd. Sec. 6, Ch. 253, L. 1955; amd. Sec. 7, Ch. 234, L. 1957; amd. Sec. 5, Ch. 162, L. 1961; amd. Sec. 5, Ch. 149, L. 1965; amd. Sec. 5, Ch. 207, L. 1967; amd. Sec. 1, Ch. 140, L. 1971; amd. Sec. 1, Ch. 204, L. 1973; amd. Sec. 2, Ch. 386, L. 1975; R.C.M. 1947, 92-709(part); amd. Sec. 26, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 555, L. 1993.

39-71-709. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. 92-709.2 by Sec. 1, Ch. 386, L. 1975; R.C.M. 1947, 92-709.2.

39-71-710. Termination of benefits upon retirement.

(1) If a claimant is receiving disability or rehabilitation compensation benefits and the claimant receives social security retirement benefits or is eligible to receive or is receiving full social security retirement benefits or retirement benefits from a system that is an alternative to social security retirement, the claimant is considered to be retired. When the claimant is retired, the liability of the insurer is ended for payment of permanent partial disability benefits other than the impairment award, payment of permanent total disability benefits, and payment of rehabilitation compensation benefits. However, the insurer remains liable for temporary total disability benefits, any impairment award, and medical benefits.
(2) If a claimant who is eligible under subsection (1) to receive retirement benefits and while gainfully employed suffers a work-related injury, the insurer retains liability for temporary total disability benefits, any impairment award, and medical benefits.

History: En. Sec. 1, Ch. 386, L. 1981; amd. Sec. 27, Ch. 464, L. 1987; amd. Sec. 14, Ch. 243, L. 1995; amd. Sec. 13, Ch. 516, L. 1995.

39-71-711. Impairment evaluation – ratings.

(1) An impairment rating:
  (a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;
  (b) must be based on the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment;
  (c) must be expressed as a percentage of the whole person; and
  (d) must be established by objective medical findings and may not be based exclusively on complaints of pain.

(2) A claimant or insurer, or both, may obtain an impairment rating from an evaluator if the injury falls within the scope of the evaluator's practice and if the evaluator is one of the following:
  (a) a physician or an osteopath licensed under Title 37, chapter 3, with admitting privileges to practice in one or more hospitals, if any, in the area where the physician or osteopath is located;
  (b) a chiropractor licensed under Title 37, chapter 12;
  (c) a physician assistant licensed under Title 37, chapter 20;
  (d) a dentist licensed under Title 37, chapter 4;
  (e) an advanced practice registered nurse licensed under Title 37, chapter 8; or
  (f) for a claimant residing out of state or upon approval of the insurer, an evaluator referred to in subsections (2)(a) through (2)(e) who is licensed or certified in another state.

(3) If the claimant and insurer cannot agree upon the rating, the mediation procedure in Title 39, chapter 71, part 24, must be followed.

(4) Disputes over impairment ratings are subject to the provisions of 39-71-605.

History: En. Sec. 24, Ch. 464, L. 1987; amd. Sec. 2, Ch. 161, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 558, L. 1991; amd. Sec. 15, Ch. 243, L. 1995; amd. Sec. 2, Ch. 141, L. 2005; amd. Sec. 17, Ch. 112, L. 2009; amd. Sec. 11, Ch. 167, L. 2011; amd. Sec. 2, Ch. 133, L. 2025.

39-71-712. Temporary partial disability benefits.

(1) Subject to the provisions of subsection (5), if prior to maximum healing an injured worker has a physical restriction and is approved to return to a modified or alternative employment that the worker is able and qualified to perform and the worker suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial disability benefits.

(2) An insurer's liability for temporary partial disability must be the difference between the injured worker's average weekly wage received at the time of the injury, subject to a maximum of 40 hours a week, and the actual weekly wages earned during the period that the claimant is temporarily partially disabled, not to exceed the injured worker's temporary total disability benefit rate.

(3) Except as provided in subsection (5), a worker is not eligible for temporary partial disability benefits or temporary total disability benefits if:
  (a) the worker has been released by the treating physician to return to a modified or alternative position that the individual is able and qualified to perform with the same employer;
  (b) the wages payable in the modified or alternative position, when combined with the temporary partial disability benefits, would result in an equivalent or higher wage than the worker received at the time of injury; and
  (c) the worker refuses to accept the modified or alternative position. A worker requalifies for temporary total disability benefits if the modified or alternative position is no longer available to the worker for any reason except for the worker's incarceration as provided for in 39-71-

744, resignation, or termination for disciplinary reasons caused by a violation of the employer's policies that provide for termination of employment and if the worker continues to be temporarily totally disabled as defined in 39-71-116.

(4) Temporary partial disability may not be credited against any permanent partial disability award or settlement under 39-71-703.

(5) Unless a collective bargaining agreement precludes an injured worker from working in a modified or alternative position with a different employer or includes criteria different from those outlined in this subsection (5), an injured worker who has not reached maximum healing and who has a physical restriction may return to a modified or alternative position with a different employer at the same or a lower rate of wages as the rate paid by the employer at the time of injury if:

(a) a modified or alternative employment with the employer at the time of injury is not provided and the injured worker and that employer agree to the modified or alternative position with a different employer;

(b) a written description and all required duties of the modified or alternative position with a different employer are approved by the treating physician;

(c) both the employer at the time of injury and the injured worker agree to the type of alternative work, the alternative employer, and the terms and conditions of employment, including payment of benefits and employment taxes for the modified or alternative position with a different employer;

(d) an employee is not displaced as a result of the injured worker's placement in the modified or alternative position with a different employer; and

(e) the employer at the time of injury, the different employer, and the injured worker agree in writing to the terms and conditions, including payment of benefits, covering the injured worker for subsequent injury, unemployment insurance, employment taxes, and liability and provide a copy of the agreement to the injured employee.

(6) Any additional expenses related to the modified or alternative position, including travel, equipment, or training, must be paid by either the employer at the time of injury or the different employer and may not be charged to or deducted from the wages or benefits of the injured employee.

(7) Notwithstanding a written agreement between the employer at the time of injury and a different employer, the employer at the time of injury is the primary employer if a dispute over wages, benefits, employment taxes, workers' compensation insurance, or other terms or conditions of employment occurs.

(8) The injured worker may refuse to accept a modified or alternative position with an employer other than the employer at the time of injury without penalty. If the injured worker is offered a modified or alternative position with a different employer, the injured worker must be given written notice of the right of refusal from the employer at the time of injury and the insurer prior to beginning work with the different employer.

History: En. Sec. 6, Ch. 619, L. 1993; amd. Sec. 16, Ch. 243, L. 1995; amd. Sec. 13, Ch. 276, L. 1997; amd. Sec. 2, Ch. 121, L. 2001; amd. Sec. 1, Ch. 292, L. 2001; amd. Sec. 18, Ch. 112, L. 2009.

39-71-713. Compensation for occupational diseases and medical benefits – diminution of compensation.

(1) Compensation for occupational diseases must be equal to the compensation and medical benefits provided for injuries in this chapter.
(2) When the same medical condition may be claimed as an injury and an occupational disease, compensation payable to the claimant, the claimant's beneficiaries, or the claimant's dependents may not be duplicated for the same conditions over the same time period.

History: En. Sec. 2, Ch. 416, L. 2005.

39-71-714. Autopsy.

Upon the filing of a claim for compensation for death caused by an occupational disease, if an autopsy is necessary to determine the cause of death, an autopsy may be requested by an insurer. The autopsy must be made under the supervision of the county coroner or a medical examiner. The expense of the autopsy must be paid by the insurer.

History: En. Sec. 3, Ch. 416, L. 2005.

39-71-715. Benefits for pneumoconiosis – definition.

(1) Pneumoconiosis is an occupational disease that is compensable under this part. However, any benefits granted a claimant under this chapter for pneumoconiosis must be reduced, but not below zero, by an amount equal to the benefits granted the claimant under any program under federal law that pays benefits for a claimant suffering disability from pneumoconiosis.
(2) "Pneumoconiosis" means a chronic dust disease of the lungs arising out of employment in coal mines and includes anthracosis, coal workers' pneumoconiosis, silicosis, or anthracosilicosis arising out of employment.

History: En. Sec. 4, Ch. 416, L. 2005.

39-71-716. Prohibiting supplementing of benefits.

A person receiving compensation or benefits under chapter 73 of this title is not entitled to compensation or benefits under this chapter.

History: En. Sec. 5, Ch. 416, L. 2005.

39-71-717. Reopening of terminated medical benefits – medical review.

(1) A petition to reopen medical benefits that terminate under 39-71-704(1)(f) must be reviewed as provided in this section.
(2) Medical benefits may be reopened only if the worker's medical condition is a direct result of the compensable injury or occupational disease and requires medical treatment in order to allow the worker to continue to work or return to work. Medical benefits closed by settlement or court order are not subject to reopening.
(3) A review of a petition to reopen medical benefits must be conducted by a medical review panel as provided in subsection (4) or, if stipulated by the worker and the insurer, solely by the department's medical director.
(4) The medical review panel must be composed of the department's medical director and two additional physicians who are licensed to practice medicine in Montana and who have expertise and experience in the area of medicine that is relevant to the worker's condition. The department's

medical director shall serve as the presiding officer of the medical review panel. Participants on the medical review panel must be reimbursed as provided in 2-18-501 through 2-18-503 if travel is required for a review and must be paid a reasonable fee for services.

(5) A petition for reopening of medical benefits must be filed with the department within 5 years of the termination of medical benefits pursuant to 39-71-704(1)(f). A petition may not be filed more than 90 days before benefits are to terminate.

(6) Upon receipt of a petition to reopen medical benefits, the department shall request from the insurer a copy of the worker's medical records contained in the insurer's claim file. The worker or the insurer may submit additional information that is relevant to the petition to reopen medical benefits.

(7) The proof necessary to support reopening of medical benefits must be a preponderance of the evidence.

(8) Within 60 days of the submission of a petition to reopen medical benefits, the medical review panel or the department's medical director shall issue a report. The report must provide the rationale for the decision reached. A report issued by the medical review panel must be supported by a majority of the panel members. If the report concludes that medical benefits must be reopened, the report must state the extent to which the benefits must be reopened consistent with the utilization and treatment guidelines. Benefits reopened pursuant to this section remain open for 2 years or until maximum medical improvement is achieved following surgery or the recommended medical treatment, whichever occurs first. If the medical panel specifically approves treatment beyond 2 years, medical benefits remain open for as long as recommended by the medical panel. The petitioner and the insurer shall submit updated information to the medical panel every 2 years, and every subsequent 2 years the medical panel shall review the claims that were reopened for longer than 2 years to determine whether to change the previous recommendation.

(9) If a joint petition to reopen medical benefits is filed by the insurer and worker, the medical and other records required by subsections (3), (4), and (6) do not need to be submitted. A report on a joint petition is not required from the medical director or a medical review panel. A joint petition reopens medical benefits. The joint petition may specify the term for which benefits will remain open. Nothing in this subsection may be construed to require an insurer to jointly petition to reopen medical benefits.

(10) A party aggrieved by a decision of the department's medical director or medical review panel may, after satisfying the dispute resolution requirements provided in this chapter, file a petition with the workers' compensation court. The report of the department's medical director or the medical review panel is presumed to be correct and may be overcome only by clear and convincing evidence.

History: En. Sec. 29, Ch. 167, L. 2011; amd. Sec. 2, Ch. 79, L. 2021.

39-71-718 through 39-71-720 reserved.

39-71-721. Compensation for injury causing death – limitation.

(1) (a) If an injured employee dies and the injury was the proximate cause of the death, the beneficiary of the deceased is entitled to the same compensation as though the death occurred immediately following the injury. A beneficiary's eligibility for benefits commences after the date of death, and the benefit level is established as set forth in subsection (2).

(b)the insurer is entitled to recover any overpayments or compensation paid in a lump sum to a worker prior to death but not yet recouped. The insurer shall recover the payments from the beneficiary's biweekly payments as provided in 39-71-741(5).

(2) To beneficiaries as defined in 39-71-116(4)(a) through (4)(d), weekly compensation benefits for an injury causing death are 66 2/3% of the decedent's wages. The maximum weekly compensation benefit may not exceed the state's average weekly wage at the time of injury. The minimum weekly compensation benefit is 50% of the state's average weekly wage, but in no event may it exceed the decedent's actual wages at the time of death.

(3) To beneficiaries as defined in 39-71-116(4)(e) and (4)(f), weekly benefits must be paid to the extent of the dependency at the time of the injury, subject to a maximum of 66 2/3% of the decedent's wages. The maximum weekly compensation may not exceed the state's average weekly wage at the time of injury.

(4) If the decedent leaves no beneficiary, a lump-sum payment of $3,000 must be paid to the decedent's surviving parent or parents.

(5) If any beneficiary of a deceased employee dies, the right of the beneficiary to compensation under this chapter ceases. Death benefits must be paid to a surviving spouse for 500 weeks subsequent to the date of the deceased employee's death or until the spouse's remarriage, whichever occurs first. After benefit payments cease to a surviving spouse, death benefits must be paid to beneficiaries, if any, as defined in 39-71-116(4)(b) through (4)(d).

(6) In all cases, benefits must be paid to beneficiaries.

(7) Benefits paid under this section may not be adjusted for cost of living as provided in 39-71-702.

History: (1)En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; Sec. 92-608, R.C.M. 1947; (2) thru (6)Ap. p. 92-704.1 by Sec. 1, Ch. 203, L. 1973; amd. Sec. 2, Ch. 269, L. 1974; amd. Sec. 1, Ch. 270, L. 1974; amd. Sec. 2, Ch. 272, L. 1974; Sec. 92-704.1, R.C.M. 1947; Ap. p. Sec. 7, Ch. 96, L. 1915; re-en. Sec. 2892, R.C.M. 1921; re-en. Sec. 2892, R.C.M. 1935; amd. Sec. 10, Ch. 23, L. 1975; Sec. 92-502, R.C.M. 1947; R.C.M. 1947, 92-704.1, 92-502, 92-608(1); amd. Sec. 67, Ch. 197, L. 1979; amd. Sec. 29, Ch. 464, L. 1987; amd. Sec. 8, Ch. 9, Sp. L. June 1989; amd. Sec. 6, Ch. 480, L. 1991; amd. Sec. 17, Ch. 243, L. 1995; amd. Sec. 14, Ch. 516, L. 1995; amd. Sec. 9, Ch. 310, L. 1997; amd. Sec. 2, Ch. 36, L. 2011; amd. Sec. 12, Ch. 167, L. 2011.

39-71-722. Who constitutes beneficiary to be determined as of date of accident.

The question as to who constitutes a beneficiary shall be determined as of the date of the happening of the accident to the employee, whether death shall immediately result therefrom or not.

History: En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; R.C.M. 1947, 92-608(3).

39-71-723. How compensation to be divided among beneficiaries.

Compensation that is due to beneficiaries must be paid to the surviving spouse, if any, or if none, divided equally among or for the benefit of the children. In cases in which beneficiaries are a surviving spouse and stepchildren of the spouse, the compensation must be divided equally among all beneficiaries. Compensation that is due to beneficiaries, as defined in 39-71-116(4)(e) and (4)(f), if there is more than one, must be divided equitably among them.

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2919, R.C.M. 1921; amd. Sec. 15, Ch. 121, L. 1925; re-en. Sec. 2919, R.C.M. 1935; amd. Sec. 4, Ch. 213, L. 1945; amd. Sec. 7, Ch. 235, L. 1947; amd. Sec. 7, Ch. 253, L. 1955; amd. Sec. 1, Ch. 205, L. 1973; amd. Sec. 3, Ch. 269, L. 1974; R.C.M. 1947, 92-708(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 7, Ch. 480, L. 1991; amd. Sec. 18, Ch. 243, L. 1995; amd. Sec. 15, Ch. 516, L. 1995; amd. Sec. 7, Ch. 172, L. 1997.

39-71-724. Payment of compensation to beneficiary not a resident of United States.

(1) Before payment of compensation to a beneficiary who is not residing within the United States, satisfactory proof of the relationship as to constitute a beneficiary under this chapter must be furnished by the beneficiary, authenticated under seal of an officer of a court of law in the country where the beneficiary resides. The proof is conclusive as to the identity of the beneficiary, and any other claim of any other person to any compensation is barred from and after the filing of the proof.
(2) Payment of compensation to a beneficiary not residing within the United States may be made to any plenipotentiary, consul, or consular agent within the United States representing the country in which the nonresident beneficiary resides, and the written receipt of the plenipotentiary, consul, or consular agent acquits the employer or the insurer.

History: (1)En. Sec. 8, Ch. 96, L. 1915; re-en. Sec. 2896, R.C.M. 1921; re-en. Sec. 2896, R.C.M. 1935; amd. Sec. 11, Ch. 23, L. 1975; Sec. 92-506, R.C.M. 1947; (2)En. Sec. 9, Ch. 96, L. 1915; re-en. Sec. 2897, R.C.M. 1921; re-en. Sec. 2897, R.C.M. 1935; amd. Sec. 12, Ch. 23, L. 1975; Sec. 92-507, R.C.M. 1947; R.C.M. 1947, 92-506, 92-507; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 172, L. 1997.

39-71-725. Payment of burial expense.

There must be paid, in case of the death of an employee whose death is the result of an accidental injury arising out of the employment and happening in the course of the employment, the reasonable burial expenses of the employee not exceeding $10,000. The payment is not a part of the compensation that might be paid but is a benefit in addition to and separate from compensation.

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 2, Ch. 196, L. 1921; re-en. Sec. 2916, R.C.M. 1921; amd. Sec. 13, Ch. 121, L. 1925; re-en. Sec. 2916, R.C.M. 1935; amd. Sec. 1, Ch. 128, L. 1943; amd. Sec. 1, Ch. 213, L. 1945; amd. Sec. 6, Ch. 38, L. 1953; amd. Sec. 5, Ch. 234, L. 1957; amd. Sec. 1, Ch. 194, L. 1974; R.C.M. 1947, 92-705; amd. Sec. 7, Ch. 21, L. 1981; amd. Sec. 14, Ch. 377, L. 1999; amd. Sec. 1, Ch. 132, L. 2021.

39-71-726. No compensation after death when death not result of injury.

If the employee dies from some cause other than the injury, there is no liability for compensation after the death.

History: En. Sec. 12, Ch. 96, L. 1915; re-en. Sec. 2905, R.C.M. 1921; re-en. Sec. 2905, R.C.M. 1935; amd. Sec. 15, Ch. 23, L. 1975; R.C.M. 1947, 92-608(2); amd. Sec. 1548, Ch. 56, L. 2009.

39-71-727. Payment for prescription drugs – limitations.

(1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the generic-name drug is unavailable.
(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.
(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).
(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.
(5) The department shall establish a schedule of fees for prescription drugs.
(6) Except as provided in subsection (8), a pharmacist may not dispense more than a 30-day supply at any one time.

(7) For purposes of this section, the terms “brand name” and “generic name” have the meanings provided in 37-7-502.
(8) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail order pharmacy. However, an insurer may authorize up to a 90-day supply of medications from an in-state mail order pharmacy.
(9) The provisions of this section do not apply to an agreement between a preferred provider organization and an insurer.

History: En. Sec. 2, Ch. 131, L. 1991; amd. Sec. 4, Ch. 628, L. 1993; amd. Sec. 19, Ch. 243, L. 1995; amd. Sec. 7, Ch. 117, L. 2007; amd. Sec. 19, Ch. 112, L. 2009; amd. Sec. 20, Ch. 726, L. 2025.

39-71-728 through 39-71-735 reserved.

39-71-736. Compensation – from what dates paid.

(1) (a) Except as provided in subsection (1)(c), compensation may not be paid for the first 32 hours or 4 days of loss of wages, whichever is less, that the worker is totally disabled and unable to work because of an injury. A worker is eligible for compensation starting with the 5th day.
(b) separate benefits of medical and hospital services must be furnished from the date of injury.
(c) if the worker is totally disabled and unable towork in any capacity for 21 days or longer, compensation must be paid retroactively to the first day of total wage loss unless the worker waives the payment as provided in subsection (2)(b)(ii).
(2) (a) For the purpose of this section, except as provided in subsection (3), a worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 4-day waiting period.
(b) a worker who is entitled to receive retroactive compensation benefits pursuant to subsection (1)(c) but who took sick leave as provided in subsection (2)(a) may elect to either:
(i) repay the employer the amount of salary for the sick leave received; or
(ii) waive the retroactive payment of benefits attributable to any days or hours for which the worker received sick leave.
(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective bargaining agreement may not disqualify a worker from receiving temporary total disability benefits.
(4) Receipt of vacation leave or paid time off leave, other than sick leave, by a worker may not affect the worker’s eligibility for temporary total disability benefits.

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 4, Ch. 196, L. 1921; re-en. Sec. 2918, R.C.M. 1921; amd. Sec. 3, Ch. 177, L. 1929; re-en. Sec. 2918, R.C.M. 1935; amd. Sec. 3, Ch. 213, L. 1945; amd. Sec. 5, Ch. 7, L. 1949; amd. Sec. 1, Ch. 144, L. 1969; amd. Sec. 18, Ch. 23, L. 1975; amd. Sec. 45, Ch. 535, L. 1975; R.C.M. 1947, 92-707; amd. Sec. 9, Ch. 103, L. 1979; amd. Sec. 30, Ch. 464, L. 1987; amd. Sec. 6, Ch. 333, L. 1989; amd. Sec. 18, Ch. 619, L. 1993; amd. Sec. 1, Ch. 274, L. 2001; amd. Sec. 1, Ch. 486, L. 2003; amd. Sec. 13, Ch. 167, L. 2011; amd. Sec. 3, Ch. 123, L. 2015

39-71-737. Compensation to run consecutively – exceptions.

Compensation must run consecutively and not concurrently, and payment may not be made for two classes of disability over the same period, except that impairment awards and auxiliary rehabilitation benefits may be paid concurrently with other classes of benefits.

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2919, R.C.M. 1921; amd. Sec. 15, Ch. 121, L. 1925; re-en. Sec. 2919, R.C.M. 1935; amd. Sec. 4, Ch. 213, L. 1945; amd. Sec. 7, Ch. 235, L. 1947; amd. Sec. 7, Ch. 253, L. 1955; amd. Sec. 1, Ch. 205, L. 1973; amd. Sec. 3, Ch. 269, L. 1974; R.C.M. 1947, 92-708(part); amd. Sec. 2, Ch. 374, L. 1985; amd. Sec. 1, Ch. 502, L. 1985; amd. Sec. 31, Ch. 464, L. 1987; amd. Sec. 16, Ch. 516, L. 1995.

39-71-738. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2923, R.C.M. 1921; amd. Sec. 5, Ch. 177, L. 1929; re-en. Sec. 2923, R.C.M. 1935; R.C.M. 1947, 92-712; amd. Sec. 68, Ch. 397, L. 1979.

39-71-739. Compensation in case of changes in degree of injury.

If aggravation, diminution, or termination of disability takes place or is discovered after the rate of compensation is established or compensation is terminated in any case where the maximum payments for disabilities as provided in this chapter are not reached, adjustments may be made to meet such changed conditions by increasing, diminishing, or terminating compensation payments in accordance with the provisions of this chapter.

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2924, R.C.M. 1921; amd. Sec. 6, Ch. 177, L. 1929; re-en. Sec. 2924, R.C.M. 1935; R.C.M. 1947, 92-713; amd. Sec. 69, Ch. 397, L. 1979.

39-71-740. Payments – how made in most cases.

All payments of compensation as provided in this chapter shall be made at the end of each 2-week period, except as otherwise provided herein.

History: En. Sec. 16, Ch. 96, L. 1915; re-en. Sec. 2925, R.C.M. 1921; re-en. Sec. 2925, R.C.M. 1935; amd. Sec. 9, Ch. 235, L. 1947; amd. Sec. 1, Ch. 197, L. 1961; R.C.M. 1947, 92-714.

39-71-741. Settlements and lump-sum payments – legislative intent.

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

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

(a) all benefits if a claimant and an insurer dispute the initial compensability of an injury and there is a reasonable dispute over compensability;

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

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

(i) relates to:

(A) the necessities of life;

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

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

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

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

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

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

(i) the insurer and claimant mutually agree to a settlement of all or a portion of medical benefits; and

(ii) a settlement is in the best interest of the parties to the settlement.

(3) The parties to a medical settlement agreement shall set out the rationale that is the basis for the settlement under subsection (2)(f), and the claimant shall indicate by a signed acknowledgment an understanding of what medical benefits will terminate because of the settlement.

(4) Any lump-sum conversion of benefits under this section must be converted to present value using the rate prescribed under subsection (5)(b).

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

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

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

(6) A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump sum is considered a dispute for which a mediator and the workers' compensation court have jurisdiction to make a determination.

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

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

History: En. Sec. 16, Ch. 96, L. 1915; amd. Sec. 9, Ch. 100, L. 1919; re-en. Sec. 2926, R.C.M. 1921; re-en. Sec. 2926, R.C.M. 1935; amd. Sec. 1, Ch. 225, L. 1951; amd. Sec. 8, Ch. 234, L. 1957; amd. Sec. 2, Ch. 197, L. 1961; amd. Sec. 1, Ch. 9, L. 1975; amd. Sec. 1, Ch. 11, L. 1975; amd. Sec. 19, Ch. 23, L. 1975; R.C.M. 1947, 92-715; amd. Sec. 3, Ch. 63, L. 1979; amd. Sec. 1, Ch. 471, L. 1985; amd. Sec. 32, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 6, Ch. 574, L. 1991; amd. Sec. 20, Ch. 243, L. 1995; amd. Sec. 10, Ch. 310, L. 1997; amd. Sec. 9, Ch. 103, L. 2005; amd. Sec. 3, Ch. 36, L. 2011; amd. Sec. 14, Ch. 167, L. 2011.

39-71-742. Who may receive payment.

(1) A payment due to a child under 18 years of age or to a person adjudged incompetent must be made to the parent, the appointed guardian, the appointed conservator, or the appointed benefits administrator, and the written receipt for the payment must acquit the employer, the insurer, or the department of further liability.

(2) A payment due to a member of the highway patrol receiving the salary benefit provided in 44-1-511 must be made to the department of justice to offset the salary benefit until the member is no longer eligible to receive the salary benefit.

(3) In other cases, payment must be made to the person entitled to the payment or to the person's authorized representative.

(4) For the purposes of subsection (1), the term "benefits administrator" means a person appointed by the workers' compensation judge as provided in 3-9-111 to pursue benefits or receive payments on behalf of a child under 18 years of age [or a person] adjudged incompetent.

History: En. Sec. 9, Ch, 96, L. 1915; re-en. Sec. 2898, R.C.M. 1921; amd. Sec. 8, Ch. 121, L. 1925; re-en. Sec. 2898, R.C.M. 1935; amd. Sec. 13, Ch. 23, L. 1975; R.C.M. 1947, 92-508; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 12, L. 2007; amd. Sec. 1, Ch. 140, L. 2025.

39-71-743. Assignment or attachment of payments.

(1) Payments under this chapter are not assignable, subject to attachment or garnishment, or held liable in any way for debts, except:
   (a) as provided in 71-3-1118;
   (b) a portion of any lump-sum award or periodic payment to pay a monetary obligation for current or past-due child support, subject to the limitations in subsection (2), whenever the support obligation is established by order of a court of competent jurisdiction or by order rendered in an administrative process authorized by state law;
   (c) as provided in 53-2-612 or 53-2-613 for medical benefits paid pursuant to this chapter;
   (d) as provided in 39-71-742; or
   (e) for workers' compensation benefits payable to an injured worker to pay restitution to an insurer whenever the injured worker is subject to court-ordered restitution for theft of workers' compensation benefits. The insurer shall notify the injured worker in writing of the withholding of any court-ordered restitution from the injured worker's benefits.

(2) Payments under this chapter are subject to assignment, attachment, or garnishment for child support as follows:
   (a) for any periodic payment, an amount up to the percentage amount established in the guidelines promulgated by the department of public health and human services pursuant to 40-5-209; or
   (b) for any lump-sum award, an amount up to that portion of the award that is necessary to pay current child support and a past-due child support obligation.

(3) After determination that the claim is covered under the Workers' Compensation Act, the liability for payment of the claim is the responsibility of the appropriate workers' compensation insurer. Except as provided in 39-71-704(11), a fee or charge is not payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

History: En. Sec. 17, Ch. 96, L. 1915; re-en. Sec. 2927, R.C.M. 1921; re-en. Sec. 2927, R.C.M. 1935; R.C.M. 1947, 92-801; amd. Sec. 3, Ch. 496, L. 1983; amd. Sec. 1, Ch. 485, L. 1987; amd. Sec. 19, Ch. 702, L. 1989; amd. Sec. 14, Ch. 628, L. 1993; amd. Sec. 2, Ch. 424, L. 1995; amd. Sec. 104, Ch. 546, L. 1995; amd. Sec. 1, Ch. 31, L. 2005; amd. Sec. 10, Ch. 103, L. 2005; amd. Sec. 26, Ch. 416, L. 2005; amd. Sec. 2, Ch. 12, L. 2007; amd. Sec. 2, Ch. 330, L. 2007; amd. Sec. 20, Ch. 112, L. 2009; amd. Sec. 7, Ch. 433, L. 2017.

Cross-References

Property exempt from execution without limitation – exceptions, 25-13-608

Exempt property – bankruptcy proceeding, 31-2-106.

39-71-744. Benefits not due while claimant is incarcerated – exceptions.

(1) Except as provided in subsection (2), a claimant is not eligible for disability or rehabilitation compensation benefits while the claimant is incarcerated for a period exceeding 30 days in a correctional institution or jail as the result of conviction of a felony or a misdemeanor. The insurer remains liable for medical benefits. A time limit on benefits otherwise provided in this chapter is not extended due to a period of incarceration.

(2) A person who is employed while participating in a prerelease center program or a diversionary program is eligible for temporary total benefits as provided in 39-71-701 and medical benefits for a work-related injury received while participating in a prerelease center program or a diversionary program. Other disability or rehabilitation benefits are not payable while the worker is participating in a prerelease center. This subsection does not prohibit the reinstatement of other benefits upon release from incarceration, nor does it apply to an employee performing community service described in 39-71-118(1)(e).

History: En. Sec. 28, Ch. 464, L. 1987; amd. Sec. 1, Ch. 457, L. 1993; amd. Sec. 21, Ch. 243, L. 1995; amd. Sec. 31, Ch. 308, L. 1995; amd. Sec. 105, Ch. 546, L. 1995.

39-71-745. Calculation of volunteer firefighter benefits and premiums – definitions.

(1) (a) a plan No. 1 or plan No. 2 insurer shall designate whether an employer, as defined in 7-33-4510, is to use actual volunteer hours or a flat assumed payroll amount for each volunteer firefighter for calculating premiums. The coverage option must be the same for all fire agencies organized under Title 7, chapter 33, that are covered by that insurer and meet the definition of employer in 7-33-4510. A plan No. 3 insurer shall use a flat assumed payroll amount for each volunteer firefighter for calculating premiums.

(b) if a plan No. 1 or plan No. 2 insurer uses actual volunteer hours, the payroll calculation is the number of actual volunteer hours of each volunteer firefighter, not to exceed 60 hours a week, times the state's average weekly wage divided by 40 hours.

(c) when a plan No. 1, plan No. 2, or plan No. 3 insurer uses a flat assumed payroll amount, the assumed payroll for each volunteer firefighter must be reported as a full month for any month in which the volunteer firefighter is on the roster of service as defined in 7-33-4510. The employer shall maintain the roster of service with the effective date of membership for each volunteer firefighter.

(2) For benefit purposes, if concurrent employment under 39-71-123 does not apply, a volunteer firefighter injured in the course and scope of employment as a volunteer firefighter is eligible for medical and compensation benefits provided in Title 39, chapter 71. Any weekly compensation

benefit must be based on either the actual volunteer hours if chosen as provided in subsection (1)(b) or the flat assumed payroll amount on which premiums are based, whichever is applicable.

(3) For the purposes of this section, the following definitions apply:

(a) "volunteer firefighter" has the meaning provided in 7-33-4510.

(b) "volunteer hours" means the time spent by a volunteer firefighter in the service of a fire agency organized under Title 7, chapter 33, that meets the definition of employer in 7-33-4510, including but not limited to training time, response time, and time spent at the premises of the fire agency.

History: En. Sec. 6, Ch. 412, L. 2013.

Part 8
Compensation for Occupational Deafness (Repealed)

39-71-801. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(part); amd. Sec. 70, Ch. 397, L. 1979.

39-71-802. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(part).

39-71-803. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(8); amd. Sec. 33, Ch. 464, L. 1987.

39-71-804. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(1)(a).

39-71-805. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(1)(b) thru (f); amd. Sec. 11, Ch. 214, L. 2001.

39-71-806. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(2).

39-71-807. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(3); amd. Sec. 71, Ch. 397, L. 1979.

39-71-808. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(4).

39-71-809. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(9).

39-71-810. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(6).

39-71-811. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(10).

39-71-812. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(7).

39-71-813. Repealed.

Sec. 10, Ch. 26, L. 2005.

History: En. 92-710 by Sec. 1, Ch. 366, L. 1971; amd. Sec. 1, Ch. 381, L. 1973; R.C.M. 1947, 92-710(5); amd. Sec. 72, Ch. 397, L. 1979.

Part 9
Subsequent Injury Received by Vocationally Handicapped

Part Cross-References

Definitions, 39-71-116, 39-71-901.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-901. Definitions.

As used in this part, the following definitions apply:

(1) "Certificate" means documentation issued by the department to an individual who is a person with a disability.
(2) "Fund" means the subsequent injury fund in the proprietary fund category.
(3) "Person with a disability" means a person who has a medically certifiable permanent impairment that is a substantial obstacle to obtaining employment or to obtaining reemployment if the person should become unemployed, considering such factors as the person's age, education, training, experience, and employment rejection.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(1); amd. Sec. 10, Ch. 103, L. 1979; amd. Sec. 73, Ch. 397, L. 1979; amd. Sec. 24, Ch. 613, L. 1989; amd. Sec. 40, Ch. 472, L. 1997; amd. Sec. 19, Ch. 389, L. 1999; amd. Sec. 7, Ch. 193, L. 2003.

39-71-902. Repealed.

Sec. 7, Ch. 284, L. 1997.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 74, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 555, L. 1993; amd. Sec. 17, Ch. 516, L. 1995.

39-71-903. Procedure.

When a person with a disability receives an injury, as defined in 39-71-119, the procedure provided in this chapter applies to all proceedings under this part, except when specifically otherwise provided.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 75, Ch. 397, L. 1979; amd. Sec. 4, Ch. 284, L. 1997; amd. Sec. 41, Ch. 472, L. 1997.

39-71-904. Rules for certification.

The department shall promulgate rules for certification of persons with disabilities.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(4); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 42, Ch. 472, L. 1997.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

39-71-905. Certification as person with disability – eligibility for benefits under fund.

(1) A person who wishes to be certified as a person with a disability for purposes of this part shall apply to the department on forms furnished by the department. The department shall conduct an investigation and shall issue a certificate to a person who, in the department's discretion, meets the requirements for certification. A person shall apply for certification before an injury occurs that is covered by this part. The certification is effective retroactively to the date the department received the application.

(2) If a claimant has met the provisions of subsection (1) and a subsequent claim has been accepted by an insurer, the claim is eligible for the benefits under the fund.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(2); amd. Sec. 11, Ch. 103, L. 1979; amd. Sec. 1, Ch. 151, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 558, L. 1991; amd. Sec. 43, Ch. 472, L. 1997; amd. Sec. 15, Ch. 377, L. 1999; amd. Sec. 1, Ch. 257, L. 2005; amd. Sec. 21, Ch. 112, L. 2009.

39-71-906. Repealed.

Sec. 2, Ch. 257, L. 2005.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(3); amd. Sec. 12, Ch. 103, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 44, Ch. 472, L. 1997; amd. Sec. 12, Ch. 214, L. 2001.

39-71-907. Certified person with a disability to be compensated for injury as provided by chapter – insurer liability for compensation limited.

(1) A person certified as having a physical or mental disability that constitutes or results in a substantial impediment to employment who receives an injury, as defined in 39-71-119, that results in death or disability must be paid compensation in the manner and to the extent provided in this chapter or, in case of death resulting from the injury, the compensation must be paid to the person's beneficiaries or dependents. The liability of the insurer for payment of medical and burial benefits as provided in this chapter is limited to those benefits arising from services rendered during the period of 104 weeks after the date of injury. The liability of the insurer for payment of benefits as provided in this chapter is limited to 104 weeks of compensation benefits actually paid. Thereafter, all compensation and the cost of all medical care and burial are the liability of the fund.

(2) The liability of the fund for reimbursement under this section is limited to the amount currently in the fund at the time the reimbursement request is received by the fund and the amount collectible in the next assessment period pursuant to 39-71-915.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(5); amd. Sec. 76, Ch. 397, L. 1979; amd. Sec. 1, Ch. 213, L. 1987; amd. Sec. 9, Ch. 555, L. 1993; amd. Sec. 5, Ch. 284, L. 1997; amd. Sec. 45, Ch. 472, L. 1997; amd. Sec. 20, Ch. 389, L. 1999; amd. Sec. 7, Ch. 48, L. 2007.

39-71-908. Notification of fund of its potential liability under part – review by fund.

Not less than 90 or more than 150 days before the expiration of 104 weeks after the date of injury, the insurer shall notify the fund whether it is likely that compensation may be payable beyond a period of 104 weeks after the date of the injury. The fund thereafter may review, at reasonable times, such information as the insurer has regarding the accident and the nature and extent of the injury and disability.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 77, Ch. 397, L. 1979; amd. Sec. 25, Ch. 613, L. 1989.

39-71-909. Effect of fund's failure to give notification of its intent to dispute liability – subsequent notification by fund authorized

If the fund does not notify the insurer of its intent to dispute the payment of compensation, medical, and burial benefits, the insurer shall continue to make payments on behalf of the fund and shall be reimbursed by the fund for all benefits paid in excess of the insurer's liability. However, at any time subsequent to 104 weeks after the date of injury, the fund may notify the insurer of a dispute as to payment of benefits. The liability of the fund to reimburse the insurer shall be suspended 30 days thereafter until the controversy is determined.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(7); amd. Sec. 2, Ch. 213, L. 1987.

39-71-910. Repealed.

Sec. 7, Ch. 284, L. 1997.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(9) thru (12); amd. Sec. 78, Ch. 397, L. 1979; amd. Secs. 26, 64, Ch. 613, L. 1989.

39-71-911. Obligation to make payments on behalf of fund not independent liability.

Except as provided in 39-71-909 and 39-71-920, the obligation imposed by this part on the insurer to make payments on behalf of the fund does not impose an independent liability on the insurer.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 27, Ch. 613, L. 1989; amd. Sec. 8, Ch. 193, L. 2003.

39-71-912. Reimbursement to be promptly made.

After the right to reimbursement has been established, reimbursement payment shall be made promptly on a proper showing every 6 months.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part).

39-71-913. Repealed.

Sec. 7, Ch. 284, L. 1997.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part); amd. Sec. 28, Ch. 613, L. 1989.

39-71-914. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. 92-709.1 by Sec. 1, Ch. 254, L. 1973; R.C.M. 1947, 92-709.1(part).

39-71-915. Assessment of insurer – employers – definition – collection.

(1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the Workers' Compensation Act without regard to the application of any deductible, regardless ofwhether the employer or the insurer pays the losses:
   (a) total compensation benefits paid; and
   (b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount from April 1 of the previous year through March 31 of the current year paid by the fund plus the expenses of administration less other realized income that is deposited in the fund. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1.The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a)all assessments paid to the department must be deposited in the fund.

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

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

(d)the state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

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

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge.

(10) If the total assessment is less than $1 million for any year, the department may defer the assessment amount for that year and add that amount to the assessment amount for the subsequent year.

History: En. Sec. 1, Ch. 284, L. 1997; amd. Sec. 16, Ch. 377, L. 1999; amd. Sec. 13, Ch. 214, L. 2001; amd. Sec. 9, Ch. 193, L. 2003; amd. Sec. 6, Ch. 69, L. 2005; amd. Sec. 27, Ch. 416, L. 2005; amd. Sec. 8, Ch. 48, L. 2007; amd. Sec. 22, Ch. 112, L. 2009; amd. Sec. 4, Ch. 123, L. 2015.

39-71-916. Reimbursement of subsequent injury fund – effect on claims experience rating.

An insurer that uses an employer's claims costs experience as a factor that influences the amount of premium charged to that particular employer by using an experience modification factor or similar rating technique may not base that factor on those claims costs that are reimbursed by the subsequent injury fund.

History: En. Sec. 2, Ch. 48, L. 2007.

39-71-917 through 39-71-919 reserved.

39-71-920. Concurrence of fund in settlements.

(1) Petitions for compromise settlements that potentially involve payments from the fund must have written concurrence by an authorized representative of the fund prior to submission for department approval.

(2) The failure to receive written concurrence from the fund's representative relieves the fund of any liability for payment of benefits for a compromise settlement, and the obligation to pay remains with the insurer.

History: En. Sec. 10, Ch. 193, L. 2003.

Part 10
Stay-at-Work/Return-to-Work Assistance

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-1001. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 1, Ch. 21, L. 1961; amd. Sec. 1, Ch. 221, L. 1963; amd. Sec. 83, Ch. 23, L. 1975; R.C.M. 1947, 92-1401; amd. Sec. 79, Ch. 397, L. 1979.

39-71-1002. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 2, Ch. 21, L. 1961; amd. Sec. 84, Ch. 23, L. 1975; R.C.M. 1947, 92-1402.

39-71-1003. Repealed.

Sec. 7, Ch. 51, L. 2019.

History: En. Sec. 3, Ch. 21, L. 1961; amd. Sec. 1, Ch. 363, L. 1971; R.C.M. 1947, 92-1403; amd. Sec. 80, Ch. 397, L. 1979; amd. Sec. 3, Ch. 374, L. 1985; amd. Sec. 35, Ch. 464, L. 1987; amd. Sec. 7, Ch. 574, L. 1991; amd. Sec. 106, Ch. 546, L. 1995; amd. Sec. 1, Ch. 122, L. 1997

39-71-1004. Repealed.

Sec. 7, Ch. 51, L. 2019.

History: En. Sec. 7, Ch. 21, L. 1961; amd. Sec. 3, Ch. 221, L. 1963; amd. Sec. 85, Ch. 23, L. 1975; R.C.M. 1947, 92-1406; amd. Sec. 2, Ch. 283, L. 1983; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 107, Ch. 546, L. 1995; amd. Sec. 2, Ch. 122, L. 1997; amd. Sec. 17, Ch. 377, L. 1999; amd. Sec. 11, Ch. 193, L. 2003

39-71-1005. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. Sec. 1, Ch. 123, L. 1979.

39-71-1006. Rehabilitation benefits.

(1) A worker is eligible for rehabilitation benefits if:

(a)(i) the worker meets the definition of a disabled worker as provided in 39-71-1011; or

(ii) the worker has, as a result of the work-related injury, a whole person impairment rating of 15% or greater, as established by objective medical findings, and has no actual wage loss;

(b) a rehabilitation provider, as designated by the insurer, certifies that the worker has reasonable vocational goals and reasonable reemployment opportunity. If eligible because of an impairment rating of 15% or more, with rehabilitation the worker will have a reasonable increase in the worker's wage compared to the wage that the worker received at the time of injury. If eligible because of a wage loss, the worker will have a reasonable reduction in the worker's actual wage loss with rehabilitation.

(c) a rehabilitation plan is agreed upon by the worker and the insurer and a written copy of the plan is provided to the worker. The plan must take into consideration the worker's age, education, training, work history, residual physical capacities, and vocational interests. The plan must specify a beginning date and a completion date. The plan must specify the cost of tuition, fees, books, and other reasonable and necessary retraining expenses required to complete the plan.

(2) A disabled worker is entitled to receive biweekly rehabilitation benefits at the worker's temporary total disability rate. The benefits must be paid for the period specified in the rehabilitation plan, not to exceed 104 weeks. The rehabilitation plan must be completed within 26 weeks of the completion date specified in the plan. Rehabilitation benefits must be paid biweekly while the worker is satisfactorily progressing in the agreed-upon rehabilitation plan. Rehabilitation benefits payable pursuant to a retraining rehabilitation plan under this section are not payable in a lump sum. Rehabilitation benefits may be paid in a lump sum for job placement services.

(3) In addition to rehabilitation benefits payable under subsection (2), a disabled worker who was injured on or after July 1, 1997, is entitled to receive payment for tuition, fees, books, and other reasonable and necessary retraining expenses, excluding travel and living expenses paid pursuant to the provisions of 39-71-1025, as set forth in department rules and as specified in the rehabilitation plan. Expenses must be paid directly by the insurer.
(4) A worker may not receive temporary total benefits and the benefits under subsection (2) during the same period of time.
(5) A rehabilitation provider authorized by the insurer shall continue to assist the injured worker until the rehabilitation plan is completed.
(6) To be eligible for benefits under this section, a worker is required to begin the rehabilitation plan within 78 weeks of reaching maximum medical healing.
(7) A worker may not receive both wages and rehabilitation benefits without the written consent of the insurer. A worker who receives both wages and rehabilitation benefits without written consent of the insurer is guilty of theft and may be prosecuted under 45-6-301.

History: En. Sec. 10, Ch. 574, L. 1991; amd. Sec. 7, Ch. 296, L. 1993; amd. Sec. 24, Ch. 243, L. 1995; amd. Sec. 111, Ch. 546, L. 1995; Sec. 39-71-2001, MCA 1993; redes. 39-71-1006 by Code Commissioner, 1995; amd. Sec. 3, Ch. 122, L. 1997; amd. Sec. 14, Ch. 276, L. 1997; amd. Sec. 11, Ch. 103, L. 2005.

39-71-1007 through 39-71-1010 reserved.

39-71-1011. Definitions.

As used in this part, the following definitions apply:
(1) "Assistance fund" means the stay-at-work/return-to-work assistance fund provided for in 39-71-1049.
(2) "Commission on rehabilitation counselor certification" means the nonprofit, independent, fee-structured organization that is a member of the national commission for health certifying agencies and that is established to certify rehabilitation providers.
(3) "Disabled worker" means a worker who has a permanent impairment, established by objective medical findings, resulting from a work-related injury that precludes the worker from returning to the job the worker held at the time of the injury or to a job with similar physical requirements and who has an actual wage loss as a result of the injury.
(4) "Insurer's stay-at-work/return-to-work assistance policy" or "assistance policy" means a written stay-at-work/return-to-work policy that explains to the worker the process of evaluation, planning, implementation, and provision of services by the insurer prior to the determination that the worker meets the definition of a disabled worker. The services are intended to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan.
(5) "Rehabilitation benefits" means benefits provided in 39-71-1006 and 39-71-1025.
(6) "Rehabilitation plan" means a written individualized plan that assists a disabled worker in acquiring skills or aptitudes to return to work through job placement, on-the-job training, education, training, or specialized job modification and that reasonably reduces the worker's actual wage loss.
(7) "Rehabilitation provider" means a rehabilitation counselor certified by the commission on rehabilitation counselor certification and designated by the insurer.
(8) "Rehabilitation services" means a program of evaluation, planning, and implementation of a rehabilitation plan to assist a disabled worker to return to work.

(9) "Stay-at-work/return-to-work assistance" or "assistance" means the evaluation, planning, implementation, and provision of appropriate services prior to the determination that the worker meets the definition of a disabled worker that are designed to facilitate a worker's return to work as soon as possible following the worker's injury or occupational disease. This assistance may include a rehabilitation plan.

History: En. Sec. 34, Ch. 464, L. 1987; amd. Sec. 2, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 574, L. 1991; amd. Sec. 22, Ch. 243, L. 1995; amd. Sec. 108, Ch. 546, L. 1995; amd. Sec. 4, Ch. 122, L. 1997; amd. Sec. 49, Ch. 130, L. 2005; amd. Sec. 15, Ch. 167, L. 2011.

39-71-1012. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 36, Ch. 464, L. 1987.

39-71-1013. Repealed.

Sec. 8, Ch. 122, L. 1997; Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 43, Ch. 464, L. 1987; amd. Sec. 9, Ch. 574, L. 1991.

39-71-1014. Rehabilitation services – required and provided by insurers.

(1) Rehabilitation services are required for disabled workers and may be initiated by:
   (a)an insurer by designating a rehabilitation provider; or
   (b)a disabled worker through a request to the department. The department shall then require the insurer to designate a rehabilitation provider.

(2) Rehabilitation services provided under this part must be delivered through a rehabilitation counselor certified by the commission on rehabilitation counselor certification.

History: En. Sec. 37, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 109, Ch. 546, L. 1995; amd. Sec. 5, Ch. 122, L. 1997; amd. Sec. 50, Ch. 130, L. 2005.

39-71-1015. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 38, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1016. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 39, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1017. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 40, Ch. 464, L. 1987; amd. Sec. 9, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1018. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 41, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1019. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 42, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 40, Ch. 16, L. 1991.

39-71-1020 through 39-71-1022 reserved.

39-71-1023. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 44, Ch. 464, L. 1987; amd. Sec. 3, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1024. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 45, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 9, Ch. 9, Sp. L. June 1989.

39-71-1025. Auxiliary benefits.

(1) In addition to benefits otherwise provided in this chapter, separate benefits not exceeding a total of $4,000, adjusted as provided in subsection (2), may be paid by the insurer for specialized job modification, reasonable travel, and relocation expenses used for any of the following:
(a)search for new employment;
(b)return to work but in a new location;
(c)the implementation of a rehabilitation plan that has been filed with the department; or
(d)attendance at an on-the-job training program.

(2) The separate benefit may be adjusted by an amount that is the percentage increase, if any, in the current state's average weekly wage over the state's average weekly wage adopted for the previous year.

History: En. Sec. 46, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 11, Ch. 574, L. 1991; amd. Sec. 22, Ch. 167, L. 2011.

39-71-1026. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 47, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1027 through 39-71-1030 reserved.

39-71-1031. Exchange of information.

The insurer, the rehabilitation provider, and the department shall provide to one another case information as necessary to carry out the purposes of this part.

History: En. Sec. 48, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 110, Ch. 546, L. 1995; amd. Sec. 6, Ch. 122, L. 1997; amd. Sec. 23, Ch. 167, L. 2011.

39-71-1032. Termination of benefits for noncooperation with rehabilitation provider – appeal.

(1) If an insurer believes that a worker is refusing unreasonably to cooperate with the rehabilitation provider, the insurer, with 14 days' written notice to the worker and the department, may terminate any benefits, except medical benefits and the impairment award, that the worker is receiving until the worker cooperates.
(2) If the worker disputes the termination of benefits, the worker may, after mediation pursuant to department rule, petition the workers' compensation court for resolution of the dispute.

History: En. Sec. 49, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 12, Ch. 574, L. 1991; amd. Sec. 23, Ch. 243, L. 1995; amd. Sec. 7, Ch. 122, L. 1997; amd. Sec. 20, Ch. 442, L. 1999.

39-71-1033. Repealed.

Sec. 14, Ch. 574, L. 1991.

History: En. Sec. 50, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989.

39-71-1034 and 39-71-1035 reserved.

39-71-1036. Medical status form.

(1) The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease.
(2) The form must contain, at a minimum, the following information:
(a) the worker's first and last names and claim number;
(b) the affected body part that is directly related to the compensable injury or occupational disease;
(c) the timeframe during which the treating physician recommends that the worker be completely off work;
(d) the date or anticipated date of the worker's release to modified duty;
(e) the date or anticipated date of the worker's release to full duty;
(f) any temporary work restrictions applicable to the worker;
(g) any permanent work restrictions applicable to the worker; and
(h) the date of the worker's next appointment.
(3) An insurer may request additional information from the health care provider not contained in the department's form.
(4) The treating physician or a designee shall complete the form following every office visit with the worker.

History: En. Sec. 16, Ch. 167, L. 2011; amd. Sec. 4, Ch. 282, L. 2025.

39-71-1042. Request for and delivery of stay-at-work/return-to-work assistance.

(1) (a) A worker who is claiming an injury or occupational disease, an employer, or a medical provider may ask that the department furnish stay-at-work/return-to-work assistance. After the worker signs a claim for benefits, the department shall promptly attempt to determine which insurer is at risk for the injury or occupational disease and contact that insurer. The department shall advise the insurer of the request for stay-at-work/return-to-work assistance and shall coordinate the assistance with the insurer.

(b) if an insurer has accepted liability for the claim, the insurer shall provide stay-at-work/return-to-work assistance either in accordance with the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services. The insurer is directly liable for paying for the stay-at-work/return-to-work assistance furnished.

(c) if an insurer at risk has not accepted liability for the claim, the insurer may choose one of the following actions:

(i) the insurer at risk for the claim may initiate stay-at-work/return-to-work assistance either in accordance with the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services and shall notify the department within 3 business days of being contacted by the department that the insurer is acting under this subsection (1)(c)(i). If the insurer provides either type of assistance, the insurer becomes responsible for directly paying for the assistance. Payment of assistance pursuant to this subsection (1)(c)(i) does not constitute admission of liability or a waiver of any right of defense.

(ii) if the insurer at risk for the claim does not notify the department within 3 business days of being contacted by the department that the insurer will provide assistance, the department shall obtain stay-at-work/return-to-work assistance for the worker by designating a rehabilitation provider.

(d) if the department cannot promptly determine which insurer is at risk for coverage, the department shall obtain stay-at-work/return-to-work assistance for the worker by designating a rehabilitation provider.

(e) a rehabilitation provider designated by the department under this section shall bill the department for services provided. The department shall pay for the stay-at-work/return-to-work assistance out of the assistance fund until the maximum allowed amount of assistance is provided or until the insurer denies the claim and notifies the department of the denial.

(f) if an insurer is providing assistance pursuant to the insurer's stay-at-work/return-to-work assistance policy, the insurer shall provide in writing to a worker, with a copy to the department, an explanation of the stay-at-work/return-to-work assistance being provided to the worker under this section and shall include contact information for the person providing the assistance.

(2) Rather than make a request to the department, a worker, an employer, or a medical provider may directly ask the insurer to provide stay-at-work/return-to-work assistance.

(3) In the absence of a request by a worker, an employer, or a medical provider, an insurer may initiate and provide stay-at-work/return-to-work assistance by providing the worker with a copy of the insurer's stay-at-work/return-to-work assistance policy or by designating a rehabilitation provider to provide rehabilitation services.

(4) Stay-at-work/return-to-work assistance requested under this section is available as a service apart from a determination regarding indemnity benefits. A worker or an employer may decline to accept stay-at-work/return-to-work assistance. The failure of a worker to voluntarily agree to assistance is not a dispute concerning benefits. However, if the assistance provided under this part results in a job offer for a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury and the worker refuses the offer, the workers' indemnity benefits may end as provided in 39-71-701 and 39-71-712.

(5) Stay-at-work/return-to-work assistance is available at any time unless:
   (a) the worker, prior to a determination that the worker meets the definition of a disabled worker, has refused a job offer for a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury;
   (b) the worker has actually returned to work; or
   (c) the claim has been closed pursuant to 39-71-704(1)(f)(i) or indemnity benefits have been settled pursuant to the definition of a settled claim in 39-71-107.

(6) If the insurer determines that the worker has not suffered a compensable injury or occupational disease and denies liability for the claim, the insurer or the department shall terminate any stay-at-work/return-to-work assistance that was initiated before the insurer's denial of liability.

History: En. Sec. 17, Ch. 167, L. 2011.

39-71-1043. Rehabilitation provider – evaluation.

(1) Stay-at-work/return-to-work assistance must be provided by a rehabilitation provider pursuant to this section if:
   (a) the department provides assistance; or
   (b) an insurer elects to designate a rehabilitation provider instead of using the insurer's own stay-at-work/return-to-work assistance policy.

(2) (a) the rehabilitation provider shall evaluate and determine the stay-at-work/return-to-work capabilities of the worker pursuant to the stay-at-work/return-to-work goals listed in 39-71-1041.
   (b) if the worker has returned to work, the rehabilitation provider shall provide documentation of the assistance to the worker, the insurer, and the department.
   (c) if the worker has not returned to work and has not received a job offer to return to work, the rehabilitation provider shall document the reasons the stay-at-work/return-to- work assistance was unsuccessful. The documentation must be provided to the worker, the insurer, the treating physician, and the department.
   (d) the following conditions allow termination of assistance prior to the time a worker meets the definition of a disabled worker:
      (i) the worker has returned to work earning wages that are at least as much as at the time of injury;
      (ii) the worker has received an offer to return to work at a position that is within the worker's physical abilities, for which the worker is qualified, and for which the wages are at least equal to the worker's wages at the time of injury;
      (iii) the worker has returned to work in an alternative position that pays less than the worker's wages at the time of injury and that qualifies the worker for temporary partial disability benefits pursuant to 39-71-712; or
      (iv) the worker receives a job offer to return to work in a position that is within the worker's physical abilities, for which the worker is qualified, for which the wages are less than the worker's wages at the time of injury, and that qualifies the worker for temporary partial disability benefits under 39-71-712.
   (e) if a worker has requested stay-at-work/return-to-work assistance and a rehabilitation plan has been agreed to by the worker and the insurer, the plan continues until completed.

(3) If the worker or insurer disputes the availability or level of assistance, the worker or insurer may, after mediation, petition the workers' compensation court for resolution of the dispute.

History: En. Sec. 18, Ch. 167, L. 2011.

39-71-1044 through 39-71-1048 reserved.

39-71-1049. Stay-at-work/return-to-work assistance fund – purpose – payment process – rulemaking.

(1) There is a stay-at-work/return-to-work assistance fund in the proprietary fund category.
(2) The purpose of the assistance fund is to pay for stay-at-work/return-to-work assistance provided by the department so that assistance may be provided as early as practicable in the workers' compensation claims process.
(3) (a)The department may establish by rule:
(i) the amounts and types of assistance to be provided; and
(ii) the maximum hourly rate that may be charged for stay-at-work/return-to-work assistance obtained by the department and paid for by the assistance fund.
(b)the rules adopted under subsection (3)(a) regarding the payment amounts to rehabilitation providers do not apply if the insurer has taken direct responsibility for providing stay-at-work/return-to-work assistance.
(c)if rules are not adopted to implement subsection (3)(a), the department may not provide more than $2,000 in assistance.

History: En. Sec. 19, Ch. 167, L. 2011.

39-71-1050 .Assessment for stay-at-work/return-to-work assistance fund – definition.

(1) (a) the assistance fund must be maintained by assessing employers insured by plan No. 1, plan No. 2, and plan No. 3 an amount as provided in subsections (2) through (10).
(b) the board of investments shall invest the money in the assistance fund. The investment income must be deposited in the assistance fund.
(2) The assessment amount is the total amount paid by the assistance fund in the preceding fiscal year less other realized income that is deposited in the assistance fund. Allocation of the total assessment amount among employers insured by plan No. 1, plan No. 2, and plan No. 3 must be based on each plan's proportionate share of money expended from the assistance fund for the calendar year preceding the year in which the assessment is collected.
(3) On or before May 31 of each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. On or before April 30 of each year, the department shall consult with the advisory organization designated under 33-16-1023 and notify plan No. 2 insurers and plan No. 3, the state fund, of the premium surcharge rate to be effective for policies written or renewed on or after July 1 in that year.
(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is the amount actually expended by the assistance fund on behalf of injured workers employed by that plan No. 1 employer. A group of employers insured jointly under plan No. 1 is considered to be an individual employer for the purposes of this subsection.
(5) After subtracting plan No. 1 assessments from the total assessment, the department shall determine the surcharge rate for plan No. 2 insurers and plan No. 3, the state fund, by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured

under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided in subsection (9).

(6) Employers insured under plan No. 2 or plan No. 3 shall pay their portion of the assessment in a surcharge on premiums for policies written or renewed annually on or after July 1.

(7) (a) Each plan No. 2 insurer and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (5). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation stay-at-work/return-to-work assistance fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner as the premium for the coverage. The assessment premium surcharge must be excluded from the definition of premium for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium.

(b) if an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge described in 39-71-201 first, then to the assessment premium surcharge described in 50-71-128, then to the assessment premium surcharge in this section, and then to the surcharge in 39-71-915, with any remaining amount applied to the premium due.

(8) (a) The department shall deposit all assessments due under this section into the assistance fund.

(b) each plan No. 1 employer shall pay its assessment due under this section by July 1.

(c) each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter no later than 20 days following the end of the quarter.

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

(9) Each year, the department shall compare the amount of the assessment premium surcharge actually collected pursuant to subsection (5) with the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator for the following year's assessment premium surcharge as provided in subsection (5).

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

(11) As used in this section, "money expended" means expenditures for stay-at-work/return-to-work assistance from the assistance fund.

History: En. Sec. 20, Ch. 167, L. 2011; amd. Sec. 3, Ch. 365, L. 2015.

39-71-1051. Rulemaking authority.

The department may adopt rules to implement this part.

History: En. Sec. 21, Ch. 167, L. 2011.

Part 11
Treatment by Designated Providers

39-71-1101. Choice of health care provider by worker – insurer designation or approval of treating physician or referral to managed care or preferred provider organization – payment terms – definition.

(1) Prior to the insurer's designation or approval of a treating physician as provided in subsection (2) or a referral to a managed care organization or preferred provider organization as provided in subsection (8), a worker may choose a person who is listed in 39-71-116(42) for initial treatment. Subject to subsection (2), if the person listed under 39-71-116(42) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician.

(2) Any time after acceptance of liability by an insurer, the insurer may designate or approve a treating physician who agrees to assume the responsibilities of the treating physician. The designated or approved treating physician:

(a) is responsible for coordinating the worker's receipt of medical services as provided in 39-71-704;

(b) shall provide timely determinations required under this chapter, including but not limited to maximum medical healing, physical restrictions, return to work, and approval of job analyses, and shall provide documentation;

(c) shall provide or arrange for treatment within the utilization and treatment guidelines or obtain prior approval for other treatment; and

(d) shall conduct or arrange for timely impairment ratings.

(3) The treating physician may refer the worker to other health care providers for medical services, as provided in 39-71-704, for the treatment of a worker's compensable injury or occupational disease. A health care provider to whom the worker is referred by the designated treating physician is not responsible for coordinating care or providing determinations as required of the treating physician.

(4) The treating physician designated or approved by the insurer must be reimbursed at 110% of the department's fee schedule.

(5) A health care provider to whom the worker is referred by the treating physician must be reimbursed at 90% of the department's fee schedule.

(6) A health care provider providing health care on a compensable claim prior to the designation or approval of the treating physician by the insurer must be reimbursed at 100% of the department's fee schedule.

(7) Regardless of the date of injury, the medical fee schedule rates in effect as adopted by the department in 39-71-704 and the percentages referenced in subsections (4) through (6) of this section apply to the medical service on the date on which the medical service was provided.

(8) The insurer may direct the worker to a managed care organization or a preferred provider organization for designation of the treating physician.

(9) After the insurer directs a worker to a managed care organization or preferred provider organization, a health care provider who otherwise qualifies as a treating physician but who is not a member of a managed care organization may not provide treatment unless authorized by the insurer.

(10) After the date that a worker subject to the provisions of subsection (9) receives individual written notice of a referral, the worker must, unless otherwise authorized by the insurer, receive medical services from the organization designated by the insurer, in accordance with 39-71-1102 and 39-71-1104. The designated treating physician in the organization then becomes the worker's treating physician. The insurer is not liable for medical services obtained otherwise, except that a worker may receive immediate emergency medical treatment for a compensable injury from a health care provider who is not a member of a managed care organization or a preferred provider organization.

(11) Posting of managed care requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to a managed care organization must be provided to the worker in written form by mail or in person after the date of injury or occupational disease.

History: En. Sec. 5, Ch. 628, L. 1993; amd. Sec. 1, Ch. 468, L. 1999; amd. Sec. 24, Ch. 167, L. 2011; amd. Sec. 18, Ch. 55, L. 2015; amd. Sec. 3, Ch. 197, L. 2021.

39-71-1102. Preferred provider organizations -- establishment -- limitations.

(1) In order to promote cost containment of medical care provided for in 39-71-704, development of preferred provider organizations by insurers is encouraged. Insurers may establish arrangements with suppliers of soft and durable medical goods and health care providers in addition to or in conjunction with managed care organizations. Workers' compensation insurers may contract with other entities to use the other entities' preferred provider organizations. After the date that an injured worker is given an individual written notice by the insurer of a preferred provider, the insurer is not liable for charges from nonpreferred providers.

(2) Posting of preferred provider requirements in the workplace on bulletin boards, in personnel policies, in company manuals, or by other general or broadcast means does not constitute individual written notice. To constitute individual written notice under this section, information regarding referral to preferred providers must be provided to the worker in written form by mail or in person after the date of injury.

History: En. Sec. 6, Ch. 628, L. 1993; amd. Sec. 2, Ch. 468, L. 1999; amd. Sec. 25, Ch. 167, L. 2011.

39-71-1103. Workers' compensation managed care.

(1) A managed care system is a program organized to serve the medical needs of injured workers in an efficient and cost-effective manner by managing the delivery of medical services for a defined population of injured workers, pursuant to 39-71-1101, through appropriate health care professionals.

(2) The department shall develop criteria pursuant to 39-71-1105 for certification of managed care organizations. The department may adopt rules for certification of managed care organizations.

(3) Insurers may contract with certified managed care organizations for medical services for injured workers. A worker who is subject to managed care may choose from managed care organizations in the worker's community that have a contract with the insurer responsible for the worker's medical services.

History: En. Sec. 7, Ch. 628, L. 1993.

39-71-1104. Managed care organizations – notification.

Workers who are subject to managed care must receive medical services in the manner prescribed in the contract. Each contract must comply with the certification requirements provided in 39-71-1105. Insurers who contract with a managed care organization for medical services shall give written notice to workers of eligible service providers and shall give notice of the manner of receiving medical services.

History: En. Sec. 8, Ch. 628, L. 1993.

39-71-1105. Managed care organizations – application – certification.

(1) A health care provider, a group of medical service providers, or an entity with a managed care organization may make written application to the department to become certified under this section to provide managed care to workers for injuries or occupational diseases that are covered under this chapter. However, this section does not authorize an organization that is formed, owned, or operated by a workers' compensation insurer or self-insured employer other than a health care provider to become certified to provide managed care. When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought.

(2) Each application for certification must be accompanied by an application fee if prescribed by the department. A certificate is valid for the period prescribed by the department, unless it is revoked or suspended at an earlier date.

(3) The department shall establish by rule the form for the application for certification and the required information regarding the proposed plan for providing medical services. The information includes but is not limited to:

(a) a list of names of each individual who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for that individual to practice in the state;

(b) names of the individuals who will be designated as treating physicians and who will be responsible for the coordination of medical services;

(c) a description of the times, places, and manner of providing primary medical services under the plan;

(d) a description of the times, places, and manner of providing secondary medical services, if any, that the applicants wish to provide; and

(e) satisfactory evidence of the ability to comply with any financial requirements to ensure delivery of service in accordance with the plan that the department may require.

(4) The department shall certify a group of medical service providers or an entity with a managed care organization to provide managed care under a plan if the department finds that the plan:

(a) proposes to provide coordination of services that meet quality, continuity, and other treatment standards prescribed by the department and will provide all primary medical services that may be required by this chapter in a manner that is timely and effective for the worker;

(b) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of services;

(c) provides adequate methods of peer review and service utilization review to prevent excessive or inappropriate treatment, to exclude from participation in the plan those individuals who violate these treatment standards, and to provide for the resolution of any medical disputes that may arise;

(d) provides for cooperative efforts by the worker, the employer, the rehabilitation providers, and the managed care organization to promote an early return to work for the injured worker;

(e) provides a timely and accurate method of reporting to the department necessary information regarding medical and health care service cost and utilization to enable the department to determine the effectiveness of the plan;

(f) authorizes workers to receive medical treatment from a primary care physician who is not a member of the managed care organization but who maintains the worker's medical records and with whom the worker has a documented history of treatment, if that primary care physician agrees to refer the worker to the managed care organization for any specialized treatment, including physical therapy, that the worker may require and if that primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed by the managed care organization. As used in this subsection (4)(f), "primary care physician" means a physician who is qualified to be a treating physician and who is a family practitioner, a general practitioner, an internal medicine practitioner, or a chiropractor.

(g) complies with any other requirements determined by department rule to be necessary to provide quality medical services and health care to injured workers.

(5) The department shall refuse to certify or may revoke or suspend the certification of a health care provider, a group of medical service providers, or an entity with a managed care organization to provide managed care if the department finds that:

(a) the plan for providing medical care services fails to meet the requirements of this section; and

(b) service under the plan is not being provided in accordance with the terms of a certified plan.

History: En. Sec. 9, Ch. 628, L. 1993; amd. Sec. 28, Ch. 416, L. 2005.

39-71-1106. Compliance with medical treatment required -- termination of compensation benefits for noncompliance.

An insurer that provides 14 days' notice to the worker and the department may terminate any compensation benefits that the worker is receiving until the worker cooperates, if the insurer believes that the worker is unreasonably refusing:

(1) To cooperate with a managed care organization, a preferred provider organization, or the treating physician;

(2) To submit to medical treatment recommended by the treating physician, except for invasive procedures; or

(3) To provide access to health care information to health care providers, the insurer, or an agent of the insurer.

History: En. Sec. 10, Ch. 628, L. 1993; amd. Sec. 26, Ch. 167, L. 2011.

39-71-1107. Domiciliary care -- requirements -- evaluation.

(1) Reasonable domiciliary care must be provided by the insurer:

(a) from the date the insurer knows of the employee's need for home medical services that results from an industrial injury;

(b) when the preponderance of credible medical evidence demonstrates that nursing care is necessary as a result of the accident and describes with a reasonable degree of particularity the nature and extent of duties to be performed;

(c) when the services are performed under the direction of the treating physician who, following a nursing analysis, prescribes the care on a form provided by the department;

(d) when the services rendered are of the type beyond the scope of normal household duties; and

(e) when subject to subsections (3) and (4), there is a means to determine with reasonable certainty the value of the services performed.

(2) When a worker suffers from a condition that requires domiciliary care, which results from the accident, and requires nursing care as provided for in Title 37, chapter 8, a licensed nurse shall provide the services.

(3) When a worker suffers from a condition that requires 24-hour care and that results from the accident but that requires domiciliary care other than as provided in Title 37, chapter 8, the care may be provided by a family member. The insurer's responsibility for reimbursement for the care is limited to no more than the daily statewide average medicaid reimbursement rate for the current fiscal year for care in a nursing home. The insurer is not responsible for respite care.

(4) Domiciliary care by a family member that is necessary for a period of less than 24 hours a day may not exceed the hourly mean wage by area for home health aides, as published by the department in the most recent edition of the Montana Informational Wage Rates by Occupation and adopted annually by the department prior to January 1. The insurer is not liable for more than 8 hours of care each day at the rate in effect at the time that the services are rendered.

History: En. Sec. 11, Ch. 628, L. 1993; amd. Sec. 8, Ch. 117, L. 2007.

39-71-1108. Physician self-referral prohibition.

(1) Unless authorized by the insurer, a treating physician may not refer a claimant to a health care facility at which the physician does not directly provide care or services when the physician has an investment interest in the facility, unless there is a demonstrated need in the community for the facility and alternative financing is not available. The insurer or the claimant is not liable for charges incurred in violation of this section.

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

History: En. Sec. 12, Ch. 628, L. 1993; amd. Sec. 18, Ch. 516, L. 1995.

39-71-1109. Repealed.

Sec. 13, Ch. 310, L. 1997.

History: En. Sec. 13, Ch. 628, L. 1993.

39-71-1110. Schedule II and III drugs – prescriber obligation.

(1) In order to ensure high-quality health care for an individual with a compensable occupational injury or disease, prescriptions for Schedule II or Schedule III drugs identified in Title 50, chapter 32, part 2, may be carefully monitored for potential abuse, dependence, interaction, and diversion. Ongoing prescriptions for Schedule II and Schedule III drugs may be prescribed only by a treating physician.

(2) (a)A treating physician authorized to prescribe prescription drugs may query the prescription drug registry provided for in Title 37, chapter 7, part 15, prior to the initial prescribing or refilling of a Schedule II or Schedule III drug for treatment of a workers' compensation injury or occupational disease. After consulting the prescription drug registry, a treating physician may decline to prescribe or refill a Schedule II or Schedule III drug if, in the treating physician's judgment, the drug should not be prescribed or refilled.

(b)prior to the initial prescribing of a Schedule II or Schedule III drug, a treating physician may discuss the risks and benefits of the use of the controlled substance, including risk of tolerance and drug dependence, with the patient or the patient's legal guardian.

(c)a treating physician shall note in the patient's medical file each query conducted.

(3) This section does not apply to a health care provider administering a Schedule II or Schedule III drug under the following circumstances:

(a)immediately prior to or after surgery;

(b)at the scene of an emergency;

(c)in a licensed ambulance; or

(d)in the emergency department or intensive care unit of a licensed hospital.

History: En. Sec. 1, Ch. 407, L. 2013.

Parts 12 through 13 reserved

Part 14
Presumptive Occupational Disease - Firefighters

39-71-1401. *(Temporary)* Presumptive occupational disease for firefighters – rebuttal – applicability – definitions.

(1) (a)A firefighter for whom coverage is required under the Workers' Compensation Act is presumed to have a claim for a presumptive occupational disease under the Workers' Compensation Act if the firefighter meets the requirements of 39-71-1402 and is diagnosed with one or more of the diseases listed in subsection (2) within the period listed.

(b)coverage under 39-71-1402 and this section is optional for the employer of a firefighter for whom coverage under the Workers' Compensation Act is voluntary. An employer of a volunteer firefighter under 7-33-4109 or 7-33-4510 may elect as part of providing coverage under the Workers' Compensation Act to additionally obtain the presumptive occupational disease coverage, subject to the insurer agreeing to provide presumptive coverage.

(2) The following diseases are presumptive occupational diseases proximately caused by firefighting activities, provided that the evidence of the presumptive occupational disease becomes manifest after the number of years of the firefighter's employment as listed for each occupational disease and within 10 years of the last date on which the firefighter was engaged in firefighting activities for an employer:

(a)bladder cancer after 12 years;

(b)brain cancer of any type after 10 years;

(c)breast cancer after 5 years if the diagnosis occurs before the firefighter is 40 years old and is not known to be associated with a genetic predisposition to breast cancer;

(d)cervical cancer after 15 years;

(e)colorectal cancer after 10 years;

(f) esophageal cancer after 10 years;
(g) kidney cancer after 15 years;
(h) leukemia after 5 years;
(i) lung cancer after 4 years;
(j) mesothelioma or asbestosis after 10 years;
(k) ultiple myeloma after 15 years;
(l) myocardial infarction after 10 years;
(m) non-Hodgkin's lymphoma after 15 years; and
(n) testicular cancer after 10 years.

(3) For purposes of calculating the number of years of a firefighter's employment history under subsection (2), a firefighter's employment history after July 1, 2014, may be calculated.

(4) The beneficiaries of a firefighter who otherwise would be eligible for presumptive occupational disease benefits under this section but who dies prior to filing a claim, as provided in 39-71-1402, are eligible for death benefits in the same manner as for a death from an injury, as provided in 39-71-407. The beneficiaries under this subsection are similarly bound by the provisions of exclusive remedy as provided in 39-71-411 and subject to the filing requirements in 39-71-601.

(5) (a) Subject to the provisions of subsection (5)(c), an insurer is liable for the payment of compensation for presumptive occupational disease benefits under this chapter in the same manner as provided in 39-71-407, including objective medical findings of a disease listed in subsection (2) but excluding the requirement in 39-71-407(10) that the objective medical findings trace a relationship between the presumptive occupational disease and the claimant's job history. For myocardial infarction or lung cancer under subsection (2), the diseases must be the type that can reasonably be caused by firefighting activities.

(b)(i) an insurer under plan 1, 2, or 3 that disputes a presumptive occupational disease claim has the burden of proof in establishing by a preponderance of the evidence that the firefighter is not suffering from a compensable presumptive occupational disease. An insurer that disputes the claim may pay benefits under 39-71-608 or 39-71-615 and may pursue dispute mechanisms established in Title 39, chapter 71, part 24.

(ii) an insurer is not liable for the payment of workers' compensation benefits for presumptive occupational disease if the insurer establishes by a preponderance of the evidence that the firefighter was not exposed during the course and scope of the firefighter's duties to smoke or particles in a quantity sufficient to have reasonably caused the disease claimed.

(c) a total claim payment by an insurer under this section is limited to $5 million for each claim.

(6) This section does not limit an insurer's ability to assert that the occupational disease was not caused by the firefighter's employment history as a firefighter.

(7) A firefighter or the firefighter's beneficiaries may pursue the dispute remedies as provided in Title 39, chapter 71, part 24, if an insurer disputes a claim.

(8) The use of the term "occupational disease" includes a presumptive occupational disease when used in the definitions in 39-71-116 for "claims examiner", "permanent partial disability", "primary medical services", and "treating physician" and when used in 39-71-107, 39-71-307, 39-71-412, 39-71-503, 39-71-601, 39-71-604, 39-71-606, 39-71-615, 39-71-703, 39-71-704, 39-71-713, 39-71-714, 39-71-717, 39-71-1011, 39-71-1036, 39-71-1041, 39-71-1042, 39-71-1101, 39-71-1110, 39-71-1504, 39-71-2311, 39-71-2312, 39-71-2313, 39-71-2316, and 39-71-4003.

(9) Section 39-71-1402 and this section:
(a) apply only to presumptive occupational diseases for firefighters; and

(b) do not apply to any other issue relating to workers' compensation and may not be used or cited as guidance in the administration of Title 33 or 37.

(10) For the purposes of 39-71-1402 and this section, the following definitions apply:

(a) "Firefighter" means an individual whose primary duties involve extinguishing or investigating fires, with at least 1 year of firefighting operations in Montana beginning on or after July 1, 2019, as:

(i) a firefighter defined in 19-13-104;

(ii) a volunteer firefighter defined in 7-33-4510, but only if the volunteer firefighter's employer has elected coverage under Title 39, chapter 71, with an insurer that allows an election and the employer has opted separately to include presumptive occupational disease coverage under 39-71-1402 and this section; or

(iii) a volunteer described in 7-33-4109 for a firefighting entity that has elected coverage under Title 39, chapter 71, with an insurer that allows an election and that has opted separately to include presumptive occupational disease coverage.

(b) "firefighting activities" means actions required of a firefighter that expose the firefighter to extreme heat or inhalation or physical exposure to chemical fumes, smoke, particles, or other toxic gases arising directly out of employment as a firefighter.

(c) "presumptive occupational disease" means harm or damage from one or more of the diseases listed under subsection (2) that is established by objective medical findings and that is contracted in the course and scope of employment as a firefighter from either a single day or work shift or for more than a single day or work shift but that is not specific to an accident. (Void on occurrence of contingency–sec. 7, Ch. 158, L. 2019.)

History: En. Sec. 1, Ch. 158, L. 2019 ; amd. Sec. 1, Ch. 442, L. 2023.

39-71-1402. (Temporary) Conditions for claiming presumptive occupational disease.

(1) Except as provided in subsection (4), the following must be satisfied for the presumption in 39-71-1401 to apply:

(a) the firefighter must timely file a claim for a presumptive occupational disease under Title 39, chapter 71, as soon as the firefighter knows or should have known that the firefighter's condition resulted from a presumptive occupational disease; and

(b)(i) the firefighter must have undergone, within 90 days of hiring, a medical examination that did not reveal objective medical evidence or a family history of the presumptive occupational disease for which the presumption under 39-71-1401 is sought; and

(ii) the firefighter must have undergone subsequent periodic medical examinations at least once every 2 years.

(2) (a) Subsection (1)(b) does not require the employer of a firefighter to provide or pay for a medical examination, either at the time of hiring or during the subsequent term of employment.

(b) if the employer of a firefighter does not provide or pay for a medical examination under subsection (1)(b), the firefighter may satisfy the requirements of subsection (1)(b) by obtaining the medical examination at the firefighter's expense or at the expense of another party.

(3) To qualify for a presumptive occupational disease, a firefighter may not:

(a) be a regular user of tobacco products;

(b) have a history of regular tobacco use in the 10 years preceding the filing of the claim under subsection (1)(a); or

(c) have been exposed by a cohabitant who regularly and habitually used tobacco products within the home for a period of 10 or more years prior to the diagnosis.

(4) A firefighter who, prior to July 1, 2019, did not receive a medical examination as frequently as the intervals set forth in subsection (1)(b) is not ineligible on that basis for a presumptive occupational disease claim under 39-71-1401 and this section. (Void on occurrence of contingency–sec. 7, Ch. 158, L. 2019.)

History: En. Sec. 2, Ch. 158, L. 2019.

Part 15
Montana Safety Culture Act

39-71-1501. Short title.

This part may be cited as the "Montana Safety Culture Act".

History: En. Sec. 1, Ch. 295, L. 1993; amd. Sec. 1, Ch. 170, L. 2003.

39-71-1502. Purpose.

The purpose of this part is to reduce the incidence of occupational injury and illness by promoting safety in the workplace in order to control the costs of claims for workers' compensation insurance. The creation of a safety culture requires employers to provide training and education to make safety awareness part of the requirement for each worker's satisfactory job performance and requires the department to promote safety awareness for the public through the education and preparation of each student for entrance into the labor market. A reduction in workplace injuries, illnesses, and deaths through enhanced safety on the job benefits the public as well as the employers and the employees by lowering both financial and physical costs. Ensuring immunity to insurers in the provision of safety consultation services encourages and promotes safety in the workplace and improves the relationship between employers and employees.

History: En. Sec. 2, Ch. 295, L. 1993; amd. Sec. 2, Ch. 170, L. 2003.

39-71-1503. Safety consultation.

(1) As used in this part, "safety consultation services" means assistance rendered by an insurer or the department to advise and aid an employer in the identification, evaluation, and control of existing and potential accidental and occupational health problems. The services may be delivered in person, by mail, electronically, or by telephone, based upon need.

(2) Safety consultation services include but are not limited to:

(a) surveys consisting of onsite identification and subsequent evaluation of exposures relative to employees, materials, equipment, work methods, processes, and facilities;

(b) recommendations expressed in the form of communications to an employer, with reference to control of exposures to occupational accident, injury, or illness and to improvement of safety programs and systems;

(c) education and training programs, including aids, programs, and materials made available to assist in the control of exposures;

(d) consultations to advise employers relative to risk, exposure, and experience in the employer's business;

(e) accident analysis consisting of review of reported accidents to determine cause and trends; and

(f) industrial hygiene services, including recognition, evaluation, and control of chemical, physical, and biological exposures.

History: En. Sec. 3, Ch. 295, L. 1993; amd. Sec. 3, Ch. 170, L. 2003; amd. Sec. 16, Ch. 27, L. 2009.

39-71-1504. Safety programs – educational activities.

(1) To promote health and safety in places of employment in this state:
   (a) each public or private employer shall establish and administer a safety program in accordance with rules adopted by the department pursuant to 39-71-1505; and
   (b) the department, relying upon the support and assistance of concerned private entities or other governmental agencies, shall produce and distribute material to the schools of Montana and provide guest speakers intended to:
      (i) educate students about the necessity for safe work practices;
      (ii) prepare students to embark on accident-free careers; and
      (iii) disseminate information promoting the reduction and control of the rate of incidence of workplace injuries or occupational disease.

(2) An employer who employs temporary workers shall include those workers in the employer's safety program. A temporary services contractor shall provide a safety program for employees not employed by other employers.

(3) The department may issue a safety recommendation to an employer who fails to comply with the requirements of this section or with rules adopted by the department pursuant to 39-71-1505.

History: En. Sec. 4, Ch. 295, L. 1993; amd. Sec. 1, Ch. 58, L. 2001.

39-71-1505. Rulemaking authority.

The department shall adopt rules, including but not limited to rules that require:

(1) Each employer to conduct an educational-based safety program, including but not limited to:
   (a) a safety training program to provide:
      (i) new employee general safety orientation;
      (ii) job- or task-specific safety training; and
      (iii) continuous refresher safety training, including periodic safety meetings;
   (b) periodic hazard assessment, with corrective actions identified; and
   (c) appropriate documentation of performance of the activities; and

(2) An employer of more than five employees to have a comprehensive and effective safety program, including but not limited to:
   (a) subject to subsection (3), a safety committee composed of employee and employer representatives that holds regularly scheduled meetings;
   (b) procedures of reporting and investigating all work-related incidents, accidents, injuries, and illnesses; and
   (c) policies and procedures that assign specific safety responsibilities and safety performance accountability.

(3) The department may adopt rules authorizing:
   (a) a plan No. 2 or plan No. 3 insurer to waive the requirement in subsection (2)(a) for a safety committee if the employer presents sufficient evidence of an effective written safety plan and has a satisfactory modification factor, if applicable, or has a low incident record of injuries; or
   (b) the department to waive the requirement in subsection (2)(a) for a safety committee if a plan No. 1 insurer approved by the department presents sufficient evidence of an effective safety program, including a written safety plan. A waiver granted under this subsection (3)(b) to a member of the self-insurers guaranty fund must be made with the concurrence of the fund.

History: En. Sec. 5, Ch. 295, L. 1993; amd. Sec. 1, Ch. 238, L. 1995.

39-71-1506. Notification of safety consultation services available by insurer.

To implement safety requirements, each insurer shall notify each insured employer of the type of safety consultation services available and the location where the safety consultation services may be requested.

History: En. Sec. 6, Ch. 295, L. 1993.

39-71-1507. Safety consultation services – safety program as provision of insurance contract or agreement.

(1) Each insurer shall provide safety consultation services to each of its insured employers who request the assistance.
(2) The safety consultation services to be provided are within the discretion of the insurer but must include consideration of the hazard, experience, and size of the insured employer's operations.
(3) The insurer shall establish a system of priorities to use in responding to worksite safety consultation service requests, giving first priority to insured employers that have an unreasonably high actual or potential loss experience.
(4) Each insurer's insurance contract or agreement must require each insured employer to implement a safety program as part of the contract or agreement to provide workers' compensation coverage.

History: En. Sec. 7, Ch. 295, L. 1993.

Cross-References

Safety program requirement in workers' compensation policies, 33-15-318.

39-71-1508. Safety consultation services – insurer's exemption from civil liability – exceptions.

(1) The furnishing of or the failure to furnish safety consultation services related to, in connection with, or incidental to a workers' compensation insurance contract or agreement to provide workers' compensation coverage does not subject the insurer or its agents, employees, or service contractors to liability for damages from injury, loss, or death, whether direct or consequential, occurring as a result of any act or omission by any person in the course of providing safety consultation services.
(2) Subsection (1) does not apply:
   (a) if the injury, loss, or death occurred during the actual performance of safety consultation services and was directly and proximately caused by the negligence of the insurer or its agents, employees, or service contractors;
   (b) to any safety consultation services required to be performed under the provisions of a written service contract for which a specific charge is made and not incidental to a policy of insurance; or
   (c) in an action against an insurer or its agents, employees, or service contractors for damages caused by the act or omission of the insurer or its agents, employees, or service contractors in which it is judicially determined that the act or omission constituted a crime or involved actual malice.

History: En. Sec. 9, Ch. 295, L. 1993.

Parts 16 through 19 Reserved

Part 20
Rehabilitation Benefits (Renumbered)

39-71-2001. Renumbered 39-71-1006.

Code Commissioner, 1995.

Part 21
Compensation Plan Number One

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-2101. General requirements for electing coverage under plan.

(1) An employer may elect to be bound by compensation plan No. 1 upon furnishing satisfactory proof to the department and the Montana self-insurers guaranty fund of solvency and financial ability to pay the compensation and benefits provided for in this chapter and to discharge all liabilities that are reasonably likely to be incurred during the fiscal year for which the election is effective. The employer may, by order of the department and with the concurrence of the guaranty fund, make the payments directly to employees as they become entitled to receive payments under the terms and conditions of this chapter.

(2) Employers who comply with the provisions of this chapter and who are participating in collectively bargained, jointly administered Taft-Hartley trust funds are eligible to provide self-insured workers' compensation benefits for their employees.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2970, R.C.M. 1921; re-en. Sec. 2970, R.C.M. 1935; amd. Sec. 2, Ch. 443, L. 1973; R.C.M. 1947, 92-901; amd. Sec. 81, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 163, L. 1991; amd. Sec. 7, Ch. 619, L. 1993.

39-71-2102. Proof of solvency to be filed.

Each employer who has elected to be bound by compensation plan No. 1 shall file proof of solvency within the time and in the form prescribed by the rules or orders of the department.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2971, R.C.M. 1921; amd. Sec. 5, Ch. 139, L. 1931; re-en. Sec. 2971, R.C.M. 1935; amd. Sec. 3, Ch. 176, L. 1957; amd. Sec. 169, Ch. 147, L. 1963; amd. Sec. 1, Ch. 183, L. 1965; amd. Sec. 1, Ch. 170, L. 1969; amd. Sec. 1, Ch. 143, L. 1971; amd. Sec. 3, Ch. 443, L. 1973; amd. Sec. 2, Ch. 318, L. 1975; R.C.M. 1947, 92-902; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1549, Ch. 56, L. 2009.

39-71-2103. Employer permitted to carry on business and settle directly with employee – individual liability.

(1) If the employer making the election is found by the department and the Montana self-insurers guaranty fund to have the requisite financial ability to pay the compensation and benefits in this chapter, then the department, with the concurrence of the guaranty fund, shall grant to the employer permission to carry on business for the year within which the election is made and proof

filed, or the remaining portion of the year, and to make payments directly to the employees as they may become entitled to receive the payments.

(2) Each individual employer in an association, corporation, limited liability company, or organization of employers given permission by the department to operate as self-insured under plan No. 1 of this chapter is jointly and severally liable for all obligations incurred by the association, corporation, limited liability company, or organization under this chapter. An association, corporation, limited liability company, or organization of employers given permission to operate as self-insured shall maintain excess liability coverage in amounts and under conditions as provided by rules of the department.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2972, R.C.M. 1921; re-en. Sec. 2972, R.C.M. 1935; amd. Sec. 51, Ch. 23, L. 1975; R.C.M. 1947, 92-903(part); amd. Sec. 2, Ch. 480, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 2, Ch. 163, L. 1991; amd. Sec. 19, Ch. 516, L. 1995.

39-71-2104. Renewal of application.

An employer, so long as that employer continues to employ and continues to be bound by compensation plan No. 1, shall annually renew the application to be permitted to continue to make payments directly to employees for the next year. The department may, with the concurrence of the Montana self-insurers guaranty fund, renew the application from year to year. The annual renewal application must be in the form, for the period, and subject to the time limits prescribed by the department.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2972, R.C.M. 1921; re-en. Sec. 2972, R.C.M. 1935; amd. Sec. 51, Ch. 23, L. 1975; R.C.M. 1947, 92-903(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 3, Ch. 163, L. 1991; amd. Sec. 10, Ch. 555, L. 1993.

39-71-2105. Additional proof of solvency -- revocation of order.

(1) The department, with the concurrence of the Montana self-insurers guaranty fund, may at any time require from any employer acting under compensation plan No. 1 additional proof of solvency and financial ability to pay the benefits provided by this chapter.

(2) The department may, after providing an opportunity for an administrative review conference to consider information submitted by a plan No. 1 employer, revoke any order of approval upon 20 days' notice to the employer. A decision to revoke approval involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund. A plan No. 1 employer that is dissatisfied with the decision following the administrative review conference may appeal the decision and request a contested case hearing pursuant to 39-71-2401(2).

(3) A decision revoking an order of approval is final unless the employer files an appeal with the department within 20 days of the issuance of the notice. An employer may not continue to self insure after the 20-day period provided for in subsection (2) has expired unless the department is satisfied that the employer has provided sufficient security and financial ability to pay the benefits provided by this chapter. A decision issued pursuant to this subsection involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2973, R.C.M. 1921; re-en. Sec. 2973, R.C.M. 1935; amd. Sec. 52, Ch. 23, L. 1975; R.C.M. 1947, 92-904; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 150, L. 1993; amd. Sec. 7, Ch. 69, L. 2005.

39-71-2106. Requiring security of employer.

(1) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require any employer who elects to be bound by compensation plan No. 1 to provide a security deposit in accordance with rules adopted by the department. All securities of the United States treasury must be in book-entry form. The security deposit may be a surety bond, government bond, certificate of deposit, or letter of credit approved by the department and the Montana self-insurers guaranty fund. For the first 3 years of operating as a self-insured employer, the employer's security deposit must be the greater of:

(i) $250,000; or

(ii) an average of the workers' compensation liabilities incurred by the employer in Montana for the first 3 of the last 4 completed calendar years.

(b) the department, with the concurrence of the Montana self-insurers guaranty fund, may, in accordance with rules adopted by the department, require a larger deposit as additional evidence of ability to pay the benefits provided by this chapter.

(c) the department may, with the concurrence of the Montana self-insurers guaranty fund, reduce the amount of the security deposit if the evidence indicates that the full amount of the deposit is unnecessary.

(2) (a) The department, with the concurrence of the Montana self-insurers guaranty fund, may require an employer to give security in addition to the security deposit described in subsection (1) if:

(i) the department, with the concurrence of the Montana self-insurers guaranty fund, determines that the employer lacks the ability to pay the benefits that are expected to be paid by the employer under the terms and conditions of this chapter that are chargeable to the employer during the year to be covered by the permission provided for in 39-71-2103; or

(ii) the employer is a group of individual employers seeking permission to operate under compensation plan No. 1.

(b) the additional security required in subsection (2)(a) must be an amount that the department, with the concurrence of the Montana self-insurers guaranty fund, finds reasonable and necessary to pay the benefits provided under the terms and conditions of this chapter that the employer may accrue during the year.

(3) (a) The security deposit provided for in subsection (1) must be deposited with the department. The security deposit may consist of:

(i) a bond executed to the department with a surety. The security deposit must state that the employer will pay or cause to be paid to employees the amount for which the employer was given permission under 39-71-2103 and for which the employer is liable under the terms and conditions of this chapter during the year.

(ii) any Montana state, county, municipal, or school district bonds that the department and the Montana self-insurers guaranty fund consider solvent; or

(iii) other security deposits allowed in subsection (1)(a).

(b) each security deposit and the character and amount of the security deposit are subject to approval, revision, or change considered necessary by the department and the Montana self-insurers guaranty fund.

(c) upon proof of the final payment of the liability for which the security deposit is given, the security deposit or any remainder of the security deposit must be returned to the depositor.

(d) payment must be made from the security deposit within 30 days of a demand by the department for payment. If payment is not made within 30 days by the obligor on the security deposit, the obligor is liable to the department for interest at the annual rate of 10% on the amount unpaid.

(4) The department is liable for the value and safekeeping of all security deposits and shall, at any time, upon demand of the depositor, account for the security deposits.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2974, R.C.M. 1921; re-en. Sec. 2974, R.C.M. 1935; amd. Sec. 53, Ch. 23, L. 1975; R.C.M. 1947, 92-905; amd. Sec. 3, Ch. 480, L. 1985; amd. Sec. 51, Ch. 464, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 120, L. 1991; amd. Sec. 9, Ch. 558, L. 1991; amd. Sec. 2, Ch. 150, L. 1993; amd. Sec. 11, Ch. 555, L. 1993; amd. Sec. 1, Ch. 83, L. 1995; amd. Sec. 9, Ch. 117, L. 2007.

39-71-2107. When employer to make deposit or security to guarantee payment of compensation.

Within 30 days after the happening of an accident where death or the nature of the injury renders the amount of future payments certain or reasonably certain, the employer shall make a deposit or give security, as herein defined, with the department for the protection and guaranty of the payment of such liability in such sum as the department may direct. However, if sufficient securities are already on deposit with the department or if the department determines that the employer has sufficient financial responsibility to meet the liability of the employer, together with other liabilities already accrued, no such additional deposit or security shall be demanded.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2976, R.C.M. 1921; re-en. Sec. 2976, R.C.M. 1935; amd. Sec. 55, Ch. 23, L. 1975; R.C.M. 1947, 92-907; amd. Sec. 64, Ch. 613, L. 1989.

39-71-2108. Failure of employer to pay benefits -- duty of department.

Upon the failure of the employer to pay any benefits provided for in this chapter upon the terms, in the amounts, and at the times when the benefits become due and payable, the department shall, upon demand of the person to whom benefits are due, apply any deposits made with the department to the payment of the benefits, and the department shall take the proper steps to convert any securities on deposit with the department or sufficient deposits to pay the liabilities of the employer accruing under the terms of this chapter. The department shall, when necessary, collect and enforce the collection of the liability of all sureties upon any bonds that may be given by the employer to ensure the payment of the employer's liability. The department is considered the owner of the deposit and security and the obligee in the bond in trust for the purposes and may proceed in its own name to recover upon the bonds or foreclose and liquidate the securities. All interest earnings on liquidated security deposits must be retained by the department for payment of benefits pursuant to this section.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2975, R.C.M. 1921; re-en. Sec. 2975, R.C.M. 1935; amd. Sec. 54, Ch. 23, L. 1975; R.C.M. 1947, 92-906; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 8, Ch. 69, L. 2005.

39-71-2109. Repealed.

Sec. 21, Ch. 555, L. 1993.

History: En. Sec. 30, Ch. 96, L. 1915; re-en. Sec. 2977, R.C.M. 1921; re-en. Sec. 2977, R.C.M. 1935; amd. Sec. 56, Ch. 23, L. 1975; R.C.M. 1947, 92-908; amd. Sec. 2, Ch. 471, L. 1985; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 4, Ch. 163, L. 1991.

39-71-2110 through 39-71-2114 reserved.

39-71-2115. Transfer of claim liabilities – rules.

(1) A current or former self-insurer or group may transfer existing workers' compensation claim liabilities to another entity upon authorization from the department and concurrence of the Montana self-insurers guaranty fund by:
(a)submitting an application on a form designated by the department;
(b)completing an agreement of assumption and guarantee of workers' compensation liabilities;
(c)submitting a loss portfolio transfer agreement; and
(d)posting a security deposit.
(2) If the assuming entity fails to meet the terms of the transfer agreement, liability reverts to the original self-insurer.
(3) The entity assuming liability for a claim shall comply with all reporting requirements set by the department.
(4) The department shall adopt rules to implement this section.

History: En. Sec. 2, Ch. 112, L. 2009.

Part 22
Compensation Plan Number Two

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.
Employee defined, 39-71-118.
Injury defined, 39-71-119.

39-71-2201. Election to be bound by plan – captive reciprocal insurers.

(1) Any employer except those specified in 39-71-403 may, by filing an election to become bound by compensation plan No. 2, insure the employer's liability to pay the compensation and benefits provided by this chapter with any insurance company authorized to transact such business in this state.
(2) Any employer electing to become bound by compensation plan No. 2 shall make the election on the form and in the manner prescribed by the department.
(3) A captive reciprocal insurer established by or on behalf of an employer or a group of employers is considered to be a compensation plan No. 2 insurer. Pursuant to 33-28-205, a captive reciprocal insurer may not be a member of an insurance guaranty association or guaranty fund.

History: (1)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2978, R.C.M. 1921; re-en. Sec. 2978, R.C.M. 1935; amd. Sec. 1, Ch. 49, L. 1961; Sec. 92-1001, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; Sec. 92-1002, R.C.M. 1947; R.C.M. 1947, 91-1001, 92-1002(1); amd. Sec. 82, Ch. 397, L. 1979; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 117, L. 2007.

39-71-2202. Policies made subject to chapter.

Every policy for insurance written under compensation plan No. 2 shall be considered to be made subject to the provisions of this chapter.

History: En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2982, R.C.M. 1921; re-en. Sec. 2982, R.C.M. 1935; amd. Sec. 1, Ch. 217, L. 1951; amd. Sec. 5, Ch. 176, L. 1957; amd. Sec. 1, Ch. 203, L. 1959; amd. Sec. 170, Ch. 147, L. 1963; amd. Sec. 1, Ch. 142, L. 1971; amd. Sec. 59, Ch. 23, L. 1975; amd. Sec. 3, Ch. 318, L. 1975; R.C.M. 1947, 92-1005; amd. Sec. 13, Ch. 103, L. 1979.

39-71-2203. Content of policies – policies subject to approval, change, or revision by department.

(1) All policies insuring the payment of compensation under this chapter must contain a clause to the effect that, as between the employee and the insurer:
   (a) the notice to or knowledge of the occurrence of the injury on the part of the insured constitutes notice or knowledge, as the case may be, on the part of the insurer;
   (b) jurisdiction of the insured for the purpose of this chapter is the jurisdiction of the insurer; and
   (c) the insurer is in all things bound by and subject to the awards, orders, judgments, or decrees rendered against the insured.

(2) A policy may not be issued unless it contains the agreement of the insurer that it will promptly pay to the person entitled to compensation all the installments of compensation or other payments provided for in this chapter and that the obligation is not affected by any default of the insured after the injury or by any default in the giving of any notice required by the policy or by this chapter or otherwise. The agreement must be construed to be a direct promise by the insured to the person entitled to compensation.

(3) Every policy or contract insuring against liability for compensation under compensation plan No. 2 must contain a clause to the effect that the insurer is directly and primarily liable to and will pay directly to the employee or in case of death to the employee's beneficiaries or major or minor dependents the compensation, if any, for which the employer is liable.

(4) Every policy must at all times be subject to approval, change, or revision by the department and must contain the clauses, agreements, and promises required by this chapter.

(5) All Montana operations of an employer, as defined in 39-71-117, covered under plan No. 2 must be insured by the same insurer.

History: (1)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2980, R.C.M. 1921; amd. Sec. 6, Ch. 139, L. 1931; re-en. Sec. 2980, R.C.M. 1935; amd. Sec. 4, Ch. 176, L. 1957; Sec. 92-1003, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; amd. Sec. 10, Ch. 100, L. 1919; re-en. Sec. 2981, R.C.M. 1921; amd. Sec. 11, Ch. 177, L. 1929; re-en. Sec. 2981, R.C.M. 1935; amd. Sec. 1, Ch. 141, L. 1971; amd. Sec. 58, Ch. 23, L. 1975; Sec. 92-1004, R.C.M. 1947; (3), (4)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2988, R.C.M. 1921; re-en. Sec. 2988, R.C.M. 1935; Sec. 92-1011, R.C.M. 1947; R.C.M. 1947, 92-1003, 92-1004(part), 92-1011; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 9, Ch. 69, L. 2005.

Cross-References

Policies to provide for freedom of choice in selection of practitioners- professional practice not enlarged, 33-22-111.

39-71-2204. Insurer to submit notice of coverage within 30 days – penalty for failure.

(1) The insurer shall, within 30 days after the issuance of a policy of workers' compensation insurance, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information that may be required by the department. Notice to the department under this section must be provided electronically.

(2) The department:
   (a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and
   (b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the insurer's notice of coverage.

(3) The department may, in its discretion, assess a penalty of not more than $200 against an insurer that does not comply with the 30-day notice requirement set forth in subsection (1). The penalty may be assessed for each policy that is not reported to the department in a timely manner.

History: En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; R.C.M. 1947, 92-1002(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 12, Ch. 555, L. 1993; amd. Sec. 25, Ch. 186, L. 1995; amd. Sec. 14, Ch. 214, L. 2001; amd. Sec. 10, Ch. 69, L. 2005; amd. Sec. 11, Ch. 117, L. 2007.

39-71-2205. Policy in effect until canceled or replaced – 20-day notification of cancellation required – penalty.

(1) The policy remains in effect until canceled, and cancellation may take effect only by written notice to the named insured and to the department at least 20 days prior to the date of cancellation. However, the policy terminates on the effective date of a replacement or succeeding workers' compensation insurance policy issued to the insured. Nothing in this section prevents an insurer from canceling a policy of workers' compensation insurance before a replacement policy is issued to the insured. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the insurer's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against an insurer that does not comply with the notice requirement in subsection (1). The penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

(b) an insurer may contest the penalty assessment in a hearing conducted according to department rules.

History: En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2979, R.C.M. 1921; re-en. Sec. 2979, R.C.M. 1935; amd. Sec. 2, Ch. 49, L. 1961; amd. Sec. 57, Ch. 23, L. 1975; amd. Sec. 1, Ch. 324, L. 1977; R.C.M. 1947, 92-1002(part); amd. Sec. 1, Ch. 333, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 13, Ch. 555, L. 1993; amd. Sec. 26, Ch. 186, L. 1995; amd. Sec. 15, Ch. 214, L. 2001; amd. Sec. 11, Ch. 69, L. 2005; amd. Sec. 12, Ch. 117, L. 2007.

39-71-2206. Repealed.

Sec. 13, Ch. 310, L. 1997.

History: (1)En. Sec. 35, Ch. 96, L. 1915; amd. Sec. 10, Ch. 100, L. 1919; re-en. Sec. 2981, R.C.M. 1921; amd. Sec. 11, Ch. 177, L. 1929; re-en. Sec. 2981, R.C.M. 1935; amd. Sec. 1, Ch. 141, L. 1971; amd. Sec. 58, Ch. 23, L. 1975; Sec. 92-1004, R.C.M. 1947; (2)En. Sec. 35, Ch. 96, L. 1915; amd. Sec. 11, Ch. 100, L. 1919; re-en. Sec. 2984, R.C.M. 1921; re-en. Sec. 2984, R.C.M. 1935; amd. Sec. 61, Ch. 23, L. 1975; Sec. 92-1007, R.C.M. 1947; (3)En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2989, R.C.M. 1921; re-en. Sec. 2989, R.C.M. 1935; Sec. 92-1012, R.C.M. 1947; R.C.M. 1947, 92-1004(part), 92-1007, 92-1012; amd. Sec. 83, Ch. 397, L. 1979; amd. Sec. 1, Ch. 242, L. 1987; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 14, Ch. 555, L. 1993.

39-71-2207. Repealed.

Sec. 21, Ch. 555, L. 1993.

History: En. Sec. 35, Ch. 96, L. 1915; re-en. Sec. 2985, R.C.M. 1921; re-en. Sec. 2985, R.C.M. 1935; amd. Sec. 62, Ch. 23, L. 1975; R.C.M. 1947, 92-1008; amd. Sec. 3, Ch. 471, L. 1985; amd. Sec. 64, Ch. 613, L. 1989.

39-71-2208. Repealed.

Sec. 16, Ch. 117, L. 2007.

History: En. Sec. 1, Ch. 69, L. 2005.

39-71-2209 and 39-71-2210 reserved.

39-71-2211. Premium rates for construction industry – filing required.

(1) With respect to each classification of risk in the construction industry under plan No. 2, the advisory organization designated under 33-16-1023 shall file with the commissioner of insurance a method of computing premiums that does not impose a higher insurance premium solely because of an employer's higher rate of wages paid.
(2) The commissioner shall accept a filing under subsection (1) that includes a reasonable method of recognizing differences in rates of pay. This method must use a credit scale with the starting point set at 1.168 times the state's average weekly wage as reported by the department.
(3) The advisory organization shall file a revenue neutral plan for new and renewed policies for prompt and orderly transition to a method of computing premiums that is in compliance with the requirements of this section.
(4) The state compensation insurance fund, plan No. 3, shall use the plan filed by the designated advisory organization or use a credit scale plan that meets the requirements of this section.
(5) For the purposes of this section, "construction industry" means the construction group of code classifications filed with and approved by the commissioner to be used by the advisory organization to comply with this section.

History: En. Sec. 3, Ch. 480, L. 1991; amd. Sec. 1, Ch. 224, L. 1993; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 27, Ch. 186, L. 1995; amd. Sec. 1, Ch. 131, L. 1999; amd. Sec. 8, Ch. 26, L. 2005; amd. Sec. 1, Ch. 193, L. 2017.

39-71-2212 through 39-71-2214 reserved.

39-71-2215. Repealed.

Sec. 3, Ch. 79, L. 2021.

History: En. Sec. 15, Ch. 117, L. 2007; amd. Sec. 3, Ch. 150, L. 2011.

Part 23
Compensation Plan Number Three

Part Cross-References

Definitions, 39-71-116.
Employer defined, 39-71-117.

39-71-2301. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2993, R.C.M. 1921; re-en. Sec. 2993, R.C.M. 1935; amd. Sec. 4, Ch. 123, L. 1957; amd. Sec. 176, Ch. 147, L. 1963; amd. Sec. 22, Ch. 329, L. 1969; amd. Sec. 69, Ch. 23, L. 1975; amd. Sec. 1, Ch. 171, L. 1975; R.C.M. 1947, 92-1105(1); amd. Sec. 14, Ch. 103, L. 1979.

39-71-2302. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2990, R.C.M. 1921; re-en. Sec. 2990, R.C.M. 1935; amd. Sec. 1, Ch. 123, L. 1957; amd. Sec. 175, Ch. 147, L. 1963; amd. Sec. 1, Ch. 233, L. 1969; amd. Sec. 20, Ch. 329, L. 1969; amd. Sec. 65, Ch. 23, L. 1975; R.C.M. 1947, 92-1101; amd. Sec. 1, Ch. 232, L. 1987.

39-71-2303. Renumbered 39-71-2336.

Code Commissioner, 1989.

39-71-2304. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: (1)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2992, R.C.M. 1921; re-en. Sec. 2992, R.C.M. 1935; amd. Sec. 3, Ch. 123, L. 1957; amd. Sec. 21, Ch. 329, L. 1969; amd. Sec. 68, Ch. 23, L. 1975; Sec. 92-1104, R.C.M. 1947; (2) thru (5)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2993, R.C.M. 1921; re-en. Sec. 2993, R.C.M. 1935; amd. Sec. 4, Ch. 123, L. 1957; amd. Sec. 176, Ch. 147, L. 1963; amd. Sec. 22, Ch. 329, L. 1969; amd. Sec. 69, Ch. 23, L. 1975; amd. Sec. 1, Ch. 171, L. 1975; Sec. 92-1105, R.C.M. 1947; R.C.M. 1947, 92-1104, 92-1105(3), (4); amd. Sec. 4, Ch. 283, L. 1983; amd. Sec. 2, Ch. 232, L. 1987; amd. Sec. 1, Ch. 239, L. 1987; amd. Sec. 10, Ch. 333, L. 1989; amd. Sec. 2, Ch. 641, L. 1989.

39-71-2305. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: En. 92-1105.1 by Sec. 28, Ch. 341, L. 1969; amd. Sec. 70, Ch. 23, L. 1975; R.C.M. 1947, 92-1105.1; amd. Sec. 1, Ch. 109, L. 1987.

39-71-2306. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2996, R.C.M. 1921; re-en. Sec. 1996, R.C.M. 1935; amd. Sec. 4, Ch. 233, L. 1969; amd. Sec. 71, Ch. 23, L. 1975; R.C.M. 1947, 92-1108; amd. Sec. 15, Ch. 103, L. 1979.

39-71-2307. Renumbered 39-71-2339.

Code Commissioner, 1989.

39-71-2308. Renumbered 39-71-2340.

Code Commissioner, 1989.

39-71-2309. Repealed.

Sec. 16, Ch. 103, L. 1979.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3003, R.C.M. 1921; re-en. Sec. 3003, R.C.M. 1935; amd. Sec. 182, Ch. 147, L. 1963; amd. Sec. 76, Ch. 23, L. 1975; R.C.M. 1947, 92-1115.

39-71-2310. Repealed.

Sec. 16, Ch. 103, L. 1979.

History: (1)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3004, R.C.M. 1921; re-en. Sec. 3004, R.C.M. 1935; amd. Sec. 183, Ch. 147, L. 1963; Sec. 92-1116, R.C.M. 1947; (2)En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3005, R.C.M. 1921; re-en. Sec. 3005, R.C.M. 1935; amd. Sec. 77, Ch. 23, L. 1975; Sec. 92-1117, R.C.M. 1947; R.C.M. 1947, 92-1116, 92-1117.

39-71-2311. Intent and purpose of plan – expense constant defined.

(1) It is the intent and purpose of the state fund to allow employers an option to insure their liability for workers' compensation and occupational disease coverage with the state fund. The state fund must be neither more nor less than self-supporting. Premium rates must be set at least annually at a level sufficient to ensure the adequate funding of the insurance program, including the costs of administration, benefits, and adequate reserves, during and at the end of the period for which

the rates will be in effect. In determining premium rates, the state fund shall make every effort to adequately predict future costs. When the costs of a factor influencing rates are unclear and difficult to predict, the state fund shall use a prediction calculated to be more than likely to cover those costs rather than less than likely to cover those costs. The prediction must take into account the goal of pooling risk and may not place an undue burden on employers that are not eligible for the tier with the lowest-rated premium for workers' compensation purposes.

(2) Unnecessary surpluses that are created by the imposition of premiums found to have been set higher than necessary because of a high estimate of the cost of a factor or factors may be refunded by the declaration of a dividend as provided in this part. For the purpose of keeping the state fund solvent, the board of directors may implement multiple rating tiers as provided in 39-71-2330 and may assess an expense constant, a minimum premium, or both.

(3) As used in this section, "expense constant" means a premium charge applied to each workers' compensation policy to pay expenses related to issuing, servicing, maintaining, recording, and auditing the policy.

History: En. Sec. 1, Ch. 613, L. 1989; amd. Sec. 7, Ch. 4, Sp. L. May 1990; amd. Sec. 6, Ch. 323, L. 1991; amd. Sec. 12, Ch. 295, L. 1993; amd. Sec. 1, Ch. 305, L. 1995; amd. Sec. 7, Ch. 314, L. 2001; amd. Sec. 3, Ch. 218, L. 2009.

39-71-2312. Definitions.

Unless the context requires otherwise, in this part the following definitions apply:

(1) "Board" means the board of directors of the state compensation insurance fund provided for in 2-15-1019.

(2) "Commissioner" means the commissioner of insurance as provided in 2-15-1903.

(3) "Executive director" means the chief executive officer of the state compensation insurance fund.

(4) "Fiscal year" means for the purposes of the state fund under Title 33 and this part the period from January 1 in one year to December 31 of that same year. A fiscal year for the purposes of assessments under Title 39, chapter 71, is as defined in 39-71-116.

(5) "Guaranteed market"means the insurer that is required to insure any employer in this state who requests to insure their liability for workers' compensation and occupational disease coverage and that may not refuse to provide coverage unless an employer or the employer's principals have defaulted on an obligation and the default remains unsatisfied.

(6) "State fund" means the state compensation insurance fund provided for in 39-71-2313 that serves as the guaranteed market for this state. It is also known as compensation plan No. 3 or plan No. 3.

History: En. Sec. 2, Ch. 613, L. 1989; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 9, Ch. 26, L. 2005; amd. Sec. 13, Ch. 320, L. 2015.

39-71-2313. State compensation insurance fund created – obligation to insure.

(1) There is a state compensation insurance fund known as the state fund that is a nonprofit, independent public corporation established for the purpose of allowing an option for employers to insure their liability for workers' compensation and occupational disease coverage under this chapter.

(2) The state fund is required to insure any employer in this state who requests coverage, and it may not refuse to provide coverage unless an employer or the employer's principals have defaulted on a state fund obligation and the default remains unsatisfied.

History: En. Sec. 4, Ch. 613, L. 1989; amd. Sec. 8, Ch. 4, Sp. L. May 1990; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 2, Ch. 305, L. 1995.

39-71-2314. Repealed.

Sec 22, Ch. 320, L. 2015.

History: En. Sec. 10, Ch. 613, L. 1989; amd. Sec. 9, Ch. 4, Sp. L. May 1990; amd. Sec. 3, Ch. 630, L. 1993; amd. Sec. 11, Ch. 310, L. 1997.

39-71-2315. Management of state fund – powers and duties of the board – business plan required.

(1) The management and control of the state fund is vested in the board, subject to the statutory limitations imposed by this part.

(2) The board is vested with full power, authority, and jurisdiction over the state fund except that the board may not dissolve or liquidate the state fund. To fulfill the objectives and intent of this part, the board may perform all acts necessary or convenient in the exercise of any power, authority, or jurisdiction over the administration of the state fund or in connection with the insurance business to be carried on under the provisions of this part, as fully and completely as the governing body of a private mutual insurance carrier and subject to the regulatory authority of the insurance commissioner in Title 33, except as provided in 33-1-115 and 39-71-2375.

(3) Neither the board, the state fund, nor the executive director may issue bonds on behalf of the state fund.

(4) (a) The board shall adopt a business plan no later than December 31 for the next fiscal year.

(b)at a minimum, the plan must include:

(i) specific goals for the fiscal year for financial performance. The standard for measurement of financial performances must include an evaluation of premium to surplus.

(ii) specific goals for the fiscal year for operating performance. Goals must include but not be limited to specific performance standards for staff in the area of senior management, underwriting, and claims administration. Goals must, in general, maximize efficiency, economy, and equity as allowed by law.

(5) The business plan must be available upon request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(6) No sooner than January 1 or later than March 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board shall publish, by May 30 of each year, a report of the state fund's actual performance as compared to the business plan.

(7) The state fund board of directors shall establish in-house guidelines for procurement of insurance-related services and shall include guidelines for the solicitation of submissions of information regarding insurance-related services from more than one vendor. The board may include guidelines for the circumstances when business necessity or expedience may preclude the solicitation of submissions from more than one vendor. The board may also include in the guidelines the exemptions to the procurement process in 18-4-132.

History: En. Sec. 5, Ch. 613, L. 1989; amd. Sec. 10, Ch. 4, Sp. L. May 1990; amd. Sec. 19, Ch. 619, L. 1993; amd. Sec. 2, Ch. 407, L. 1999; amd. Sec. 14, Ch. 320, L. 2015.

39-71-2316. Powers of state fund.

(1) For the purposes of carrying out its functions, the state fund may:

(a) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, as part of the coverage, provide related employers' liability insurance upon approval of the board;

(b) sue and be sued;

(c) enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(d) collect and disburse money received;

(e) except as provided in subsection (1)(f), use the uniform classification system as required in 33-16-1023 and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting;

(f) continue the use of special classification codes that were in use prior to January 1, 2016, for agriculture, municipalities, towns, cities, counties, and state agencies. The board shall file with the commissioner rates and supplementary rate information for these special classifications.

(g) use the uniform experience rating plan provided for in 33-16-1023, except upon approval of the board may adopt experience modification thresholds for use by the state fund for its insured employers;

(h) pay the amounts determined to be due under a policy of insurance issued by the state fund;

(i) hire personnel;

(j) declare dividends if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside.

(k) adopt and implement one or more alternative personal leave plans pursuant to 39-71-2328;

(l) upon approval of the board, contract with licensed resident insurance producers;

(m) upon approval of the board, enter into agreements with licensed workers' compensation insurers, insurance associations, or insurance producers to provide workers' compensation coverage in other states to Montana-domiciled employers insured with the state fund;

(n) upon approval of the board, expend funds for scholarship, educational, or charitable purposes;

(o) upon approval of the board, including terms and conditions, provide employers coverage under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901, et seq., the federal Merchant Marine Act, 1920 (Jones Act), 46 U.S.C. 688, and the federal Employers' Liability Act, 45 U.S.C. 51, et seq.;

(p) perform all functions and exercise all powers of a private insurance carrier that are necessary, appropriate, or convenient for the administration of the state fund.

(2) The state fund shall include a provision in every policy of insurance issued pursuant to this part that incorporates the restriction on the use and transfer of money collected by the state fund as provided for in 39-71-2320.

History: En. Sec. 8, Ch. 613, L. 1989; amd. Sec. 11, Ch. 4, Sp. L. May 1990; amd. Sec. 4, Ch. 630, L. 1993; amd. Sec. 28, Ch. 186, L. 1995; amd. Sec. 3, Ch. 305, L. 1995; amd. Secs. 15, 16, Ch. 276, L. 1997; amd. Sec. 8, Ch. 314, L. 2001; amd. Sec. 1, Ch. 603, L. 2003; amd. Sec. 51, Ch. 130, L. 2005; amd. Sec. 15, Ch. 320, L. 2015.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
Workers' compensation coverage, liability, and subrogation, Title 39, ch. 71, part 4.

39-71-2317. Appointment of executive director – management staff.

The board shall appoint an executive director of the state fund who has general responsibility for the operations of the state fund. The executive director must have executive level experience, with knowledge of the insurance industry. The executive director must receive compensation as set by the board and serve at the pleasure of the board. The executive director may hire the management staff of the state fund, each of whom serves at the pleasure of the executive director.

History: En. Sec. 7, Ch. 613, L. 1989.

39-71-2318. Personal liability excluded.

The members of the board, the executive director, and employees of the state fund are not liable personally, either jointly or severally, for any debt or obligation created or incurred by the state fund.

History: En. Sec. 6, Ch. 613, L. 1989.

Cross-References

State subject to suit, Art. II, sec. 18, Mont. Const.
Liability exposure of state government, Title 2, ch. 9, part 1.

39-71-2319. Assets and liabilities of prior state fund.

All assets and funds held by the state compensation insurance fund established in former 39-71-2301, 39-71-2302, 39-71-2304 through 39-71-2306, and 39-71-2324 and 39-71-2321 through 39-71-2323, 39-71-2325 through 39-71-2327, 39-71-2336, 39-71-2339, and 39-71-2340 must be transferred to the state fund, and the state fund shall assume liability for all outstanding claims and indebtedness of the previously existing state fund.

History: En. Sec. 11, Ch. 613, L. 1989.

39-71-2320. Property of state fund – investment required – exception.

All premiums and other money paid to the state fund, all property and securities acquired through the use of money belonging to the state fund, and all interest and dividends earned upon money belonging to the state fund are the sole property of the state fund and must be used exclusively for the operations and obligations of the state fund. The money collected by the state fund for claims for injuries occurring on or after July 1, 1990, may not be used for any other purpose and may not be transferred by the legislature to other funds or used for other programs. However, state fund money must be invested by the board of investments provided for in 2-15-1808, and subject to the investment agreement with the board of investments, the earnings on investments are the sole property of the state fund as provided in this section.

History: En. Sec. 9, Ch. 613, L. 1989; amd. Sec. 3, Ch. 424, L. 1995; amd. Sec. 17, Ch. 276, L. 1997; amd. Sec. 2, Ch. 603, L. 2003.

39-71-2321. What to be deposited in state fund.

(1) All premiums, penalties, recoveries by subrogation, interest earned upon money belonging to the state fund, securities acquired by or through use of money, and all interest and penalties on taxes in accordance with 17-2-124 must be deposited in the state fund. Except for a transfer authorized under 39-71-2352, the money must be separated into two accounts based upon whether they relate to claims for injuries resulting from accidents that occurred before July 1, 1990, or claims for injuries resulting from accidents that occur on or after that date.

(2) All funds deposited in the state fund may be spent as provided in 17-8-101(2)(b).

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2993, R.C.M. 1921; re-en. Sec. 2993, R.C.M. 1935; amd. Sec. 4, Ch. 123, L. 1957; amd. Sec. 176, Ch. 147, L. 1963; amd. Sec. 22, Ch. 329, L. 1969; amd. Sec. 69, Ch. 23, L. 1975; amd. Sec. 1, Ch. 171, L. 1975; R.C.M. 1947, 92-1105(2); amd. Sec. 5, Ch. 283, L. 1983; amd. Sec. 32, Ch. 613, L. 1989; amd. Sec. 12, Ch. 4, Sp. L. May 1990; amd. Sec. 4, Ch. 797, L. 1991; amd. Sec. 10, Ch. 630, L. 1993; amd. Secs. 18, 19, Ch. 276, L. 1997; amd. Sec. 6, Ch. 184, L. 1999; amd. Sec. 21, Ch. 389, L. 1999; amd. Sec. 26, Ch. 475, L. 2007.

39-71-2322. Money in state fund held in trust – disposition of funds upon repeal of chapter.

The money coming into the state fund must be held in trust for the purpose for which the money was collected. If this chapter is repealed, the money is subject to the disposition provided by the legislature repealing this chapter. In the absence of a legislative provision, distribution must be in accordance with the justice of the matter, due regard being given to obligations of compensation incurred and existing.

History: En. Sec. 24, Ch. 96, L. 1915; re-en. Sec. 2966, R.C.M. 1921; re-en. Sec. 2966, R.C.M. 1935; amd. Sec. 168, Ch. 147, L. 1963; R.C.M. 1947, 92-840; amd. Sec. 6, Ch. 283, L. 1983; amd. Sec. 33, Ch. 613, L. 1989; amd. Sec. 20, Ch. 276, L. 1997; amd. Sec. 3, Ch. 603, L. 2003.

39-71-2323. Surplus in state fund – payment of dividends.

Subject to the provisions of 39-71-2316, if at the end of any fiscal year there exists in the state fund account created by 39-71-2321 for claims for injuries resulting from accidents that occur on or after July 1, 1990, an excess of assets over liabilities, including necessary reserves and an appropriate surplus as determined by the board in accordance with 39-71-2330, and if the excess may be refunded safely, then the board, after consultation with the independent actuary engaged pursuant to 39-71-2330, may declare a dividend. The state fund must prescribe the manner of payment to those employers who have paid premiums into the state fund in excess of liabilities.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 2998, R.C.M. 1921; re-en. Sec. 2998, R.C.M. 1935; amd. Sec. 6, Ch. 123, L. 1957; amd. Sec. 180, Ch. 147, L. 1963; amd. Sec. 72, Ch. 23, L. 1975; R.C.M. 1947, 92-1110; amd. Sec. 7, Ch. 283, L. 1983; amd. Sec. 34, Ch. 613, L. 1989; amd. Sec. 13, Ch. 4, Sp. L.May1990; amd. Sec. 5, Ch. 630, L. 1993; amd. Sec. 3, Ch. 407, L. 1999; amd. Sec. 16, Ch. 320, L. 2015.

39-71-2324. Repealed.

Sec. 59, Ch. 613, L. 1989.

History: En. Sec. 40, Ch. 96, L. 1915; amd. Sec. 7, Ch. 196, L. 1921; re-en. Sec. 3000, R.C.M. 1921; re-en. Sec. 3000, R.C.M. 1935; amd. Sec. 17, Ch. 176, L. 1953; amd. Sec. 186, Ch. 147, L. 1963; amd. Sec. 73, Ch. 23, L. 1975; R.C.M. 1947, 92-1112; amd. Sec. 8, Ch. 283, L. 1983.

39-71-2325. State fund to keep accounts of segregations.

The state fund shall keep an accurate account of all the segregations of the state fund and shall divert from the fund any sums necessary to meet monthly payments, pending the conversion into cash of any security, and in such case shall repay the same out of the cash realized from the security.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3001, R.C.M. 1921; re-en. Sec. 3001, R.C.M. 1935; amd. Sec. 187, Ch. 147, L. 1963; amd. Sec. 74, Ch. 23, L. 1975; R.C.M. 1947, 92-1113; amd. Sec. 9, Ch. 283, L. 1983; amd. Sec. 35, Ch. 613, L. 1989.

39-71-2326. Repealed.

Sec. 6, Ch. 664, L. 1987.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3010, R.C.M. 1921; re-en. Sec. 3010, R.C.M. 1935; amd. Sec. 184, Ch. 147, L. 1963; amd. Sec. 81, Ch. 23, L. 1975; R.C.M. 1947, 92-1122; amd. Sec. 10, Ch. 283, L. 1983.

39-71-2327. Earnings of state fund to be credited to fund – improper use a felony.

All earnings made by the state fund by reason of interest paid for the deposit of funds or otherwise must be credited to and become a part of the fund, and the making of profit, either directly or indirectly, by any person out of the use of the fund is a felony. A person convicted of an offense under this section is punishable by imprisonment in the state prison for a term not to exceed 2 years or a fine of not more than $5,000, or both.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3011, R.C.M. 1921; re-en. Sec. 3011, R.C.M 1935; amd. Sec. 185, Ch. 147, L. 1963; amd. Sec. 82, Ch. 23, L. 1975; R.C.M. 1947, 92-1123; amd. Sec. 11, Ch. 283, L. 1983; amd. Sec. 36, Ch. 613, L. 1989; amd. Sec. 21, Ch. 276, L. 1997; amd. Sec. 4, Ch. 603, L. 2003.

39-71-2328. State fund alternative personal leave plan – exception – collective bargaining negotiation – personal leave definition.

(1) Except as provided in subsection (2), the state fund, after consultation with the department of administration, may develop an alternative personal leave plan for all state compensation insurance fund employees. The number of days and the rate at which the number of days are earned for the alternative personal leave plan must be the same as the combined total of days provided for in 2-18-612 and 2-18-618. Prior to implementation, the alternative personal leave plan must be adopted by the board and the board may adopt changes to the plan.

(2) The state fund, after consultation with the department of administration, may develop one or more alternative personal leave plans for some or all of its employees or may choose to develop an alternative personal leave plan for a particular class of employees or work unit.

(3) To the extent that an alternative personal leave plan applies to an employee who is a member of a collective bargaining unit, the implementation of the personal leave plan is subject to negotiation under 39-31-305.

(4) As used in this section, "personal leave" means all leave provided to an employee under the provisions of Title 2, chapter 18, part 6.

History: En. Sec. 1, Ch. 314, L. 2001.

39-71-2329 reserved.

39-71-2330. Rate setting -- surplus -- multiple rating tiers.

(1) The board has the authority to establish the rates to be charged by the state fund and the supplementary rate information to determine the applicable premium as provided in 39-71-2311 and 39-71-2316 and shall file the rates and supplementary rate information with the commissioner as provided in Title 33, chapter 16. The board shall engage the services of an independent actuary who is a member in good standing with the American academy of actuaries to develop and recommend actuarially sound rates. Rates must be set at amounts sufficient, when invested, to carry the estimated cost of all claims to maturity, to meet the reasonable expenses of conducting the business of the state fund, and to amass and maintain an excess of surplus over the amount produced by the national association of insurance commissioners' risk-based capital requirements for a casualty insurer.

(2) Because surplus is desirable in the insurance business, the board shall annually determine the level of surplus that must be maintained by the state fund pursuant to this section. The state fund shall use the amount of the surplus above the risk-based capital requirements to secure the state fund against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements.

(3) The board may establish multiple rating tiers for classifications that take into consideration losses, premium size, and other factors relevant in placing an employer within a rating tier. The board shall file any multiple rating tiers with the commissioner for review as provided in Title 33, chapter 16.

History: En. Sec. 7, Ch. 630, L. 1993; amd. Sec. 4, Ch. 407, L. 1999; amd. Sec. 9, Ch. 314, L. 2001; amd. Sec. 17, Ch. 320, L. 2015.

Cross-References

Powers of State Fund, 39-71-2316.

39-71-2331. Workplace safety program.

(1) An employer that is not eligible for the tier with the lowest-rated premium for workers' compensation purposes is eligible to join a state fund pooled risk safety group, as provided in 39-71-2332, if the employer:

(a) adopts and maintains a written, comprehensive workplace safety program that has been in place for more than 1 year and that meets the criteria established by rule implementing Title 39, chapter 71, part 15;

(b) adopts transitional and return-to-work programs;

(c) has at least 3 years of experience without losses;

(d) uses available safety consultation services or programs offered by the department or the state fund. Safety consultation may be provided to individual employers or to groups. The department and the state fund shall notify each employer in a group, as provided in 39-71-2332, regarding the availability of safety and return-to-work resources.

(e) complies with the terms and conditions of the state fund pooled risk safety group as provided in 39-71-2332.

(2) The state fund and the department shall share information on workplace safety programs and transitional and return-to-work programs.

History: En. Sec. 1, Ch. 218, L. 2009.

39-71-2332. Pooled risk safety group.

(1) Subject to Title 33, chapter 16, the state fund may establish one or more groups of individual policies in a pooled risk safety group to promote safety as a way to reduce losses among members of the pooled risk safety group.
(2) Each member of a pooled risk safety group must be eligible as provided in 39-71-2331 and must have an individual workers' compensation plan No. 3 policy. An individual policy may be included in only one group.
(3) The state fund shall annually establish the terms and conditions of the plan that defines the requirements of participation for a pooled risk safety group. The plan must include the criteria to be eligible for an aggregate return of premium and a method for apportioning the return of premium among members of the group.
(4) The aggregate record of the individual members of the pooled risk safety group is the basis for determining if the members of the pooled risk safety group qualify for a return on premiums.

History: En. Sec. 2, Ch. 218, L. 2009; amd. Sec. 18, Ch. 320, L. 2015.

39-71-2333 through 39-71-2335 reserved.

39-71-2336. Manner of electing – contract or policy of insurance – payment of premium.

The state fund shall prescribe the procedure by which an employer may elect to be bound by compensation plan No. 3, the effective time of the election, and the manner in which the election is terminated for reasons other than default in payment of premiums. Every employer electing to be bound by compensation plan No. 3 must receive from the state fund a contract or policy of insurance in a form approved by the department. All Montana operations of an employer, as defined in 39-71-117, covered by compensation plan No. 3 must be insured by the state compensation insurance fund. The premium must be paid by the employer to the state fund at times that the state fund prescribes and must be paid over by the state fund to the state treasurer to the credit of the state fund.

History: En. Sec. 40, Ch. 96, L. 1915; amd. Sec. 6, Ch. 196, L. 1921; re-en. Sec. 2991, R.C.M. 1921; re-en. Sec. 2991, R.C.M. 1935; amd. Sec. 2, Ch. 123, L. 1957; amd. Sec. 178, Ch. 147, L. 1963; amd. Sec. 2, Ch. 233, L. 1969; amd. Sec. 67, Ch. 23, L. 1975; R.C.M. 1947, 92-1103; amd. Sec. 3, Ch. 283, L. 1983; amd. Sec. 29, Ch. 613, L. 1989; Sec. 39-71-2303, MCA 1987; redes. 39-71-2336 by Code Commissioner, 1989; amd. Sec. 12, Ch. 69, L. 2005.

39-71-2337. State fund to submit notice of coverage within 30 days – penalty for failure.

(1) The state fund shall, within 30 days after the issuance of an insurance policy, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information the department requires. Notice to the department under this section must be provided electronically.
(2) The department:
  (a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and
  (b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the state fund's notice of coverage.
(3) The department may assess a penalty of not more than $200 against the state fund if the state fund does not comply with the 30-day notice requirement. The penalty may be assessed for each policy that is not reported to the department in a timely manner.

History: En. Sec. 44, Ch. 613, L. 1989; amd. Sec. 16, Ch. 214, L. 2001; amd. Sec. 13, Ch. 69, L. 2005; amd. Sec. 13, Ch. 117, L. 2007.

39-71-2338. Repealed.

Sec. 8, Ch. 323, L. 1991.

History: En. Sec. 45, Ch. 613, L. 1989.

39-71-2339. Cancellation of coverage – 20-day notice required.

(1) The state fund may cancel an employer's coverage under this part for failure to report payroll or pay the premiums due or for another cause provided in the insurance policy. Cancellation may take effect only by written notice to the named insured and the department at least 20 days prior to the date of cancellation or, in cases of nonreporting of payroll or nonpayment of a premium, by failure of the employer to submit payroll reports or pay a premium within 20 days after the due date. The state fund shall notify the department of the names and effective dates of all policies canceled. However, the policy terminates on the effective date of a replacement or succeeding insurance policy issued to the insured. This section does not prevent the state fund from canceling an insurance policy before a replacement policy is issued to the insured. After the cancellation date, the employer has the same status as an employer who is not enrolled under the Workers' Compensation Act unless a replacement or succeeding insurance policy has been issued. Notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the state fund's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against the state fund if it does not comply with the notice requirement in subsection (1).

(b) the penalty may be assessed for each policy cancellation that is not reported to the department in a timely manner.

(c) the state fund may contest the penalty assessment in a hearing conducted according to department rules.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3002, R.C.M. 1921; amd. Sec. 1, Ch. 201, L. 1935; re-en. Sec. 3002, R.C.M. 1935; amd. Sec. 10, Ch. 235, L. 1947; amd. Sec. 7, Ch. 123, L. 1957; amd. Sec. 181, Ch. 147, L. 1963; amd. Sec. 75, Ch. 23, L. 1975; amd. Sec. 1, Ch. 225, L. 1975; R.C.M. 1947, 92-1114(part); amd. Sec. 30, Ch. 613, L. 1989; Sec. 39-71-2307, MCA 1987; redes. 39-71-2339 by Code Commissioner, 1989; amd. Sec. 7, Ch. 323, L. 1991; amd. Sec. 4, Ch. 305, L. 1995; amd. Sec. 17, Ch. 214, L. 2001; amd. Sec. 14, Ch. 69, L. 2005; amd. Sec. 23, Ch. 112, L. 2009.

39-71-2340. Collection in case of default.

(1) If an employer under plan No. 3 defaults in any payment to the state fund, the state fund may collect the sum due in a civil action in the name of the state. The right of action is cumulative.

(2) If an employer's right to operate has been canceled by the state fund for failure to pay premiums and the state fund finds that the property and assets of the employer are not sufficient to pay the premiums, the state fund may compromise the claim for premiums and accept a payment of an amount less than the total amount due.

History: En. Sec. 40, Ch. 96, L. 1915; re-en. Sec. 3002, R.C.M. 1921; amd. Sec. 1, Ch. 201, L. 1935; re-en. Sec. 3002, R.C.M. 1935; amd. Sec. 10, Ch. 235, L. 1947; amd. Sec. 7, Ch. 123, L. 1957; amd. Sec. 181, Ch. 147, L. 1963; amd. Sec. 75, Ch. 23, L. 1975; amd. Sec. 1, Ch. 225, L. 1975; R.C.M. 1947, 92-1114(part); amd. Sec. 31, Ch. 613, L. 1989; Sec. 39-71-2308, MCA 1987; redes. 39-71-2340 by Code Commissioner, 1989.

39-71-2341. Repealed.

Secs. 11, 14(3), Ch. 314, L. 2001.

History: En. Sec. 10, Ch. 295, L. 1993; amd. Sec. 5, Ch. 407, L. 1999.

39-71-2342 through 39-71-2350 reserved.

39-71-2351. Purpose of separation of state fund liability as of July 1, 1990, and of separate funding of claims before and on or after that date.

(1) The legislature has determined that it is necessary to the public welfare to make workers' compensation insurance available to all employers through the state fund as the guaranteed market. In previous years of making this insurance available, and prior to July 1, 1990, the state fund incurred an unfunded liability. The legislature determined that the most cost-effective and efficient way to provide a source of funding for and to ensure payment of the unfunded liability and the best way to administer the unfunded liability was to separate the liability of the state fund on the basis of whether a claim is for an injury resulting from an accident that occurred before July 1, 1990, or an accident that occurs on or after that date.

(2) The legislature further determines that in order to prevent the creation of a new unfunded liability with respect to claims for injuries for accidents that occur on or after July 1, 1990, certain duties of the state fund should be clarified and regulation of the state fund, effective January 1, 2016, and subject to 33-1-115 and 39-71-2375, should be under Title 33, which governs plan No. 2 and plan No. 3 insurers operating in this state.

History: En. Sec. 1, Ch. 4, Sp. L. May 1990; amd. Sec. 5, Ch. 797, L. 1991; amd. Sec. 1, Ch. 637, L. 1993; amd. Sec. 22, Ch. 276, L. 1997; amd. Sec. 19, Ch. 320, L. 2015.

39-71-2352. Separate payment structure and sources for claims for injuries resulting from accidents that occurred before July 1, 1990, and on or after July 1, 1990 – spending limit – authorizing transfer of money.

(1) Premiums paid to the state fund based upon wages payable before July 1, 1990, may be used only to administer and pay claims for injuries resulting from accidents that occurred before July 1, 1990. Premiums paid to the state fund based upon wages payable on or after July 1, 1990, may be used only to administer and pay claims for injuries resulting from accidents that occur on or after July 1, 1990.

(2) The state fund shall:

(a) determine the cost of administering and paying claims for injuries resulting from accidents that occurred before July 1, 1990, and separately determine the cost of administering and paying claims for injuries resulting from accidents that occur on or after July 1, 1990;

(b) keep adequate and separate accounts of the costs determined under subsection (2)(a); and

(c) fund administrative expenses and benefit payments for claims for injuries resulting from accidents that occurred before July 1, 1990, and claims for injuries resulting from accidents that occur on or after July 1, 1990, separately from the sources provided by law.

(3) The state fund may not spend more than [$1.25 million] a year to administer claims for injuries resulting from accidents that occurred before July 1, 1990.
(4) As used in this section, "adequately funded" means the present value of:
(a)the total cost of future benefits remaining to be paid; and
(b)the cost of administering the claims.
(5) An amount of funds in excess of the adequate funding amount established in subsection (4), based on audited financial statements adjusted for unrealized gains and losses, must be transferred to the general fund.
(6) If in any fiscal year after the old fund liability tax is terminated claims for injuries resulting from accidents that occurred before July 1, 1990, are not adequately funded, any amount necessary to pay claims for injuries resulting from accidents that occurred before July 1, 1990, must be transferred from the general fund to the account provided for in 39-71-2321.
(7) The independent actuary engaged by the state fund pursuant to 39-71-2330 shall project the unpaid claims liability for claims for injuries resulting from accidents that occurred before July 1, 1990, each fiscal year until all claims are paid. (Bracketed language in subsection (3) terminates June 30, 2019, and reverts to $1.25 million effective July 1, 2019–secs. 13, 35, Ch. 429, L. 2017.)

History: En. Sec. 2, Ch. 4, Sp. L. May 1990; amd. Sec. 6, Ch. 797, L. 1991; amd. Sec. 6, Ch. 630, L. 1993; amd. Secs. 23, 24, Ch. 276, L. 1997; amd. Sec. 7, Ch. 184, L. 1999; amd. Sec. 1, Ch. 16, Sp. L. August 2002; amd. Sec. 1, Ch. 588, L. 2003; amd. Sec. 57, Ch. 2, L. 2009; amd. Sec. 13, Ch. 429, L. 2017.

39-71-2353. Repealed.

Sec. 9, Ch. 797, L. 1991.

History: En. Sec. 4, Ch. 4, Sp. L. May 1990.

39-71-2354. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 1, Ch. 797, L. 1991; amd. Sec. 9, Ch. 637, L. 1993; amd. Sec. 38, Ch. 422, L. 1997.

39-71-2355. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 2, Ch. 797, L. 1991.

39-71-2356. Mutually agreeable lump-sum settlements.

During the period beginning October 1, 1991, and ending September 30, 1992, a workers' compensation claimant and the state fund may, regardless of the lump-sum law in effect on the date of the injury, mutually agree to a lump-sum settlement of a claim. If a mutual agreement is not reached, the lump-sum law in effect on the date of the injury applies.

History: En. Sec. 3, Ch. 797, L. 1991.

39-71-2357 through 39-71-2360 reserved.

39-71-2361. Legislative audit of state fund.

The legislative auditor shall annually conduct or have conducted by persons appointed under 5-13-305 a financial and compliance audit of the state fund,including its operations relating to claims for injuries resulting from accidents that occurred before July 1, 1990. The audit must include evaluations of the amounts reserved. The evaluations may be conducted by persons appointed under 5-13-305. Audit and evaluation costs are an expense of and must be paid by the state fund and must be allocated between those claims for injuries resulting from accidents that occurred before July 1, 1990, and those claims for injuries resulting from accidents that occur on or after that date.

History: En.Sec. 5,Ch. 4, Sp. L.May1990; amd. Sec. 27, Ch. 167, L. 2011; amd. Sec. 20, Ch. 320, L. 2015.

39-71-2362. Repealed.

Sec. 22, Ch. 320, L. 2015.

History: En. Sec. 8, Ch. 630, L. 1993.

39-71-2363. Agency law -- annual report.

(1) The state fund is subject to state laws applying to state agencies, except as otherwise provided by law, and it is exempt from the provisions of The Legislative Finance Act in Title 5, chapter 12, and the provisions of Title 17, chapter 7, parts 1 through 4. The state fund may use the debt collection procedures provided in Title 17, chapter 4, part 1.

(2) (a) Except as provided in 2-15-2015, the executive director shall annually submit to the board for its approval an estimated budget of the entire expense of administering the state fund for the succeeding fiscal year, with due regard to the business interests and contract obligations of the state fund. A copy of the approved budget must be delivered to the governor and the legislature.

(b) dividends may not be included as administrative expenditures as provided in subsection (2)(a) but are a disbursement of excess surplus pursuant to 39-71-2323 after a determination by the state fund of income from operations.

(3) The board shall submit an annual financial report to the governor and to the legislature as provided in 5-11-210, indicating the business done by the state fund during the previous year and containing a statement of the estimated liabilities of the state fund as determined by an independent actuary.

History: En. Sec. 9,Ch. 630, L. 1993; amd. Sec. 4, Ch. 424, L. 1995; amd. Sec. 25, Ch. 276, L. 1997; amd. Sec. 52, Ch. 7,L. 2001; amd. Sec. 10, Ch. 314, L. 2001; amd. Sec. 12, Ch. 120, L. 2013; amd. Sec. 21, Ch. 320, L. 2015.

39-71-2364 through 39-71-2369 reserved.

39-71-2370. Claims expenditures codes.

The state fund shall continually review its claims expenditure coding structure to separately account for claims and administrative expenses. If a review demonstrates a compelling need for expenditure information that is not available, the state fund shall expand or modify its claims expenditure coding structure.

History: En. Sec. 20, Ch. 555, L. 1993; Sec. 39-71-226, MCA 2003; redes. 39-71-2370 by Sec. 11, Ch. 26, L. 2005.

39-71-2371 through 39-71-2374 reserved.

39-71-2375. Operation of state fund as authorized insurer—issuance of certificate of authority—exceptions—use of calendar year—risk-based capital—reporting requirements.

(1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a)The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b)the state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c)the state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(d)the state fund is subject to the provisions of Title 33, chapter 2, part 24, if it contracts with one or more pharmacy benefit managers as defined in 33-2-2402.

(3) (a)The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b)the state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a)If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee in accordance with 5-11-210 and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b)if the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312.

History: En. Sec. 1, Ch. 320, L. 2015; amd. Sec. 71, Ch. 261, L. 2021; amd. Sec. 21, Ch. 501, L. 2021.

Part 24
Mediation

Part Cross-References

Uniform Arbitration Act, Title 27, ch. 5.

39-71-2401. Disputes – jurisdiction -- settlement requirements – mediation.

(1) A dispute concerning benefits arising under this chapter, other than the disputes described in subsection (2), must be brought before a department mediator as provided in this part. If a dispute still exists after the parties satisfy the mediation requirements in this part, either party may petition the workers' compensation court for a resolution.

(2) A dispute arising under this chapter that does not concern benefits or a dispute for which a specific provision of this chapter gives the department jurisdiction must be brought before the department.

(3) An appeal from a department order may be made to the workers' compensation court.

(4) Except as otherwise provided in this chapter, before a party may bring a dispute concerning benefits before a mediator, the parties shall attempt to settle as follows:

(a) the party making a demand shall present the other party with a specific written demand that contains sufficient explanation and documentary evidence to enable the other party to thoroughly evaluate the demand.

(b) the party receiving the demand shall respond in writing within 15 working days of receipt. If the demand is denied in whole or in part, the response must state the basis of the denial.

(c) upon motion of a party or upon the mediator's own motion, the mediator has the authority to dismiss a petition if the mediator finds that either party did not comply with this subsection (4). A decision dismissing a petition under this subsection (4)(c) must be in writing and must state in detail the grounds for dismissal. The mediator's decision may be reviewed by the workers' compensation court upon motion of a party.

(d) this subsection (4) does not relieve a party of an obligation otherwise contained in this chapter.

History: En. Sec. 8, Ch. 464, L. 1987; amd. Sec. 1, Ch. 427, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 10, Ch. 558, L. 1991; amd. Sec. 29, Ch. 416, L. 2005; amd. Sec. 1550, Ch. 56, L. 2009.

39-71-2402 through 39-71-2405 reserved.

39-71-2406. Purpose.

The purpose of this part is to prevent when possible the filing in the workers' compensation court of actions by claimants or insurers relating to claims under this chapter if an equitable and reasonable resolution of the dispute may be effected at an earlier stage. To achieve this purpose, this part provides for a procedure for mandatory, nonbinding mediation. It is the intent of this part that the mediation process be used to resolve cases on an informal basis at minimal cost to the parties, and to this end, the parties are required to fully present their cases at the mediation level. However, if a cause proceeds to the workers' compensation court, the parties are not precluded from presenting additional evidence before the court. If a new issue is raised at the workers' compensation court that was not raised at mediation, the court shall remand the issue to the mediator for consideration.

History: En. Sec. 52, Ch. 464, L. 1987; amd. Sec. 2, Ch. 427, L. 1989; amd. Sec. 30, Ch. 416, L. 2005.

39-71-2407. Department authority – rules.

(1) The department shall designate mediators and shall implement the provisions of this part.
(2) The department may adopt the rules necessary to implement this part. The rules may prescribe:
    (a)the qualifications of mediators; and
    (b)a procedure for the conduct of mediation proceedings.
(3) The cost to the department of implementing this part must be paid out of the workers' compensation administration fund.

History: En. Sec. 53, Ch. 464, L. 1987.

39-71-2408. Mandatory, nonbinding mediation.

(1) Except as otherwise provided, in a dispute arising under this chapter, the insurer and claimant shall mediate any issue concerning benefits and the mediator shall issue a report following the mediation process recommending a solution to the dispute before either party may file a petition in the workers' compensation court.
(2) The resolution recommended by the mediator is without administrative or judicial authority and is not binding on the parties.

History: En. Sec. 54, Ch. 464, L. 1987; amd. Sec. 31, Ch. 416, L. 2005.

39-71-2409. Duties of mediator.

A mediator shall assist the parties in negotiating a resolution to their dispute by:
(1) Facilitating an exchange of information between the parties;
(2) Assuring that all relevant information is brought forth during the mediation process;
(3) Suggesting possible solutions to issues of dispute between the parties;
(4) Recommending a solution; and
(5) Assisting the parties to voluntarily resolve their dispute.

History: En. Sec. 55, Ch. 464, L. 1987; amd. Sec. 3, Ch. 427, L. 1989.

39-71-2410. Limitations on mediation proceedings.

(1) Except as may be necessary for the workers' compensation court to rule on issues arising under 39-71-2401(4)(c) or 39-71-2411(8)(c), mediation proceedings must be:
(a) held in private;
(b) informal and held without a verbatim record; and
(c) confidential.
(2) All communications, verbal or written, from the parties to the mediator and any information and evidence presented to the mediator during the proceeding are confidential.
(3) A mediator's files and records are closed to all persons but the parties.
(4) (a) a mediator may not be called to testify in any proceeding concerning the issues discussed in the mediation process.
(b) the mediator's report and any of the information or recommendations contained in the report are not admissible as evidence in any action subsequently brought in any court of law.
(5) Subsections (1) through (4) do not prohibit a mediator from issuing a report and the parties and the mediator may be required to attend a conference before the workers' compensation court as set forth in 39-71-2411.

History: En. Sec. 56, Ch. 464, L. 1987; amd. Sec. 4, Ch. 427, L. 1989; amd. Sec. 11, Ch. 558, L. 1991; amd. Sec. 1, Ch. 39, L. 2005.

39-71-2411. Mediation procedure.

(1) Except as otherwise provided, a claimant or an insurer having a dispute relating to benefits under this chapter may petition the department for mediation of the dispute.
(2) A party may take part in mediation proceedings with or without representation.
(3) The mediator shall review the department file for the case and may receive any additional documentation or argument either party submits.
(4) The claimant and an employee of the insurer or an authorized third-party examiner with settlement authority shall attend any scheduled mediation conference in person or shall participate by telephone conference call.
(5) The mediator shall request that each party offer an argument summarizing the party's position. A party's argument must fully present the party's case. The argument is not limited by the rules of evidence.
(6) After the parties have presented all their information and arguments to the mediator, the mediator shall recommend a solution to the parties within a reasonable time to be established by rule.
(7) A party shall notify the mediator within 25 days of the mailing of the mediator's report as to whether the party accepts the mediator's recommendation. If either party does not accept the mediator's recommendation, the party may petition the workers' compensation court for resolution of the dispute.
(8) (a) If a mediator determines that either party failed to cooperate in the mediation process, the mediator shall prepare a written report setting forth the determination and the grounds for the determination. The report must be mailed to the parties and to the workers' compensation court. Unless a party disputes the determination as set forth in subsection (8)(c), the parties shall repeat the mediation process, but only one time.
(b) a mediator may determine that a party has failed to cooperate in the mediation process only if the party failed to:
(i) supply information or offer a summary of the party's position as reasonably requested by the mediator;

(ii) attend scheduled mediation conferences unless excused by the mediator; or

(iii) listen to and review the information and position offered by the opposing party.

(c) if a party disputes a mediator's determination that the party failed to cooperate in the mediation process, the party may file a petition with the workers' compensation court. Upon receipt of a petition, the court shall summon the parties and the mediator to determine by oral discussion whether the mediator's determination of noncooperation is supportable. If the court finds that the mediator's determination is supportable, the court may order the parties to attempt a second time to mediate their dispute.

History: En. Sec. 57, Ch. 464, L. 1987; amd. Sec. 5, Ch. 427, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 20, Ch. 516, L. 1995; amd. Sec. 2, Ch. 39, L. 2005; amd. Sec. 32, Ch. 416, L. 2005.

Part 25
Employer's Old Fund Liability Tax (Repealed)

39-71-2501. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 1, Ch. 664, L. 1987; amd. Sec. 57, Ch. 83, L. 1989; amd. Sec. 43, Ch. 613, L. 1989; amd. Sec. 14, Ch. 4, Sp. L. May 1990; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 2, Ch. 637, L. 1993; amd. Sec. 2, Ch. 172, L. 1995; amd. Sec. 1, Ch. 246, L. 1995; amd. Sec. 48, Ch. 509, L. 1995; amd. Sec. 6, Ch. 572, L. 1995; amd. Sec. 26, Ch. 276, L. 1997; amd. Sec. 31, Ch. 491, L. 1997.

39-71-2502. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 2, Ch. 664, L. 1987; amd. Sec. 15, Ch. 4, Sp. L. May 1990; amd. Sec. 3, Ch. 637, L. 1993.

39-71-2503. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 3, Ch. 664, L. 1987; amd. Sec. 16, Ch. 4, Sp. L. May 1990; amd. Sec. 1, Ch. 220, L. 1991; amd. Sec. 7, Ch. 797, L. 1991; amd. Sec. 4, Ch. 637, L. 1993; amd. Sec. 3, Ch. 172, L. 1995; amd. Sec. 2, Ch. 246, L. 1995; amd. Sec. 49, Ch. 509, L. 1995; amd. Sec. 6, Ch. 529, L. 1995; amd. Sec. 7, Ch. 572, L. 1995; amd. Sec. 27, Ch. 276, L. 1997; amd. Sec. 39, Ch. 422, L. 1997; amd. Secs. 32, 33, 39(2), Ch. 491, L. 1997.

39-71-2504. Repealed.

Sec. 31(1), Ch. 276, L. 1997.

History: En. Sec. 4, Ch. 664, L. 1987; amd. Sec. 10, Ch. 9, Sp. L. June 1989; amd. Sec. 17, Ch. 4, Sp. L. May 1990; amd. Sec. 8, Ch. 797, L. 1991; amd. Sec. 33, Ch. 455, L. 1993; amd. Sec. 6, Ch. 637, L. 1993; amd. Sec. 47, Ch. 18, L. 1995; amd. Sec. 50, Ch. 509, L. 1995.

39-71-2505. Repealed.

Sec. 8, Ch. 184, L. 1999.

History: En. Sec. 5, Ch. 637, L. 1993; amd. Sec. 1, Ch. 27, L. 1995; amd. Sec. 28, Ch. 276, L. 1997; amd. Sec. 34, Ch. 491, L. 1997.

39-71-2506. Repealed.

Secs. 31(2), 34(3), Ch. 276, L. 1997.

History: En. Sec. 3, Ch. 572, L. 1995.

39-71-2507. Repealed.

Sec. 8, Ch. 184, L. 1999.

History: En. Sec. 6, Ch. 491, L. 1997.

Part 26
Self-Insurers Guaranty Fund

Part Cross-References

Insurance guaranty associations, Title 33, ch. 10.

39-71-2601. Short title.

This part may be cited as the "Montana Self-Insurers Guaranty Fund Act".

History: En. Sec. 1, Ch. 244, L. 1989.

39-71-2602. Purpose – construction.

(1) The purposes of this part are to provide a mechanism for the payment of covered workers' compensation claims of employers bound by compensation plan No. 1 who are unable to pay the claims because of insolvency, to establish a fund from which the claims may be paid, and to establish a board to assess the cost of the protection among those employers.
(2) This part must be liberally construed to effect its purposes. The statement of its purposes constitutes an aid and a guide to the act's interpretation.

History: En. Sec. 2, Ch. 244, L. 1989.

39-71-2603. Definitions.

As used in this part, unless the context requires otherwise, the following definitions apply:
(1) "Board" means the board of directors of the Montana self-insurers guaranty fund.
(2) "Fund" means the Montana self-insurers guaranty fund established pursuant to 39-71-2609.
(3) "Insolvent private self-insurer" means an employer:
    (a)(i) that is unable to pay workers' compensation claims because:
        (A) it has been determined to be insolvent by a court of competent jurisdiction; or
        (B) bankruptcy proceedings have been instituted by or against it; or
    (ii) whose claims are not being paid on its behalf; and
    (b)whose security has been exhausted pursuant to 39-71-2108.
(4) "Member" means an employer bound by compensation plan No. 1 that participates in the Montana self-insurers guaranty fund.
(5) "Private self-insurer" means a private employer bound by compensation plan No. 1 that has secured the payment of workers' compensation claims pursuant to 39-71-2101.

History: En. Sec. 3, Ch. 244, L. 1989.

39-71-2604. Board of directors of fund.

(1) There is a board of directors of the Montana self-insurers guaranty fund.
(2) The board consists of five members who are representatives of private self-insurers and who shall serve staggered 4-year terms.
(3) Board members are elected by the members of the fund, with each member having one vote.

(4) Board members may be reimbursed from the assets of the fund for the actual expenses incurred in connection with their duties as board members.

History: En. Sec. 4, Ch. 244, L. 1989.

39-71-2605 through 39-71-2608 reserved.

39-71-2609. Establishment of fund – employer participation required.

(1) There is a nonprofit unincorporated legal entity, to be known as the Montana self-insurers guaranty fund, financed as provided in 39-71-2615 and 39-71-2616. The fund shall perform its functions under rules adopted by, and powers exercised through, the board established under 39-71-2604.
(2) A private self-insurer shall participate as a member in the fund as a condition of the authority to self-insure in this state under 39-71-2101.

History: En. Sec. 5, Ch. 244, L. 1989; amd. Sec. 5, Ch. 163, L. 1991.

39-71-2610. Rulemaking – powers of fund.

(1) The board shall establish the rules necessary to carry out the purposes of this part and to meet the responsibilities of the fund.
(2) The fund may carry out its responsibilities directly or by contract. It may, if it considers necessary, purchase services and insurance and borrow funds.
(3) The fund may receive confidential information concerning the financial condition of a private self-insurer whose liabilities to pay compensation may devolve upon the fund. The board shall adopt rules to prevent dissemination of the information.

History: En. Sec. 6, Ch. 244, L. 1989.

39-71-2611. Duties, liabilities, and rights of fund.

(1) The fund shall assume the workers' compensation obligations of a private self-insurer that come due after the private self-insurer has been determined to be an insolvent self-insurer.
(2) The fund is not liable for the payment of any penalties or interest assessed for any act or omission of a person acting on behalf of the fund.
(3) The fund is a party in interest in all proceedings involving workers' compensation claims against an insolvent private self-insurer whose workers' compensation obligations have been paid or assumed by the fund. The fund has the same rights and defenses as the insolvent private self-insurer, including but not limited to all of the following:
    (a)to appear and deny, defend, and appeal a claim; and
    (b)to receive notice of, investigate, adjust, compromise, settle, and pay a claim.
(4) The fund shall concur in department decisions relating to allowing an employer to self-insure.

History: En. Sec. 7, Ch. 244, L. 1989; amd. Sec. 6, Ch. 163, L. 1991.

39-71-2612 through 39-71-2614 reserved.

39-71-2615. Initial fee – assessment.

(1) A private self-insurer shall pay to the fund an initial fee of $1,000 upon becoming a member. Thereafter, a member's financial obligation to the fund must be established by assessment as provided in subsection (2).

(2) (a)The fund may assess each of its members a pro rata share of the amount necessary to carry out the purposes of this part. However, the total annual assessments in any calendar year may not exceed 5% of the following benefits paid by each member during the preceding calendar year:
(i) compensation benefits; and
(ii) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, the total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.
(b)funds obtained by assessment pursuant to this subsection may be used only for the purposes of this part.
(3) A former member is liable for assessments made by the fund in any year following the date the member's status as a private self-insurer is terminated, whether the termination is by action of the private self-insurer or the department. A former member's assessment must be based on the benefits paid during the last calendar year immediately preceding the annual assessment.
(4) The board shall certify to the department the collection and receipt of assessments, noting any delinquencies. The board shall take appropriate action to collect a delinquent assessment.

History: En. Sec. 8, Ch. 244, L. 1989; amd. Sec. 15, Ch. 555, L. 1993; amd. Sec. 1, Ch. 68, L. 2001; amd. Sec. 1, Ch. 226, L. 2003.

39-71-2616. Reimbursement for obligations paid and assumed.

(1) The fund shall obtain reimbursement from an insolvent private self-insurer up to the amount of the insolvent private self-insurer's workers' compensation obligations paid and assumed by the fund. This includes reimbursement for reasonable administrative and legal costs.
(2) This right, as subrogee of any claimants in any action to collect against the private self-insurer as the debtor, includes but is not limited to a right to a claim for wages and other necessities of life advanced to any claimants.
(3) The fund may obtain from the security deposit or proceeds of other workers' compensation insurance of an insolvent private self-insurer the amount of the insolvent private self-insurer's compensation obligations, including reasonable administrative and legal costs, paid or assumed by the fund.
(4) The fund may bring an action against any other insurance carrier and person to recover compensation paid and liability assumed by the fund, including but not limited to:
(a)any excess insurance carrier of the private self-insurer; and
(b)any person whose negligence or breach of any obligation contributed to any underestimation of the private self-insurer's total accrual of liability as reported to the department.

History: En. Sec. 9, Ch. 244, L. 1989.

39-71-2617. Tax exemption.

The fund is exempt from payment of all fees and taxes levied by this state or by any city, county, or other political subdivision, except taxes levied on real or personal property.

History: En. Sec. 10, Ch. 244, L. 1989.

39-71-2618. Immunity.

There is no liability on the part of, and no claim for relief of any nature may arise against, any member, the fund, its agents or employees, or the board for any action taken by them in the performance of their powers and duties under this part.

History: En. Sec. 11, Ch. 244, L. 1989.

39-71-2619. Notification of insolvency by private self-insurer.

As a condition of the privilege to self-insure pursuant to Title 39, chapter 71, part 21, a private self-insurer shall agree in writing to notify the department and the fund within 24 hours of the filing of any bankruptcy or determination of insolvency relating to that private self-insurer.

History: En. Sec. 12, Ch. 244, L. 1989.

39-71-2620. Audit requirement.

Biannually or within 6 months after the close of any fiscal year in which the fund has assumed the workers' compensation obligations of an insolvent private self-insurer, the fund shall:
(1) Contract for an independent certified audit of the financial activities of the fund; and
(2) Report on the financial status of the fund to the department and to fund members.

History: En. Sec. 13, Ch. 244, L. 1989.

Parts 27 and 28 Reserved

Part 29
Workers' Compensation Judge

Part Cross-References
Definitions, 39-71-116.

39-71-2901. Renunbered 3-9-103 .

Renumbered 3-9-103

Sec. 8, Ch. 688, L. 2025.

Cross-References
Rules describing agency organization and procedures, 2-4-201.

39-71-2902. Renumbered 3-9-104.

Renumbered 3-9-104

Sec. 8, Ch. 688, L. 2025.

39-71-2903. Renumbered 3-9-106.

Renumbered 3-9-106.

Sec. 8, Ch. 688, L. 2025.

Cross-References
Montana Administrative Procedure Act, Title 2, ch. 4.

39-71-2904. Renumbered 3-9-107.

Renumbered 3-9-107.

Sec. 8, Ch. 688, L. 2025.

39-71-2905. Renumbered 3-9-111.

Renumbered 3-9-111.

Sec. 8, Ch. 688, L. 2025.

39-71-2906. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. 92-848 by Sec. 2, Ch. 537, L. 1975; R.C.M. 1947, 92-848(2).

39-71-2907. Renumbered 3-9-112.

Renumbered 3-9-112.

Sec. 8, Ch. 688, L. 2025.

39-71-2908. Repealed.

Sec. 68, Ch. 464, L. 1987.

History: En. 92-848 by Sec. 2, Ch. 537, L. 1975; R.C.M. 1947, 92-848(3).

39-71-2909. Renumbered 3-9-113.

Renumbered 3-9-113.

Sec. 8, Ch. 688, L. 2025.

39-71-2910. Renumbered 3-9-116.

Renumbered 3-9-116.

Sec. 8, Ch. 688, L. 2025.

39-71-2911. Renumbered 3-9-117.

Renumbered 3-9-117.

Sec. 8, Ch. 688, L. 2025.

39-71-2912 and 39-71-2913 reserved.

39-71-2914. Renumbered 3-9-120.

Renumbered 3-9-120.

Sec. 8, Ch. 688, L. 2025.

Parts 30 Through 39 Reserved

Part 40
Catastrophically Injured Worker's Travel Assistance Act

39-71-4001. Short title.

This part may be cited as the "Catastrophically Injured Worker's Travel Assistance Act".

History: En. Sec. 1, Ch. 345, L. 2005.

39-71-4002. Purpose and intent.

The purpose of this part is to assist catastrophically injured workers and their families by providing that funds raised by community service organizations may be matched with funds from insurers to help the workers and their families defray the costs of travel and lodging expenses incurred by family members or, if a family member is unavailable, by a person designated by the injured worker or approved by the insurer when traveling to be with the worker.

History: En. Sec. 2, Ch. 345, L. 2005.

39-71-4003. Definitions.

As used in this part, the following definitions apply:

(1) "Catastrophically injured" means a physical injury or occupational disease incurred by a worker to the extent that treatment for the injury or occupational disease:
   (a) requires inpatient care for at least 21 consecutive days in a hospital or rehabilitation center that is in Montana but that is more than 100 miles from the worker's place of residence; or
   (b) requires inpatient care for at least 21 consecutive days in a hospital or rehabilitation center that is located outside Montana; and
   (c) occurs within 90 days of the accident or events causing the worker to be catastrophically injured.

(2) "Community service organization" means a community-based, nonprofit, tax-exempt organization under section 501(c)(3) of the Internal Revenue Code that raises money to assist the catastrophically injured worker.

(3) "Worker" has the meaning as provided in 39-71-118.

History: En. Sec. 3, Ch. 345, L. 2005.

39-71-4004. Catastrophically injured worker's travel assistance program – rulemaking authority.

(1) Pursuant to subsection (3), the Department of Labor and Industry shall establish criteria to certify that the funds raised by community service organizations are eligible for matching funds from an insurer.

(2) Money raised by community service organizations to pay travel expenses for a catastrophically injured worker pursuant to this section may not be used by community service organizations to require matching funds by an insurer in an amount greater than $2,500 for each catastrophic injury.

(3) The department shall adopt rules to administer 39-71-704 and this section.

History: En. Sec. 4, Ch. 345, L. 2005.

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Workers' Compensation Mediation

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Worker's Compensation Dispute Resolution - Jurisdiction Procedures and Reports

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Chapter 28
Workers' Compensation Mediation

Subchapter 1
Workers' Compensation Dispute Mediation - Jurisdiction Procedures and Reports

24.28.101 Jurisdiction (REPEALED)

This rule has been repealed.

History: History: 39-71-2407, MCA; IMP, 39-71-2408, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; AMD, 1998 MAR p. 2871, Eff. 11/1/98; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.102 Parties, Attendance, Representation (REPEALED)

This rule has been repealed.

History: History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.103 Requests for Mediation (REPEALED)

This rule has been repealed.

History: History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.104 Time Frames for Settlement Conferences - Notices (REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.105 Motions to Dismiss for Failure to Meet Settlement Requirements (REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.106 Mediation Conferences (REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.107 Role of Mediator—Unrepresented Claimant (REPEALED)

This rule has been repealed.

History: 39-71-2407 MCA; IMP, 39-71-2411 MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22

24.28.108 Mediator's Report—Recommendation (REPEALED)

This rule has been repealed.

History: 39-71-2407 MCA; IMP, 39-71-2409, 39-71-2411 MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.109 Mediator's Report of Non-Cooperation (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2407 MCA; IMP, Sec. 39-71-2411 MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; REP, 1995 MAR p. 2818, Eff. 1/1/96.

24.28.110 Notice to Mediator When Dispute Settled (REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.111 Time-Computation Under Mediation Rules(REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1987 MAR p. 890, Eff. 6/26/87; AMD, 1995 MAR p. 2818, Eff. 1/1/96; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.112 File Information (REPEALED)

This rule has been repealed.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 1995 MAR p. 2818, Eff. 1/1/96; AMD, 1998 MAR p. 2871, Eff. 11/1/98; REP, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.121 Requests For Mediation

(1) A party may request mediation by submitting a request to the department:
   (a) by mail: Dispute Resolution Section, P.O. Box 8011, Helena, MT 59604;
   (b) by e-mail: dlierdmediation@mt.gov; or
   (c) through other means specified by the department.
(2) Electronically submitted documents may bear either a copied manual signature, or an electronic signature.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.125 Parties

(1) The following persons must attend mediation, and may be represented by counsel:
   (a) the claimant;
   (b) any potentially liable insurer or the uninsured employers' fund, through a designated representative; and
   (c) in mediations involving the uninsured employers' fund, any potentially liable employer.
(2) Failure to attend mediation may result in dismissal or a report designating the party as having failed to cooperate in mediation.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 2022 MAR p. 1660, Eff. 8/6/22.

24.28.129 Mediation Process

(1) Mediation must be held within 45 days of receipt by the department of the request for mediation. The time for mediation may be extended by mutual agreement of the parties and the mediator.
(2) The department will issue a notice of mediation, setting forth the time and means of mediation. The notice of mediation will also set forth any documentation or information requests for consideration by the mediator. The parties may supplement the requested information.
(3) Mediation may be held by telephone or remote conferencing platform, or by request of the parties and at the discretion of the mediator, by any other means believed to be beneficial in reaching a conciliated outcome.
(4) The parties may jointly agree to keep open a mediation.
(5) No more than ten days after the close of mediation, the mediator will set forth a written recommendation for the parties.

History: 39-71-2407, MCA; IMP, 39-71-2411, MCA; NEW, 2022 MAR p. 1660, Eff. 8/6/22.

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Chapter 29
Workers' Compensation and Occupational Disease

Subchapter 1
Organizational Rule

24.29.101 Division Organizational Rule (REPEALED)

This rule has been repealed.

History: Secs. 2-15-1702, 2-4-201 MCA; IMP, 2-4-201 MCA; Eff. 12/31/72; AMD, Eff. 1/3/76; AMD, Eff. 2/25/78; AMD, Eff. 6/30/83; AMD, Eff. 9/30/83; AMD, Eff. 3/31/84; AMD, Eff. 9/30/84; AMD, Eff. 3/31/85; AMD, Eff. 6/30/85; AMD, 1985 MAR p. 1563, Eff. 10/18/85; AMD, Eff. 12/31/87; REP, 1994 MAR p. 2351, Eff. 8/12/94.

Subchapter 2
Procedural Rules

24.29.201 Introduction (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-203, 39-72-203 MCA; IMP, Title 2, chapters 3 and 4 MCA; Eff. 12/31/72; AMD, 1983 MAR p. 992, Eff. 7/29/83; AMD, 1996 MAR p. 1673, Eff. 7/1/96; REP, 2022 MAR p. 907, Eff. 6/11/22.

24.29.202 Public Participation (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-3-103 MCA; IMP, Title 2, chapter 3, part 1 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

24.29.203 Adopting, Amending, and Repealing Division Rules (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-4-201 MCA; IMP, Title 2, chapter 4, part 3 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

24.29.204 Issuing Declaratory Rulings (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-4-201 MCA; IMP, Title 2, chapter 4, part 5 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

24.29.205 Issuing Orders (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-203 and 39-72-203, MCA; IMP, 2-4-201, 2-4-202, 39-71-116, 39-71-120, 39-71-415 and 39-72-203, MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; AMD, 1996 MAR p. 1673, Eff. 7/1/96; AMD, 2000 MAR p. 2701, Eff. 10/6/00; REP, 2024 MAR p. 1066, Eff. 5/11/24

24.29.206 Administrative Review (REPEALED)

This rule has been repealed.

History: History: 2-4-201, 39-71-203 and 39-72-202, MCA; IMP, 39-71-204 and 39-72-402, MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; AMD, 1996 MAR p. 1673, Eff. 7/1/96; AMD, 2000 MAR p. 2701, Eff. 10/6/00; REP, 2024 MAR p. 1066, Eff. 5/11/24

24.29.207 Contested Cases (REPEALED)

This rule has been repealed.

History: 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; NEW, 1983 MAR p. 992, Eff. 7/29/83; AMD, 1996 MAR p. 1673, Eff. 7/1/96; AMD, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2024 MAR p. 1066, Eff. 5/11/24

24.29.208 Subpoenas (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-4-201 MCA; IMP, 2-4-104 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

24.29.209 Representation (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-4-201 MCA; IMP, 2-4-106 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

24.29.210 Service (REPEALED)

This rule has been repealed.

History: 2-15-1702 and 2-4-201 MCA; IMP, 2-4-106 MCA; NEW, 1983 MAR p. 992, Eff. 7/29/83; REP, 1996 MAR p. 1673, Eff. 7/1/96.

Rules 24.29.211 and 24.29.212 reserved

24.29.213 Procedure For Issuing Workers' Compensation Determinations Regarding Employment Status, Including That of Independent Contractor (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-120 and 39-71-415 MCA; NEW, 1996 MAR p. 1673, Eff. 7/1/96; REP, 2024 MAR p. 1066, Eff. 5/11/24

Rule 24.29.214 reserved

24.29.215 Time Limits (REPEALED)

This rule has been repealed.

History: 39-71-203 and 39-72-203 MCA; IMP, Title 2, chapter 6 and 2-4-702 MCA; NEW, 1987 MAR p. 1212, Eff. 7/31/87; AMD, 1996 MAR p. 1673, Eff. 7/1/96; REP, 2024 MAR p. 1066, Eff. 5/11/24

Rule 24.29.216 through 24.29.220 reserved

24.29.221 Use of Signatures When Documents Are Being Electronically Transmitted

(1) For purposes of Title 39, chapter 71, MCA, except those which require a signature under oath, the department accepts electronic signatures as follows:

(a) an electronic scan or photocopy of a manual signature for documents transmitted to the department by fax or attached to electronic mail or File Transfer Service in portable document format; or

(b) a signature properly authenticated and verified by an electronic signature for which appropriate auditable records are available. Audit reports or records supporting the signature must be produced to the department upon request.

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

History: 39-71-203, MCA, IMP, 39-71-203, 39-71-717, MCA; NEW, 2018 MAR p. 2527, Eff. 1/1/19; AMD, 2021 MAR p. 276, Eff. 3/13/21.

Rules 24.29.222 through 24.29.229 reserved

24.29.230 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.

History: 39-71-203, MCA, IMP, 39-71-203, 39-71-2401, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.231 through 24.29.234 reserved

24.29.235 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.

History: 39-71-203, MCA, IMP, 39-71-504, 39-71-506, 39-71-541, 39-71-2401, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapters 3 through 5 Reserved

Subchapter 6
Plan 1 Self-Insurance

24.29.601 Definitions

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

(1) Ability to pay" means sufficient financial strength and stability to:
   (a) pay debts as they mature;
   (b) pay benefits and all liabilities which are likely to be incurred under the Workers' Compensation Act, and the Occupational Disease Act for occupational diseases that occurred prior to July 1, 2005; and
   (c) have sufficient cash or cash equivalents, security deposit, and excess insurance to pay benefits as they come due.

(2) "Administrative review" as used in Title 39, chapter 71, part 21, MCA refers to the process set forth in ARM 24.29.230, except that the timelines specified in 39-71-2105, MCA, apply.

(3) "Applicant" means an employer or employer group that makes an election to self-insure under compensation plan no. 1, regardless of whether the election is a new election or a renewal of a prior election.

(4) "Audited financial statements" means a set of documents that includes the applicant's: income statement, balance sheet, statement of cash flow, notes to the financial statements, and a signed, dated independent certified public accountant's independent audit report.

(5) "Benefits" means wage loss, legal, medical, rehabilitation, and all other benefits that are payable under the Workers' Compensation Act and the Occupational Disease Act (Title 39, chapter 72, MCA) for occupational diseases that occurred prior to July 1, 2005, including assessments or financial obligations.

(6) "Claims summary" means a compilation of information relating to prior and existing claims made under the Workers' Compensation Act and the Occupational Disease Act for occupational diseases that occurred prior to July 1, 2005, by showing by policy year, the total number of medical and indemnity claims, total benefits paid, and the total amount reserved for future liabilities.

(7) "Employer group" means employers engaged in the same trades, businesses, occupations or professions who are members of an association which was formed for purposes other than becoming a self-insurer and has existed for a period of at least two years.

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

(9) "Public employer" means a city, county, city and county, school district, irrigation district, all other districts established by law, and all public corporations and quasi-public corporations and public agencies therein.

(10) "Reviewed financial statements" means a set of documents that includes the applicant's:
   (a) income statement;
   (b) balance sheet;
   (c) statement of cash flow;
   (d) notes to the financial statements; and
   (e) a signed, dated statement from an independent certified public accountant expressing limited assurance that there are no material modifications that should be made to the statements, in order for them to be in conformity with generally accepted accounting principles.

History: 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, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 1996 MAR p. 2427, Eff. 5/1/96; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.602 and 24.29.603 reserved

24.29.604 Montana Self-Insurers Guaranty Fund-Acceptance Required for Private Employers or Private Groups

(1) The department will exchange all information with the guaranty fund pertinent to the department's review of the application.

(2) The guaranty fund shall demonstrate its concurrence or nonconcurrence with department approval of a private plan no. 1 applicant by submitting in writing to the department, a formal acceptance or denial of the plan no. 1 applicant.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2103, 39-71-2104, 39-71-2105, 39-71-2106, 39-71-2609, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.605 and 24.29.606 reserved

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.

History: 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 NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12 AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.608 Election To Be Bound By Compensation Plan No. 1 - Eligibility (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.609 Ability to Pay—Evidence Required

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

(a) audited financial statements;

(b) evidence of excess insurance, if required;

(c) a security deposit, if required;

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

(e) other documentation as required by the department.

(2) An employer electing to self-insure that does not have audited statements prepared as a normal business practice may, with the prior approval of the department, and the concurrence of the guaranty fund, substitute reviewed financial statements for audited financial statements if the employer furnishes an increased security deposit.

(3) The department will analyze the information provided by the employer or employer group. The analysis will include review of excess insurance, security deposit and financial conditions, current and historical, related to their ability to pay compensation benefits.

History: 39-71-203, 39-71-2102, MCA; IMP, 39-71-403, 39-71-2102, MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.610 When Security Required (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-403, 39-71-2106, MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; REP, 2024 MAR p. 1066, Eff. 5/11/24

24.29.611 Security Deposit -- Criteria

(1) When a security deposit is required, the following criteria apply:

(a) The department shall accept a surety bond only from companies certified by the United States Department of Treasury as "Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies," as published in the most recent Federal Register.

(i) a surety bond issued by a company that has a Best's rating of "A" or better and a financial size rating of X or greater will be approved.

(ii) a surety bond issued by a company that is rated by Best's, but does not meet the criteria specified in (1)(a)(i) will be considered for approval at the discretion of the department, with the concurrence of the guaranty fund.

(iii) a surety bond issued by a company not rated by Best's will be considered for approval at the discretion of the department, with the concurrence of the guaranty fund.

(b) the security deposit must name the department as obligee and must be held by the department as security for payment of all liabilities likely to be incurred under the Workers' Compensation Act, or the Occupational Disease Act for occupational diseases that occurred before July 1, 2005. The department, with the concurrence of the guaranty fund, shall retain a security deposit until all liabilities have been paid. In the event liabilities have not been met by the self-insurer, the department shall proceed pursuant to 39-71-2108, MCA. If the selfinsurer has placed multiple forms of security deposits, the department shall, at its discretion, convert the deposits needed to pay claims.

(c) a security deposit in the form of a surety bond or letter of credit must include a statement that the grantor of the security deposit is required to give to the principal, the department and the guaranty fund, 60 days notice of its intent to terminate future liability. The grantor of the security deposit is not relieved of liability for injuries occurring prior to the effective date of termination.

(d) the security deposit must be issued on the forms prescribed by the department.

(e) a security deposit in the form of a certificate of deposit must be issued by a financial institution located within the United States and must be fully insured by a federally chartered insurance corporation.

(f) letters of credit must be issued by a financial institution located within the United States with investment grade ratings issued by Moody's Investors Service, Standard & Poor's, or Fitch Ratings. If ratings from those rating entities are not available, the approval of the financial institution will be made at the discretion of the department, with the concurrence of the guaranty fund.

History: 39-71-203 MCA, 39-71-2106, IMP, 39-71-403, 39-71-2106, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff. 5/11/24.)

Rules 24.29.612 through 24.29.615 reserved

24.29.616 Excess Insurance—When Required

(1) Specific excess insurance is required of an employer or an employer group electing coverage under plan No. 1.

(2) Aggregate excess insurance is required by the department, with the concurrence of the guaranty fund, for an employer or an employer group unless substantive evidence is provided that it is not warranted. This evidence must include diversification of risk, industry type, financial resources, self-insured retention levels, policy limits of the specific excess policy, safety program, loss experience and other appropriate factors as determined relevant by the department, with the concurrence of the guaranty fund.

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

(a) it is issued by a carrier admitted and licensed in Montana with a Best's Rating of A- or better and a financial size rating of VI or greater. Excess coverage issued by a carrier not rated by Best's will be considered for approval at the discretion of the department, with the concurrence of the guaranty fund.

(b) a self-insurer that anticipates that it may have material changes to the provisions or coverage of its excess insurance policy must notify the department of that possibility at least 30 days before the effective date of the changes.

(i) if there is a change in the provisions or coverage, the department has the authority to evaluate the changes related to the terms of the authorization to self-insure, and the department may, with the concurrence of the guaranty fund, make adjustments in the terms of that authorization accordingly.

(ii) in the event of a temporary extension of authority, the department may condition the renewal of self-insurance authority upon a suitable change in the amount of security required from the self-insurer.

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

(d) it must include an endorsement regarding late claim reporting penalty waiver.

(e) all of the following will be applied toward the retention level in the excess insurance contract:

(i) payments made by the self-insurer; (ii) payments made on behalf of the self-insurer from the proceeds of any security deposit as ordered by the department; and

(iii) payments made on behalf of the insolvent self-insurer by the guaranty fund.

(f) copies of the certificates and policies of the excess insurance must be filed with the department for a determination that such certificates and policies fully comply with the provisions of the Workers' Compensation Act, the Occupational Disease Act, and ARM Title 24, chapter 29, subchapter 6.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2103, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2018 MAR p. 2527, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.617 Initial Election—Individual Employers

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

(a) a completed application on forms provided by the department;

(b) audited financial statements for the last two years, or an employer that does not have audited financial statements prepared as a normal business practice may, with the prior approval of the department and the concurrence of the guaranty fund, substitute reviewed financial statements if the employer furnishes an increased security deposit approved by the department with the concurrence of the guaranty fund;

(c) proof that it has been in business for a period of not less than three years; however, at the discretion of the department, with the concurrence of the guaranty fund:

(i) a new employer created from the reorganization of a self-insured employer may elect to self-insure even though it has not been in existence for a period of three years. Such election must be made on the effective date of creation of the new employer;

(ii) an employer in business less than three years may be considered if its liability is guaranteed by a parent corporation which has been in business for a period of not less than three years. The department, with the concurrence of the guaranty fund, may accept a guarantee from an employer in lieu of a parental guarantee;

(iii) an employer whose liability is guaranteed by a parent corporation, or an employer shall provide a resolution and an agreement of assumption and guarantee of workers' compensation liabilities on forms prescribed by the department and submit two years of audited financial statements demonstrating the ability to pay compensation benefits;

(d) evidence that it has obtained an insurance policy of specific excess and if required, aggregate excess insurance with policy limits, nature of coverage, and retention amounts acceptable to the department, with the concurrence of the guaranty fund, as required in ARM 24.29.616;

(e) a claims summary of claims incurred in Montana from insurance companies who provided coverage for the preceding three years;

(f) evidence that its internal or contracted claims adjustment service is in compliance with 39-71-107, MCA;

(g) evidence that it has a written safety and loss control program;

(h) a security deposit in an amount required by the department with the concurrence of the guaranty fund; (i) evidence that internal policies and procedures are satisfactory to administer a self-insurance program.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

24.29.618 Initial Election—Employer Groups

(1) An employer group applicant shall provide the following:
(a) a completed application on forms provided by the department;
(b) a list of individual employers making up the employer group;
(c) a signed copy of the by-laws adopted by the employer group, and all documents pertaining to formation, operation and contractual arrangements, including amendments and addenda;
(d) a copy of an agreement signed by each individual employer showing:
(i) each employer's agreement to accept joint and several liability for all workers' compensation and occupational disease liabilities incurred by the employer group;
(ii) provisions for addition of a new member to the self-insured employer group;
(iii) provisions for withdrawal and expulsion of a member from the self-insured employer group;
(iv) provision for power of attorney between the individual employers and the self-insured employer group;
(v) agreement to be bound by the by-laws and by the employer group's decisions; and
(vi) provisions for assessment for deficits;
(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.
(f) evidence that each private employer in the group has been in business for a period of not less than three years;
(g) a claims summary from insurance carriers who provided coverage for claims incurred in Montana for each member of the employer group for the preceding three years;
(h) evidence of specific excess and if required, aggregate excess insurance with policy limits and retention amounts acceptable to the department and guaranty fund; (i) a security deposit in an amount as required by the department, with the concurrence of the guaranty fund;
(j) evidence of its internal or contracted claims adjustment service in compliance with 39-71-107, MCA;
(k) identification of the financial institution the employer group will use to deposit and withdraw funds for purposes of paying workers' compensation and occupational disease liabilities;
(l) an explanation of how claims reserves will be established on each case and the method of review to assure accuracy and adequacy of the amount of the reserves;
(m) the estimated annual premium to be paid by each member of the employer group;
(n) a projection of annual administrative expenses;
(o) evidence that the employer group has an effective written safety and loss control program;
(p) evidence that internal policies and procedures are satisfactory to operate a group selfinsurance program;
(q) resolution by each member authorizing participation in the program;
(r) resolution designating authorized signatures for participation in the program;
(s) a feasibility study conducted by a certified actuary to include an actuarial forecasting of losses and recommended premium levels;
(t) a business plan for the employer group;
(u) pro forma financial statements for each of the first five years of the employer group's operation, to include any assumptions made; and

(v) copies of any contracts including, but not limited to, contracts with an administrative service company, claims examiner, and fiscal agent.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2106, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Rules 24.29.619 and 24.29.620 reserved

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. 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) a completed application on forms provided by the department;

(b) resolution designating authorized signatures for participation in the program;

(c) a copy of a signed agreement showing:

(i) agreement to accept joint and several liability for all workers' compensation benefits and occupational disease obligations incurred by the employer group;

(ii) provision for power of attorney between the new applicant and the employer group; and

(iii) agreement to be bound by the by-laws and by the employer group's decisions;

(d) copies of two years' audited or reviewed financial statements may be required from each new applicant by the department or the guaranty fund;

(e) a claims summary from insurance carriers who provided coverage for claims incurred in Montana during the preceding 3 years;

(f) evidence that the applicant has been accepted for coverage by the employer group's excess insurance carrier; and

(g) evidence that the private employer has been in business for a period of not less than 3 years; however, a new entity created from the reorganization of one or more self-nsured entities may elect to self-insure individually or as a member of a employer group even though the new entity has not been in existence for a period of 3 years. Such election shall be made on the effective date of the new employer entity.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2106, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.622 Permission to Self-Insure (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2101 through 39-71-2103 MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.623 Renewal Required (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-403, 39-71-2104, MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2012 MAR p. 1666, Eff. 8/24/12; REP, 2024 MAR p. 1066, Eff. 5/11/24.

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 24.29.230. If a self-insurer's permission to self-insure is revoked, the employer(s) shall elect to be bound by compensation plan no. 2 or plan no. 3 on the effective date of the revocation of permission to self-insure.

(2) Suspension or termination of membership in the Montana self-insurers guaranty fund or failure to pay the department's annual assessment may result in automatic and immediate termination of the department's permission to self-insure in accordance with 39-71-2609 and 39-71-2105 , MCA.

(3) An employer or employer group which is self-insured under plan no. 1 which intends to withdraw as a self-insurer or withdraw the self-insurance status of any subsidiaries, or members, shall notify the department and the guaranty fund, in writing, of its intent at least 60 days in advance of the change in status. Until all liabilities have been paid, the employer or employer group remains subject to these rules.

History: 39-71-203 MCA, IMP, 39-71-403, 39-71-203 MCA, IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.625 and 24.29.626 reserved

24.29.627 Right to Review (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-403, 39-71-2101 through 39-71-2108 and 39-71-2905, MCA; NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2000 MAR p. 2701, Eff. 10/6/00; 2024 MAR p. 1066, Eff. 5/11/24.

24.29.628 Notification of Changes in Self-Insurer Status Required

(1) The self-insurer shall notify the department in writing:

(a) 60 days prior to implementing changes that may affect its self-insurance status including but not limited to:

(i) name, controlling ownership, legal status, change in proposed employer group membership, or permanent employment location;

(ii) permanent increase or decrease of more than 25% in the number of employees in Montana; or

(iii) changes in the policies, procedures or administration of its self insurance program; and

(b) within 30 days subsequent to:

(i) adverse material change in financial status;

(ii) adverse material change in liabilities;

(iii) changes in excess coverage;

(iv) permanent reductions, shutdowns, suspensions, or closures of Montana operations; or

(v) new or additional location of employment in Montana as a result of a significant change of operations.

History: 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, NEW, 1996 MAR p. 1151, Eff. 5/1/96; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.629 and 24.29.630 reserved

24.29.631 Self-Insured Employers and Groups – Transfer of Claim Liabilities

(1) Any current or former self-insurer or group may transfer existing workers' compensation liabilities to another entity upon authorization from the department and concurrence of the guaranty fund. The self-insurer or group shall:
(a)make application for the transfer of the claims; and
(b)provide an actuarial analysis of the claims to be transferred.
(2) The transfer application and approval process and guidelines will be consistent with the application and approval process for all new or proposed self-insured entities as provided by part 21 of the Workers' Compensation Act and ARM Title 24, chapter 29, subchapter 6.
(3) The independent actuarial analysis of the employer's or group's claim liabilities must be made using the preceding year's data, including all years of self-insurance liabilities. The actuarial report must be completed by a qualified actuary as defined by the American Academy of Actuaries.
(4) After the transfer of claims liabilities is complete, the new owner of the claims liabilities will have the same reporting requirements as all other prior self-insureds in Montana.

History: 39-71-203, MCA; IMP, 39-71-2115, MCA; NEW, 2012 MAR p. 1666, Eff. 8/24/12.

Rules 24.29.632 and 24.29.634 reserved

24.29.635 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.

History: 39-71-203, MCA; IMP, 39-71-2104, MCA, NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 7
Employers Insurance Requirements

24.29.701 Introduction (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-203 MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84/; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702 Election to be Bound by Compensation Plan No.1—Eligibility (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2101 to 39-71-2109 MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1986 MAR p. 1903, Eff. 11/15/86; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702A Solvency and Ability to Pay (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2101 to 39-71-2109 MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; AMD, 1995 MAR p. 669, Eff. 5/1/95; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702B When Security Required (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2106 and 39-71-2107 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; AMD, 1995 MAR p. 669, Eff. 5/1/95; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702C Surety Bond Security Deposit—Amounts Required (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2106 and 39-71-2107 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; AMD, 1995 MAR p. 669, Eff. 5/1/95; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702D Surety Bonds—Criteria (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2106 and 39-71-2107 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702E Excess Insurance (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2101, 39-71-2102 and 39-71-2103 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702F Initial Election—Individual Employers (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2101, 39-71-2102, and 39-71-2103 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; AMD, 1995 MAR p. 669, Eff. 5/1/95; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702G Initial Election—Groups of Employers and New Members of Existing Groups (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103 and 39-71-2106 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; AMD, 1993 MAR p. 2240, Eff. 10/1/93; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702H Permission (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403, 39-71-2101, 39-71-2102, and 39-71-2103 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702I Renewal Required (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2104 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702J Renewal—Individual Employers (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2104 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1995 MAR p. 669, Eff. 5/1/95; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702K Renewal—Group Of Employers (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2104 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1993 MAR p. 2240, Eff. 10/1/93; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702L Suspension and Revocation of Permission (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2104 MCA; NEW, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702M Termination by Self-Insurer (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2101 to 39-71-2109 MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1986 MAR p. 1903, Eff. 11/15/86; AMD, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.702N Review Process (REPEALED)

This rule has been repealed.

History: 39-71-203 MCA; IMP, 39-71-403 and 39-71-2101 to 39-71-2109 MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1986 MAR p. 1903, Eff. 11/15/86; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.7020 Notification of Changes (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-403 and 39-71-2101 to 39-71-2109, MCA; NEW, 1987 MAR p. 2385, Eff. 1/1/88; REP, 1996 MAR p. 1151, Eff. 5/1/96.

24.29.703 Evidence of Coverage

(1) Insurance policies under plan No. 2 or 3 must include:
   (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.

History: 39-71-203, MCA; IMP, 39-71-401, MCA, NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2018 MAR p. 2527, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.704 Who Must be Bound (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-401, MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; AMD, 1995 MAR p. 1953, Eff. 10/1/95, 2024 MAR p. 1066, Eff. 5/11/24.)

24.29.705 Corporate Officer Exemption (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-401, MCA; AMD, 1984 MAR p. 983, Eff. 7/2/84; TRANS, from ARM 24.29.3201, Eff. 7/2/84; AMD, 1986 MAR p. 49, Eff. 1/17/86; AMD, 1995 MAR p. 1953, Eff. 10/1/95; REP, 2000 MAR p. 2701, Eff. 10/6/00.

24.29.706 Election not to be Bound—Independent Contractor (REPEALED)

This rule has been repealed.

History: 39-71-203 and 39-71-401 MCA; IMP, 39-71-401 MCA; NEW, 1984 MAR p. 983, Eff. 7/24/84; AMD, 1992 MAR p. 2759, Eff. 12/25/92; REP, 1996 MAR p. 1303, Eff. 5/10/96.

24.29.706A Application For Independent Contractor Exemption (TRANSFERRED)

(IS HEREBY TRANSFERRED TO ARM 24.35.111)

History: 39-71-203 and 39-71-401 MCA; IMP, 39-71-120, 39-71-401 and 39-71-409 MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96.

24.29.706B Renewal of Independent Contractor Exemption (TRANSFERRED)

(IS HEREBY TRANSFERRED TO ARM 24.35.116)

History: 39-71-203 and 39-71-401 MCA; IMP, 39-71-120 and 39-71-401 MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96.

24.29.706C Application Fee for Independent Contractor Exemption (TRANSFERRED)

(IS HEREBY TRANSFERRED TO ARM 24.35.121)

History: 39-9-103, 39-71-203 and 39-71-401 MCA; IMP, 39-9-206, 39-71-120 and 39-71-401 MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96.

24.29.706D Suspension or Revocation of Independent Contractor Exemption (TRANSFERRED)

(IS HEREBY TRANSFERRED TO ARM 24.35.131)

History: 39-71-203 and 39-71-401 MCA; IMP, 39-71-120 and 39-71-401 MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96.

24.29.706E Guidelines for Determining Whether an Independent Contractor Exemption is Needed (TRANSFERRED)

(IS HEREBY TRANSFERRED TO ARM 24.35.141)

History: 39-71-203 and 39-71-401 MCA; IMP, 39-71-120 and 39-71-401 MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96.

24.29.707 Ineffective Election to be Bound, Resulting Division Action (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-408, 39-71-504 and 39-71-507, MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.708 Posting Insurance Status in Workplace (REPEALED)

This rule has been repealed.

History: 39-71-203 and 39-71-401, MCA; IMP, 39-71-401, MCA; NEW, 1984 MAR p. 983, Eff. 7/2/84; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.709 Security Deposits for Plan Number Two Insurers – Reports (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-2215, MCA; NEW, 2012 MAR p. 1666, Eff. 8/24/12; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.710 reserved

24.29.711 Status of Certain Personal Assistants for the Purpose of Workers' Compensation Laws

(1) For the purposes of workers' compensation and occupational disease laws, a person with a disability who receives services of a personal assistant or an immediately involved representative of the disabled person, such as a parent or guardian, is not the employer of the personal assistant despite the exercise of control over the selection, management and supervision of the personal assistant if:

(a) the personal assistant is providing services to the disabled person pursuant to 53-6-145, MCA, and rules adopted by the department of public health and human services implementing that statute; and

(b) the personal assistant is the employee of another person or entity that has the right to exercise an employer's control over the personal assistant, including the right to discipline and terminate employment.

History: 53-6-145, MCA; IMP, 53-6-145, MCA; NEW, 1995 MAR p. 2145, Eff. 10/13/95.

Rule 24.29.712 reserved

24.29.713 Evidence of Insurance Coverage (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-304, 39-71-401, 39-71-402, 39-71-2201, and 39-71-2336, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.714 through 24.29.719 reserved

24.29.720 Payments that are not Wages—Employee Expenses

(1) 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) the amount of each employee's reimbursement is entered separately in the employer's records;

(b) the employee could reasonably be expected to incur the expenses while traveling on the business of the employer;

(c) the reimbursement is not based on a percentage of the employee's wages nor is it deducted from wages; and

(d) the reimbursement does not replace the customary wage for the occupation.

(2) Reimbursement for expenses may be based on any of the following methods that apply:
(a) for actual expenses incurred by the employee, to the extent that they are supported by receipts;
(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, MCA, for meals and lodging, unless, through documentation, the employer can substantiate a higher rate;
(c) for mileage, at a rate no greater than that allowed by the United States internal revenue service for that year, provided that the individual actually furnishes the vehicle;
(d) for equipment other than vehicles, the reasonable rental value for that equipment;
(e) for heavy equipment, including but not limited to semi-tractors or bulldozers, the reasonable rental value may not exceed 75% of the employee's gross remuneration;
(f) for drivers utilized or employed by a motor carrier, 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.

History: 39-71-203, MCA; IMP, 39-71-123, MCA; NEW, 1992 MAR p. 2753, Eff. 12/25/92; AMD, 1995 MAR p. 1953, Eff. 1/1/96 AMD, 2024 MAR p. 1066, Eff. 5/11/24.)

24.29.721 Value of Employer-Furnished Housing

(1) For the purposes of this rule, the following definitions apply:
(a) "agricultural employer" means an employer whose operations are assigned to an agricultural classification code for workers' compensation purposes. The term is intended to be consistent with the definition of agriculture provided by 15-1-101, MCA.
(b) "bedroom" means a room in a dwelling that is primarily used for sleeping.
(c) "dwelling" means a building equipped for human habitation.
(d) "zero bedrooms" means a dwelling that is an efficiency, dormitory, or a bunkhouse.
(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. The rental value is specified in the publications below, available on the department's website or on request:
(a) "Montana Workers Compensation Housing, Rent or Lodging Monthly Rates, 2025" beginning July 1, 2025.
(b) all prior editions of "Montana Workers Compensation Housing, Rent or Lodging Monthly Rates" are available on the department's website.
(3) In recognition of Montana's rural nature and expansive landscape, and the fact that housing supplied by an agricultural employer is likely to be remotely situated and distant from communities with an established rental housing market, housing furnished by an agricultural employer is discounted by 50 percent of the fair rental value for housing established in (2) of this rule, for the county in which the dwelling is located.
(4) If an individual is not currently using the room for sleeping, it is not considered a bedroom for the purpose of this rule.

History: 39-71-203, MCA; IMP, 39-71-123, MCA; NEW, 2018 MAR p. 640, Eff. 4/1/18; AMD, 2024 MAR p. 1066, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Subchapter 8
Rules of Practice

24.29.801 Accident Reporting

(1) A plan No. 2 or plan No. 3 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.

History: 39-71-203, 39-71-307, MCA; IMP, 39-71-307, 39-71-603, MCA; Eff. 12/31/72; AMD, Eff. 1/3/76; AMD, 1998 p. 2872, Eff. 11/1/98; AMD, 2013 MAR p. 841, Eff. 5/24/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

24.29.802 Support Documents for Reporting (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, MCA; Eff. 12/31/72; AMD, Eff. 2/5/76; AMD, 1990 MAR p. 2183, Eff. 12/14/90; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.803 Compensation to be Paid (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-740, MCA; Eff. 12/31/72; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.804 Examiners and Third-Party Administrators in Montana (REPEALED)

This rule has been repealed.

History: 39-71-107, 39-71-203, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; Eff. 12/31/72; AMD, Eff. 2/5/76; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2013 MAR p. 841, Eff. 5/24/13; AMD, 2019 MAR p. 2119, Eff. 12/1/19; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.805 Continuity of Compensation Payment (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-741, MCA; Eff. 12/31/72; AMD, Eff. 2/5/76; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.806 Medical Evaluations (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, MCA; Eff. 12/31/72; AMD, 39-71-203 MCA; IMP, 39-71-307 and 39-71-604 MCA; REP, 1990 MAR p. 2183, Eff. 12/14/90.

24.29.807 Protection of Persons (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, MCA; Eff. 12/31/72; AMD, Eff. 1/3/77; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.808 General Rules (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-605 and 39-71-1001, MCA; Eff. 12/31/72; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.809 and 24.29.810 reserved

24.29.811 Purpose of Rules (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; REP, 2019 MAR p. 2119, Eff. 12/1/19.

Rule 24.29.812 reserved

24.29.813 Definitions

For purposes of this subchapter, the following definitions apply:

(1) "Certified claims examiner" means a claims examiner who is in compliance with the requirements of 39-71-320, MCA.

(2) "Credit hours" means the value assigned to a course by the department, upon review and approval of course materials and content outline.

(3) "Hour," for the purposes of continuing education credits, means a 50-minute period.

(4) "Instructor" means an individual who meets the requirements set forth in ARM 24.29.844, is identified by a sponsoring organization in a course submission, participates in course presentations, activities and discussions, and who may monitor the attendance and conduct of course participants, or administer examinations.

(5) "New hire" means a person who has:

(a) not been previously employed by the insurer or third-party administrator as a claims examiner;

(b) been separated from employment with the insurer or third-party administrator for at least 60 days and is required to complete new hire paperwork such as a Form I-9 or Form W-4; or

(c) received an internal promotion or transfer to a claims examiner position. The term includes a temporary employee.

(6) "Significant change" means a change in two or more of the following course elements:

(a) course goals or objectives;

(b) major course topic(s);

(c) course length;

(d) syllabus or course outline;

(e) teaching method; or

(f) examination method.

(7) "Sponsoring organization" means any group(s) or organization(s) and their agent(s) that submit courses for department review and offer or provide approved courses for continuing education credit to allow claims examiner certification and are responsible for those course offerings.

(8) "Trainee" means an employee who has no prior claims examiner experience and is participating in a program by which the employer prepares the trainee to carry out the essential functions of a certified claims examiner.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.)

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.
(2) After an insurer or its agent has accepted liability for the claim or has begun paying benefits under a reservation of rights (including pursuant to 39-71-608, MCA), a certified claims examiner is responsible for making any decision that denies, reduces, or changes the type or level of benefits being provided to an injured worker or the survivors of an injured worker.
(3) A person does not violate this rule if under the following circumstances, a person not certified as a claims examiner denies initial liability on a new claim, when the first report of injury clearly shows that the alleged incident has not resulted in:
    (a) professional medical evaluation or treatment;
    (b) loss of work exceeding the shift during which the accident occurred; or
    (c) anything other than mere notice of a possible exposure to a potentially harmful substance or condition.
(4) A claim denied under the circumstances described in (4) must identify in the denial letter the certified claims examiner who is accountable for the decision to deny the claim.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-107, 39-71-116, 39-71-320, MCA; NEW, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.817 Applicability of Rules (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; REP, 2019 MAR p. 2119, Eff. 12/1/19.

24.29.818 New Hires and Claims Examiner Trainees - Designation of Certified Claims Examiner to be Accountable for Decisions

(1) A new hire or claims examiner trainee may, for a period of not more than 180 days, perform tasks otherwise required to be performed by a certified claims examiner, if the employer has designated a certified claims examiner as being accountable for the decisions made by the new hire or claims examiner trainee.
(2) 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.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.819 through 24.29.820 reserved

24.29.821 Certification of Claims Examiners

(1) Claims examiners must be certified by the department upon the following:
    (a) completion of the application form provided by the department;
    (b) payment of the required fees; and
    (c) satisfactory completion of an examination.
(2) Certification is for a two-year period. The certification date is the date of the successfully completed examination.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.822 and 24.29.823 reserved

24.29.824 Examination for Claims Examiners

(1) Certified claims examiner applicants must take and pass the department-approved examination.
(2) Any person taking an examination may use a copy of Title 39, chapter 71, MCA, during the test procedure.
(3) A passing score on an examination is at least 80 percent.
  (a)an applicant for claims examiner certification may take the examination up to three times in a 180-day period. If an applicant does not pass the examination within that 180-day period, the applicant must wait 60 days before taking the examination again.
  (b)the examination fee must be paid for each examination taken.
(4) Any examination completed through dishonest or fraudulent means is given a score of 0.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.825 reserved

24.29.826 Reporting of Employment Status or Change of Address to the Department

(1) A certified claims examiner must report to the department, within 20 days of the event:
  (a)the name and address of an insurer or third-party administrator who has hired the person to be employed as a certified claims examiner, and the date of hire;
  (b)the date of separation of employment from that employer; and
  (c)a change of address or other contact information for the certified claims examiner.
(2) An insurer or third-party administrator must report to the department, within 20 days of the event, the name and date of hire of any person who will be working as a claims examiner for the employer as either a:
  (a)new hire; or
  (b)claims examiner trainee.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2019 MAR p. 2119, Eff. 12/1/19.

24.29.827 Waiver of Examination (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; REP, 2019 MAR p. 2119, Eff. 12/1/19.

Rules 24.29.828 through 24.29.830 reserved

24.29.831 Lapse in Certification

(1) If a certification has lapsed but application for renewal is received within 24 months from the renewal date, the claims examiner must pay the application fee and provide evidence of sufficient continuing education credits received during the lapsed period.

(2) If a certification has lapsed greater than 24 months from the renewal date, the claims examiner shall submit an initial application for certification, pay the required fees, and successfully pass an examination to become a certified claims examiner. The continuing education credit requirement for renewal starts over with the new certification period.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.832 and 24.29.833 reserved

24.29.834 Continuing Education Requirements for Renewal

(1) Certification shall be renewed upon:
  (a) payment of the applicable fee;
  (b) completion of the renewal form provided by the department at any time during the certification period, but no later than the expiration of the certification period;
  (c) verification of completion of 24 hours of approved continuing education courses during the current certification period, to include at least:
    (i) four hours of training on workers' compensation statutes, administrative rules, and case law since the last certification; and
    (ii) one hour of training on appropriate and ethical communication; and
    (iii) other approved continuing education courses which may include but are not limited to mediation/negotiation; medical terminology; human anatomy; interpreting medical records; injured worker's rights and responsibilities; insurers' rights and responsibilities; prevention of injuries; stay-at-work/return-to-work training; and medical fee schedule reimbursements.

(2) The department may accept workers' compensation continuing education courses approved by the Office of Public Instruction, the state bar of Montana or the Montana insurance commissioner for the adjuster license requirements which meet the course criteria specified in these rules toward the 24 hours of approved courses required for the claims examiner certification renewal.

(3) No more than six hours of approved continuing education courses may be carried over to the next certification period. The request for approved continuing education courses to be carried over must be submitted with the renewal application for which the courses were taken.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19.

Rules 24.29.835 and 24.29.836 reserved

24.29.837 Review and Approval of Continuing Education Courses by Department

(1) Any sponsoring organization that requests continuing education credits be approved by the department for training must complete and submit a request on a form provided by the department.

(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.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-107, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24

Rules 24.29.838 through 24.29.840 reserved

24.29.841 Course Submissions

(1) The following standards, by which acceptability of submitted courses are evaluated, must all be certified by the sponsoring organization:
  (a) the practical and academic experience of each faculty member is sufficient to teach the subject assigned;
  (b) the course enhances the ability of a claims examiner to provide claims handling services to the public effectively;
  (c) the subject matter relates to professional ethics, where practicable.
(2) Submissions for approval of courses must include all information requested by the department on the form for submission.
(3) Requests for advance approval of courses must be received by the department no less than 30 days prior to the anticipated starting date of the course.
(4) Requests for approval of courses already held must be received prior to December 31 of the calendar year in which the activity was presented.
(5) Charges for courses must be clearly disclosed to students before enrollment:
  (a) if a course is canceled for any reason, all charges are refundable in full, unless the refund policy is clearly defined in the enrollment application;
  (b) in instances requiring refunds under (6)(a), the charges must be refunded within 45 days of cancellation;
  (c) in the event that a continuing education provider postpones a course for any reason, the provider must give the students a choice of attending a course at a later date or having their charges refunded in full. The provider must refund the charges within 45 days of the postponement unless the student notifies the provider that the student has chosen to attend a later course;
  (d) a sponsoring organization may have a refund policy addressing a student's cancellation or failure to complete a course, as long as that policy is made clear to potential students.
(6) A sponsoring organization must provide proof of course completion to each course participant who successfully completes the approved course of study within one month of course completion or prior to the end of the calendar year during which the participant completed the course. The department may grant the sponsoring organizations up to two months to provide such proof of course completion, if the sponsoring organization notifies the course participants in writing, in advance of the course. (7) Sponsoring organizations who add qualified course instructors after a course is approved must submit the names of those instructors to the department at least three days prior to the course offering.
(8) Course approval is for a period of two years following the course approval date.
(9) Sponsoring organizations must resubmit courses for new review and certification whenever significant changes in course content are made.
(10) The minimum number of credits that the department may award is one credit.
(11) No course may be advertised as having been approved for credit by the department until the sponsoring organization receives written approval from the department.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.842 and 24.29.843 reserved

24.29.844 Qualifications for Instructors

(1) Instructors must have experience in at least one of the following for the department to approve the course:
  (a) three or more years of managerial, supervisory, technical, or teaching experience as a subject matter expert;
  (b) appropriate national designations; or
  (c) approval on an exception basis by the department.
(2) An instructor may be disqualified if that person has:
  (a) intentionally falsified documents filed with the department; or
  (b) intentionally misrepresented course approval, credit hour assignment, curriculum, or course content to students or prospective students.
(3) Certified claims examiners teaching or lecturing approved courses will be credited with two times the number of approved credit hours of courses they instruct.
(4) Proctors will not earn continuing education credit for their services.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.845 and 24.29.846 reserved

24.29.847 Fees for Certification, Examination, Renewal, and Course Submission

(1) The following fees apply to the certified claims examiner program:
  (a) initial application for certification $100
  (b) examination $75
  (c) renewal application $75
  (d) renewal application for lapsed certification $100
  (e) approval of a continuing education course $75
(2) All fees are payable in advance.
(3) All fees are nonrefundable.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; AMD, 2019 MAR p. 2119, Eff. 12/1/19.

Rules 24.29.848 through 24.29.850 reserved

24.29.851 Maintenance of Certification Documentation (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-320, MCA; IMP, 39-71-105, 39-71-320, MCA; NEW, 2009 MAR p. 2019, Eff. 10/30/09; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 9
Administrative Assessment

24.29.901 Definitions (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.902 Definitions (REPEALED)

This rule has been repealed.

History: 39-71-203, 50-71-114, MCA; IMP, 39-71-201, 39-71-915 , 39-71-1011, 39-71-2352, 50-71-128, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; AMD, 2004 MAR p. 645, Eff. 3/26/04; AMD, 2018 MAR p. 2527, Eff. 1/1/19; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.903 reserved

24.29.904 Administrative Assessment Methodology in General (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.905 Administrative Assessment Methodology in General (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

Rule 24.29.906 reserved

24.29.907 Billing and Payment of the Administration Fund Assessment (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201 and 39-71-408, MCA; NEW, 2004 MAR p. 645, Eff. 3/26/04; REP, 2024 MAR p. 1066, Eff.5/11/24.

24.29.908 Penalties, Administrative Fines and Interest

(1) Any assessment payment, surcharge remittance, summary report, or quarterly expenditure report received by the department more than five days past the due date is considered to be late.

History: 39-71-203, MCA; IMP, 39-71-201, 39-71-306, and 39-71-915, MCA; NEW, 2004 MAR p. 645, Eff. 3/26/04; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2024 MAR p. 1066, Eff.5/11/24.

24.29.909 Recalculation of Administrative Assessments Made in Fiscal Years 1992 - 1995 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

Rules 24.29.910 and 24.29.911 reserved

24.29.912 Administrative Assessment Methodology for Fiscal Year 1992 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.913 Administrative Assessment Methodology for Fiscal Year 1993 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.914 Administrative Assessment Methodology for Fiscal Year 1994 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.915 Administrative Assessment Methodology for Fiscal Year 1995 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.916 Administrative Assessment Methodology for Fiscal Year 1996 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.917 Administrative Assessment Methodology for Fiscal Year 1997 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

24.29.918 Administrative Assessment Methodology for Fiscal Years 1998 and 1999 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

Rules 24.29.919 and 24.29.920 reserved

24.29.921 Recalculation of Administration Fund Assessments Made in Fiscal Years 1992 - 1995 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.922 Administration Fund Assessment Methodology for Fiscal Year 1992 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.923 Administration Fund Assessment Methodology for Fiscal Year 1993 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.924 Administration Fund Assessment Methodology for Fiscal Year 1994 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.925 Administration Fund Assessment Methodology for Fiscal Year 1995 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.926 Administration Fund Assessment Methodology for Fiscal Year 1996 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.927 Administration Fund Assessment Methodology for Fiscal Year 1997 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.928 Assessment Methodology for Fiscal Years 1998 and 1999 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.929 Assessments other than the Administration Fund Assessment (REPEALED)

This rule has been repealed.

History: 39-71-203, 50-71-114, MCA; IMP, 39-71-201, 39-71-915, 39-71-1011, 50-71-128, MCA; NEW, 1999 MAR p. 2877, Eff. 12/17/99; AMD, 2004 MAR p. 645, Eff. 3/26/04; AMD, 2018 MAR p. 2527, Eff. 1/1/19; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.930 through 24.29.940 reserved

24.29.941 Assessments other than Administrative Assessment (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-902 and 39-71-1004, MCA; NEW, 1997 MAR p. 1364, Eff. 8/5/97; REP, 1999 MAR p. 2877, Eff. 12/17/99.

Rules 24.29.942 through 24.29.950 reserved

24.29.951 Definitions (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, 39-71-915, 39-71-1004 and 39-71-2352, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; REP, 2004 MAR p. 645, Eff. 3/26/04.

Rules 24.29.952 and 24.29.953 reserved

24.29.954 Calculation of Amount of Administration Fund Assessment (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201, 39-71-203, 39-71-209, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; AMD, 2004 MAR p. 1023, Eff. 3/26/04; AMD, 2012 MAR p. 1666, Eff. 8/24/12; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.955 Billing for and Payment of the Administrative Assessment (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-201 and 39-71-408, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.956 Computation and Collection of the Administration Fund and Safety Fund Assessment Premium Surcharge Rate for Plan No. 2 and No. 3 (REPEALED)

This rule has been repealed.

History: 39-71-203, 50-71-114, MCA; IMP, 39-71-201, 39-71-203, 39-71-2352, 50-71-128, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; AMD, 2004 MAR p. 645, Eff. 3/26/04; AMD, 2012 MAR p. 1666, Eff. 8/24/12; AMD, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.957 through 24.29.960 reserved

24.29.961 The Subsequent Injury Fund Assessments for Years Beginning on or after (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-915, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; REP, 2004 MAR p. 645, Eff. 3/26/04.

24.29.962 Computation of the Subsequent Injury Fund Assessment Surcharge (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-915, MCA; NEW, 2004 p. 645, Eff. 3/26/04; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.963 Calculating SIF Paid Previous Year Through Current Year

(1) The total amount paid by SIF from April 1 of the previous year through March 31 of the current year includes commitments for payments by SIF on individual reimbursements or settlements.

History: 39-71-203, MCA; IMP, 39-71-915, MCA; NEW, 2018 MAR p. 2527, Eff. 1/1/19

Rules 24.29.964 through 24.29.965 reserved

24.29.966 Industrial Accident Rehabilitation Account (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-1004, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; AMD, 2004 MAR p. 645, Eff. 3/26/04; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.967 through 24.29.970 reserved

24.29.971 Failure of Insurer To Timely Report Paid Losses–Department Estimate of Paid Losses–Recalculation of Assessment and Premium Surcharge–Penalty (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-306, 50-71-114, MCA; IMP, 39-71-201, 39-71-306, 39-71-915, 50-71-128, MCA; NEW, 2000 MAR p. 844, Eff. 3/30/00; AMD, 2004 MAR p. 645, Eff. 3/26/04; AMD, 2018 MAR p. 2527, Eff. 1/1/19; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.972 through 24.29.974 reserved

24.29.975 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.

History: 39-71-203, MCA; IMP, 39-71-201, 39-71-306, 39-71-915, 39-71-1049, 50-71-128, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.976 through 24.29.979 reserved

24.29.980 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.

History: 39-71-203, MCA; IMP, 39-71-201, 39-71-306, 39-71-915, 39-71-1049, 50-71-128, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapters 10 and 11 Reserved

Subchapter 12

Rules on Lump Sum Conversions of Benefits

24.29.1201 Approval - When Required

(1) No department approval is required for a lump-sum payment of:
(a) accrued indemnity benefits;
(b) advance indemnity benefits; or
(c) an impairment award for a claim with a date of injury on or after July 1, 2005.

(2) The department presumes that biweekly benefit payments are in the best interests of the worker. Department approval of a petition for lump-sum conversion may be given only if the worker demonstrates that the worker's ability to become financially self-sustaining is more probable with a whole or partial lump-sum payment than with the biweekly payments and the worker's other resources, as outlined by ARM 24.29.1202.

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

History: 39-71-203, MCA, Chapter 471, Laws of 1985; IMP, 39-71-741, MCA; NEW, 1985 MAR p. 1564, Eff. 10/18/85; AMD, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2013 MAR p. 841, Eff. 5/24/13 AMD, 2024 MAR p. 1066, Eff. 5/11/24.

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; and
(d) an affidavit signed by the worker attesting to the validity of information provided in the written petition.

(2) A petition to the department for conversion of biweekly permanent partial disability benefits to a lump-sum payment must include an analysis of current financial conditions as described in (3) only for a claim with a date of injury prior to July 1, 1991.

(3) "Analysis of current financial condition" for purposes of (1) shall include a detailed list of all the worker's assets, liabilities, sources of income, and monthly obligations.
(4) A petition for lump-sum conversion of permanent total benefits that involves the partial or total elimination of existing delinquent or outstanding debts must include a plan for debt consolidation.
(5) If a permanent total benefit lump-sum proposal involves a business venture, the proposal must include a business plan that shows the net income available to the worker after business expenses are paid.
(6) A request for lump-sum settlement of medical benefits must include the following completed forms:
(a) "Petition for Settlement Injury/Occupational Disease Medical Benefits Closed On An Accepted Claim" form 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. (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. 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.

History: 39-71-203, MCA; IMP, 39-71-741, MCA; NEW, 1985 MAR p. 1564, Eff. 10/18/85; AMD, 2013 MAR p. 841, Eff. 5/24/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1203 Methods the Department will apply to Evaluate Information Provided

(1) The department shall deny a petition for a lump-sum conversion of permanent total disability unless the worker demonstrates that the worker's ability to become financially self-sustaining is more probable with a whole or partial lump-sum payment than with biweekly payments and the worker's other resources.
(2) The department shall approve a petition for lump-sum conversion of permanent total disability benefits when:
(a) the worker demonstrates that the worker's financial condition under the lump-sum proposal will not be greater than could have reasonably been expected had the worker not been injured and the lump sum is limited to the unpaid biweekly benefits; and
(b) the worker demonstrates that the lump-sum proposal will improve the worker's financial condition over what could have been reasonably expected had the worker not been injured and the lump sum is limited to the purchase price to the insurer of an annuity that would yield an amount equal to the biweekly benefits payable over the estimated duration of the compensation period.
(3) For claims with date of injury between April 15, 1985 and June 30, 1987, all requirements of (2) must be met and the proposed lump-sum amount of unpaid biweekly benefits may be discounted at a rate of 7% per year, compounded annually.
(4) If the claimant does not meet the requirements of 39-71-710, MCA, and the estimated duration of the compensation period is the remaining life expectancy of the worker, the insurer shall determine the remaining life expectancy in accordance with the most recent Life Table: Expectation of Life at Single Years of Age, by Race and Sex: United States, all races, both sexes column, in Vital Statistics of the United States, Volume II-Mortality, Part A, U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics.

(5) If the difference between the present discounted value of a permanent total disability lump-sum payment and the future value of the biweekly payments is the only justification provided for the lump-sum conversion, the department shall deny the petition.
(6) The department shall deny or approve a lump-sum petition within 14 days of receipt. If additional information is required to enable a determination on a petition, the department shall request the information within the 14-day review period. If additional information is not received within the 14-day review period, the department shall deny the petition on the basis of lack of information.

History: 39-71-203, MCA; IMP, 39-71-710, 39-71-741, MCA; NEW, 1985 MAR p. 1564, Eff. 10/18/85; AMD, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2013 MAR p. 841, Eff. 5/24/13.

24.29.1204 Further Studies may be Required (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-741, MCA; NEW, 1985 MAR p. 1564, Eff. 10/18/85; AMD, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2013 MAR p. 841, Eff. 5/24/13.

Subchapter 13 Reserved

Subchapter 14
General Medical Rules and Facility Service Rules

24.29.1401 Initial Liability (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-510, 39-71-704, 39-71-743, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007; MAR p. 260, Eff. 2/23/07 REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1401A Definitions

As used in subchapters 14 and 15, the following definitions apply:
(1) “Acute care hospital” or “hospital” means a health care facility appropriately licensed by the Department of Public Health and Human Services that provides inpatient and outpatient medical services to injured workers experiencing acute illness or trauma. Acute care hospitals are sometimes referred to as regulated hospitals.
(2) “Ambulatory Payment Classification (APC)” means the reimbursement system adopted by the department for outpatient services.
(3) “Ambulatory surgery center (ASC)” means a health care facility that operates primarily for the purpose of furnishing outpatient surgical services to patients.
(4) “Base rate” means the dollar value which is multiplied by the relative weight of the MS-DRG or APC to determine payment.
(5) “Bundling” means the practice of grouping multiple services, procedures, and supplies into one charge item instead of billing each separately.
(6) “CCR,” formerly known as “RCC,” means the cost-to-charge ratio computed by using the hospital’s Medicare cost report and charges.
(7) “CMS” means the Centers for Medicare and Medicaid Services.
(8) “Correct Coding Initiative (CCI)” means the code edits adopted by the department that are used to correct contradictory billing information.

(9) "Current Procedural Terminology (CPT)" codes means codes and descriptors of procedures owned, copyrighted, and published by the American Medical Association.

(10) "Designated Treating Physician" has the same meaning as a "treating physician," defined in 39-71-116, MCA, who is designated or formally approved by the insurer as the physician who will be coordinating the injured worker's care, according to the criteria in 39-71-1101, MCA.

(11) "Documentation" means written information that is complete, clear, and legible, which describes the service provided and substantiates the charge for the service.

(12) "Durable medical equipment (DME)" means durable medical appliances or devices used in the treatment or management of a condition or complaint, along with associated nondurable materials and supplies required for use in conjunction with the appliance or device. The term does not include an implantable object or device.

(13) "Evidence-based" means use of the best evidence available in making decisions about the care of the individual patient, gained from the scientific method of medical decision-making and includes use of techniques from science, engineering, and statistics, such as randomized controlled trials (RCTs), meta-analysis of medical literature, integration of individual clinical expertise with the best available external clinical evidence from systematic research, and a risk-benefit analysis of treatment (including lack of treatment).

(14) "Facility" or "health care facility" means all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term includes chemical dependency facilities, critical access hospitals, end-stage renal dialysis facilities, home health agencies, home infusion therapy agencies, hospices, hospitals, long-term care facilities, intermediate care facilities for the developmentally disabled, medical assistance facilities, mental health centers, outpatient centers for surgical services, rehabilitation facilities, residential care facilities, and residential treatment facilities. The above facilities are defined in 50-5-101, MCA. The term does not include outpatient centers for primary care, infirmaries, provider-based clinics, offices of private physicians, dentists or other physical or mental health care workers, including licensed addiction counselors.

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

(16) "Healthcare Common Procedure Coding System (HCPCS)" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code. These codes also include successor codes for CPT and HCPCS established by the American Medical Association and CMS.

(17) "Implantable" means a system of objects or devices that is made either to replace and act as a missing biological structure, to repair or support a biological structure, or to manage chronic disease processes and that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to install, operate, program, and recharge the implantable.

(18) "Improvement status" means written information that is complete, clear, and legible, which identifies objective medical findings of the claimant's medical status with respect to the treatment plan.

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

(20) "Interested party" means:

(a) the "physician" or "provider" as defined by this rule;

(b) the "claimant" or "injured worker"; or

(c) the representative of the injured worker. (21) "Medicare-Severity Diagnosis Related Group (MS-DRG or DRG)" means the inpatient diagnosis classifications of circumstances where patients demonstrate similar resource consumption, length of stay patterns, and medical severity status that are adopted by the department and are used for billing purposes.

(22) "Nonfacility" means any place not included in this rule's definition of "facility."

(23) "Objective medical findings" means medical evidence that is substantiated by clinical findings. Clinical findings include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence. Complaints of pain in the absence of clinical findings are not considered objective medical findings.

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

(25) "Physician" means a healthcare provider who meets the licensure requirements of a "treating physician" as defined by 39-71-116, MCA.

(26) "Prior authorization" means that for those matters identified by ARM 24.29.1621 the provider receives (either verbally or in writing) authorization from the insurer to perform a specific procedure or series of related procedures, prior to performing that procedure.

(27) "Provider" means any health care provider, unless the context in another rule clearly indicates otherwise. "Provider" does not include pharmacists nor does it include a supplier of medical equipment who is not a health care provider.

(28) "Relative Value Unit" or "RVU" represents a unit of measure for medical services, procedures, or supplies. RVU is used in the fee schedule formulas to calculate reimbursement fees and is expressed in numeric units. Those services that have greater costs or value have higher RVUs than those services with lower costs or value.

(29) "Resource-Based Relative Value Scale" or "RBRVS" means the publication titled "Essential RBRVS," published by OptumInsight, Inc.

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

(31) "Status indicator (SI)" codes mean CPT codes treated in the same fashion or category, such as packaged services, and apply to outpatient services only.

(32) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. The treatment plan must include a diagnosis of the condition, the specific type(s) of treatment, procedure, or modalities that will be employed, a timetable for the implementation and duration of the treatment, and the goal(s) or expected outcome of the treatment. Treatment, as used in this definition, may consist of diagnostic procedures that are reasonably necessary to refine or confirm a diagnosis. The treating physician may indicate that treatment is to be performed by a provider in a different field or specialty, and defer to the professional judgment of that provider

in the selection of the most appropriate method of treatment; however, the treatingphysician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

History: 39-71-203, MCA; IMP, 39-71-116, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; TRANS from ARM 24.29.1504 and AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

24.29.1402 Payment of Medical Claims

(1) Payment of medical claims must be made in accordance with the schedule of facility and professional medical fees adopted by the department.
   (a) payment of medical claims must also be made in accordance with the utilization and treatment guidelines adopted by the department in ARM Title 24, chapter 29, subchapter 16.
   (b) the department may assess a penalty on insurers for neglect or failure to use the correct fee schedule. It is the insurer's responsibility to ensure that the correct fee schedule is used by a third-party agent.
   (c) a provider of medical treatment or services shall only be paid for services under this chapter if the bill for medical treatment or services is timely received by the employer or appropriate payer. Absent a showing of good cause, a bill for treatment or services is timely received by the employer or appropriate payer when it is actually received within 365 days of the later of:
      (i) the date of service; or
      (ii) the date the provider of medical treatment or services knew the treatment or services was related to a claim for benefits under this chapter.

(2) The insurer shall make timely payments of all medical bills for which liability is accepted. For services provided on or after July 1, 2013, the department may assess a penalty on an insurer that without good cause neglects or fails to pay undisputed medical bills on an accepted liability claim within 60 days of receipt of the bill(s). The insurer must document receipt date of the bill(s) or the receipt date will be three days after the bill(s) was sent by the provider.

(3) For purposes of coding interest billing on unpaid charges, providers must bill the interest amount using the Montana unique code MT005 established by this rule.

(4) Payment of private room charges shall be made only if ordered by the treating physician.

(5) Special nurses shall be paid only if ordered by the treating physician.

(6) For claims arising on or after July 1, 1993, no fee or charge is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer, other than:
   (a) the co-payment provided by 39-71-704, MCA. The decision whether to require a co-payment rests with the insurer, not the medical provider. If the insurer does not require a co-payment by the worker, the provider may not charge or bill the worker any fee. The insurer must give enough advance notice to known medical providers that it will require co-payments from a worker so that the provider can make arrangements with the worker to collect the copayment;
   (b) the charges for a nonpreferred provider, after notice is given as provided in 39-71-1102, MCA;
   (c) the charges for medical services obtained from other than a managed care organization, once an organization is designated by the insurer as provided in 39-71-1101, MCA; or
   (d) the charges for medical services denied by the insurer on the basis that the services meet both of the following criteria:

(i) the medical services do not return the injured worker to employment; and
(ii) the medical services do not sustain medical stability.

(7) For compensable services provided on or after July 1, 2013, if the injured worker pays for the initial medical service prior to acceptance of the claim by the insurer, the injured worker must be reimbursed the entire amount they paid out-of-pocket within 30 days of acceptance.
(a)if the insurer pays the provider, the provider must reimburse the injured worker.
(b)otherwise, the insurer must reimburse the injured worker

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-510, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1993 MAR p. 2801, Eff. 12/1/93; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2024 MAR p. 1457, Eff. 7/1/24

24.29.1403 Selection of Physician (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; REP, 1993 MAR p. 404, Eff. 4/1/93.

24.29.1404 Disputed Medical Claims

(1) The following issues are considered to be disputes arising over the amount of a fee for medical services:
(a)amounts payable to medical providers, when benefits available directly to claimants are not an issue;
(b)access to medical records;
(c)timeliness of payments to medical providers; or
(d)requirements for documentation submitted by a provider to an insurer pursuant to ARM 24.29.1513 as a condition of the payment of medical fees.

(2) Facility records must be furnished to the insurer upon request. Facilities must obtain the necessary release by their administrative procedures.

(3) The rule of privileged communication is waived by the injured worker seeking benefits under the Workers' Compensation or Occupational Disease acts.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2024 MAR p. 1457, Eff. 7/1/24.

24.29.1405 Physicians' Reports (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 1991 MAR p. 2622, Eff. 12/27/91; REP, 1993 MAR p. 404, Eff. 4/1/93.

24.29.1406 Facility Bills

(1) Facility bills must be submitted on a UB04 when the injured worker is discharged from the facility or every 30 days.

(2) The providers and payers shall use, when possible, electronic billing for the billing and reimbursement process.

(3) It is the responsibility of the facility to use the proper service codes on any bills submitted for payment.

(4) Insurer-initiated medical necessity review, bill audits, and other administrative review procedures may only be conducted on a post-payment basis.

History: 39-71-203, MCA; IMP, 39-71-105, 39-71-107, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2013 MAR p. 1185, Eff 7/12/13; ; AMD, 2024 MAR p. 1457, Eff. 7/1/24.

24.29.1407 Prosthetic Appliances

(1) Claims for furnishing replacement or repair of prosthetic appliances shall be paid to orthotists or prosthetists, who have been certified by the American Board for Certification in Orthotics or Prosthetics, and whose services are performed in a certified facility.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; Eff. 12/31/72; AMD, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2024 MAR p. 1457, Eff. 7/1/24.

24.29.1408 Suspension Allowed

(1) An insurer may suspend compensation payments under 39-71-607 , MCA, for not more than 30 days pending the receipt of medical information, if:

(a) the insurer submits to the department a detailed written statement indicating that the insurer is having difficulty in receiving medical information relating to a claimant's condition;

(b) the department approves a suspension of compensation payments for not more than 30 days pending the receipt of medical information; and

(c) after the department approves the suspension of payments, the insurer notifies the claimant in writing that biweekly payments are being suspended pending the receipt of medical information. A copy of the notification shall be furnished to the department.

History: 39-71-607, MCA; IMP, 39-71-607, MCA; NEW, Eff. 1/3/76; AMD, 2024 MAR p. 1457, Eff. 7/1/24.

24.29.1409 Travel Expense Reimbursement

(1) Payment of travel expense is subject to the following:

(a) claims for travel reimbursement must be submitted on a form provided by the insurer within 90 days of the date the expense was incurred. After 90 days, the insurer must make reimbursement, unless, during the 90 days that the reimbursement was available:

(i) the insurer has proof of providing written notice to the injured worker that travel reimbursement is available; and

(ii) the written notice stated that a travel reimbursement claim must be submitted to the insurer within 90 days of the worker incurring the expense.

(b) the type of travel selected must be the least costly form of travel unless the travel is not suitable for the claimant's medical condition, as certified by the claimant's physician.

(c) reimbursement of travel is excluded under the following conditions:

(i) the first 100 miles of automobile travel are excluded each month unless the insurer requested the travel pursuant to 39-71-605 , MCA.

(ii) travel to a medical provider within the claimant's community is excluded.

(iii) travel outside the claimant's community is excluded if comparable treatment is available within the community, unless the insurer requests the claimant to travel to another community.

(iv) travel is excluded when it is incurred while traveling to unauthorized or disallowed treatment or procedures.

(d) for purposes of this rule, "community" means the area within a 15 mile radius of the claimant's residence as determined by the most direct automobile route between the claimant's residence and the provider.

(e) the insurer is not liable for injuries that result from an accident that occurs during travel for treatment of the claim as provided in 39-71-704 , MCA.

(f) reimbursement for travel expenses shall be determined as follows:

(i) personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the claimant's residence and the provider.

(ii) expenses for eligible meals shall be reimbursed at the meal rates established for state employees.

(iii) actual out-of-pocket receipted lodging expenses incurred by the claimant shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by a receipt from a licensed lodging facility. If the claimant fails to obtain a receipt, the reimbursement is the amount set for state employees.

(iv) miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.

(2) Preauthorized expenses incurred for direct commercial transportation by air or ground, including rental vehicles, shall be reimbursed when no other less costly form of travel is available to the claimant, or when less costly forms of travel are not suitable to the claimant's medical condition, as certified by the claimant's physician.

(a) if a claimant chooses to use commercial transportation when a less costly form of travel suitable to the claimant's medical condition is available, as certified by the claimant's physician, reimbursement shall be made according to the rates associated with the least costly form of travel.

History: 39-71-203, 39-72-203, 39-72-402, MCA; IMP, 39-71-704, 39-72-602, 39-72-608, MCA; NEW, 1990 MAR p. 1564, Eff. 8/17/90; AMD, 1993 MAR p. 2804, Eff. 12/1/93; AMD, 2006 MAR p. 210, Eff. 1/27/06; AMD, 2024 MAR p. 1457, Eff. 7/1/24.

Rules 24.29.1410 through 24.29.1414 reserved

24.29.1415 Impairment Rating Dispute Procedure (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-711, MCA; NEW, 1987 MAR p. 1985, Eff. 10/30/87; AMD, 1990 MAR p. 1004, Eff. 6/1/90; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 2007 MAR p. 260, Eff. 2/23/07.

24.29.1416 Applicability of Date Of Injury, Date of Service

(1) The amounts of the following types of payments are determined according to the specific department rates in effect on the date the medical service or services are provided, regardless of the date of injury:
(a)medical fees;
(b)facility charges;
(c)prescription drugs; and
(d)DME.
(2) When services, procedures, or supplies are bundled for purposes of billing and the bundling covers more than one day, the date of discharge must be used as the date the services are provided for purposes of this rule.

History: 39-71-203, MCA; IMP, 39-71-704, 39-71-727, MCA; NEW, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1994 MAR p. 679, Eff. 4/1/94; AMD, 2007 MAR p. 1192, Eff. 8/24/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08.

Rules 24.29.1417 through 24.29.1419 reserved

24.29.1420 Relative Value Fee Schedule (REPEALED)

This rule has been repealed.

History: 39-71-203 and 39-71-704, MCA, as amended by section 3 of Ch. 422 of Laws of 1985; IMP, 39-71-704, MCA; NEW, 1986 MAR p. 454, Eff. 4/1/86; REP, 1993 MAR p. 404, Eff. 4/1/93.

Rules 24.29.1421 through 24.29.1424 reserved

24.29.1425 Rates for Hospital Services Provided Prior to July 1, 1997 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1987 MAR p. 2388, Eff. 1/1/88; AMD, 1991 MAR p. 2622, Eff. 12/27/91; AMD, 1998 MAR p. 759, Eff. 4/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1426 Hospital Service Rules for Services Provided from April 1, 1998, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1427 Hospital Service Rules for Services Provided from January 1, 2008, Through November 30, 2008 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1428 Hospital Rates for July 1, 1997, through June 30, 1998 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1429 reserved

24.29.1430 Hospital Rates from July 1, 1998, through June 30, 2001 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1998 MAR p. 759, Eff. 4/1/98; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1431 Hospital Rates from July 1, 2001, through November 30, 2008 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1432 Facility Service Rules and Rates for Services Provided from December 1, 2008 through June 30, 2013 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; NEW, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2013 MAR p. 1185, Eff. 7/12/13.

24.29.1433 Facility Service Rules and Rates

(1) The department adopts the fee schedules provided by this rule to determine the reimbursement for medical services provided by a facility when a person is discharged on or after July 1, 2013. An insurer is obligated to pay the fee provided by the fee schedules for a service, even if the billed charge is less, unless the facility and insurer have a managed care organization (MCO) or preferred provider organization (PPO) arrangement that provides for a different payment amount. The fee schedules are available online at the 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. The fee schedules are comprised of the elements listed in 39-71-704, MCA, and the following:

(a) the Montana Status Indicator (SI) Codes;

(b) the Montana unique code, MT003, described in (11)(e) and (12)(f); and

(c) the base rates and conversion formulas are established by the department.

(d) all current and prior instruction sets for services provided starting July 1, 2013, are available on the department's website.

(2) The application of the base rate depends on the date the medical services are provided.

(3) Critical access hospitals (CAH) are reimbursed at 100 percent of that facility's usual and customary charges. CAH is a designation for a facility only. The reimbursement rate for CAH set by this rule applies to facility charges.

(a) regarding professional services provided at a physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services provided on an outpatient basis must be billed on a UB04 and reimbursed 100 percent of usual and customary. PT, OT, and ST outpatient services may not be billed on the CMS 1500.

(b) all other professional services provided at a CAH must be billed on a CMS 1500 and reimbursed according to the professional fee schedule pursuant to ARM 24.29.1534.

(4) Any services provided by a type of facility not explicitly addressed by this rule or any services using new codes not yet adopted by this rule must be paid at 75 percent of the facility's usual and customary charges.

(5) Any inpatient rehabilitation services, including services provided at a long- term inpatient rehabilitation facility must be paid at 75 percent of that facility's usual and customary charges. All CMS rehabilitation MS-DRGs are excluded from the Montana MS-DRG payment system and instead are paid at 75 percent of the facility's usual and customary charges regardless of the place of service.

(6) DME, prosthetics, and orthotics, excluding implantables, will be paid according to the professional fee schedule pursuant to ARM 24.29.1534 or, if no reimbursement value, ARM 24.29.1523.

(7) Facility billing must be submitted on a CMS Uniform Billing (UB04) form, including the 837-I form when submitting electronically.

(8) Hospitals and ASCs must, on an annual basis, submit to the department data reporting Medicare, Medicaid, commercial, unrecovered, and workers' compensation claims reimbursement in a standard form supplied by the department. The department may in its discretion conduct audits of any facility's financial records to confirm the accuracy of submitted information.

(9) Medical provider services furnished in an acute care hospital, ASC, or other facility setting, whether those professional services are furnished as an employee or as an independent professional, must be billed separately using the CMS 1500 and must be reimbursed using the professional fee schedule pursuant to ARM 24.29.1534, except as provided in (a).

(a) PT, OT, and ST services provided on an outpatient basis must be billed on a UB04 and reimbursed according to the facility fee schedule. These reimbursements are excluded from any calculation of outlier payments. PT, OT, and ST outpatient services may not be billed on the CMS 1500.

(10) Facility pharmacy reimbursements are made as follows:

(a) if a facility pharmacy dispenses prescription drugs to an individual during the course of treatment in the facility, reimbursement is part of the MS-DRG or APC reimbursement.

(b) if a patient's medications are not included in the MS-DRG or APC service bundle, the reimbursement will be according to ARM 24.29.1529.

(11) The following applies to inpatient services provided at an acute care hospital:

(a) the department may establish the base rate annually.

(i) the base rate effective July 1, 2025, is $10,384.

(ii) all prior base rates for services provided starting July 1, 2013, are available on the department's website.

(b) payments for inpatient acute care hospital services must be calculated using the base rate multiplied by the Montana MS-DRG weight.

(c) if a service falls outside of the scope of the MS-DRG and is not otherwise listed on a Montana fee schedule, including new codes not yet adopted, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) the threshold for outlier payments is three times the Montana MS-DRG payment amount. If the outlier threshold is met, the outlier payment must be the MS-DRG reimbursement amount plus an amount that is determined by multiplying the charges above the threshold by the sum of 15 percent and the individual hospital's Montana CCR.

(i) for example, if the hospital submits total charges of $100,000, the MS-DRG reimbursement amount is $25,000, and the CCR is 0.50, then the resultant calculation for reimbursement is as follows: The DRG reimbursement amount ($25,000) is multiplied by 3 to set the threshold trigger ($75,000). The threshold trigger ($75,000) is subtracted from the total charges ($100,000) resulting in the amount above the trigger ($25,000). The amount above

the trigger ($25,000) is then multiplied by .65 (which is the CCR of .5 plus .15) to obtain the outlier payment ($16,250). The total payment to the hospital in this example would be the DRG reimbursement amount ($25,000) plus the outlier payment ($16,250) = $41,250.

(ii) the department may establish the inpatient outlier amount annually.

(e) where an implantable exceeds $10,000 in cost, hospitals may seek additional reimbursement beyond the normal MS-DRG payment. Hospitals may seek additional reimbursement by using Montana unique code MT003. Any implantable that costs less than $10,000 is bundled in the implantable charge included in the MS-DRG payment.

(i) any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable (or purchase order if it lists the number of items, the wholesale price, and the shipping costs) and the operative report. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice or purchase order for the implantable, plus 15 percent of the actual amount paid for the implantable, plus the handling and freight cost for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(iii) when a hospital seeks additional reimbursement pursuant to this subsection, the implantable charge is excluded from any calculation for an outlier payment.

(iv) because the decision regarding an implantable is a complex medical analysis, this rule defers to the judgment of the individual physician and facility to determine the appropriate implantable. A payer may not reduce the reimbursement when the medical decision is to use a higher cost implantable.

(f) all facility services provided during an uninterrupted patient encounter leading to an inpatient admission must be included in the inpatient stay, except air and ground ambulance services which are paid separately pursuant to the Montana Ambulance Fee schedule. Air ambulances whose charter and certification is through the federal Department of Transportation will be paid at 100 percent of their usual and customary charges pursuant to federal law.

(g) the following applies to facility transfers when a patient is transferred for continuation of medical treatment between two acute care hospitals:

(i) a hospital receiving a patient is paid the full MS-DRG payment plus any appropriate outliers and add-ons.

(ii) facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

(12) The following applies to outpatient services provided at an acute care hospital or an ASC:

(a) the department may establish a base rate annually.

(i) the base rate effective July 1, 2025, is $133.

(ii) all prior base rates for services provided starting July 1, 2013, are available on the department's website.

(b) the department may establish a base rate annually for ASCs at 75 percent of the hospital outpatient base rate.

(i) the base rate effective July 1, 2025, is $100.

(ii) all prior base rates for services provided starting July 1, 2013, are available on the department's website.

(c) payments for outpatient services in a hospital or an ASC are based on the Montana APC system. A single outpatient visit may result in more than one APC for that claim. The payment must be calculated by multiplying the base rate times the APC weight. If an APC code is available, the services must be billed using the APC code. If the APC weight is not listed or if the APC weight is listed as null, reimbursement for that service must be paid at 75 percent of the facility's usual and customary charges. Examples of such services include but are not limited to laboratory tests and radiology. If a service falls outside of the scope of the APC and is not otherwise listed on a Montana fee schedule, reimbursement for that service must be 75 percent of that facility's usual and customary charges.

(d) CCI and MUE code edits must be used to determine bundling and unbundling of charges.

(e) outpatient medical services include observation in an outpatient status.

(f) where an outpatient implantable exceeds $500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC payment. In such an instance, the provider may bill using Montana unique code MT003. Any implantable that costs less than $500 is bundled in the APC payment.

(i) any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable (or purchase order if it lists the number of items, the wholesale price, and the shipping cost) and the operative report. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) reimbursement is set at a total amount that is determined by adding the actual amount paid for the implantable on the invoice or purchase order for the implantable, plus 15 percent of the actual amount paid for the implantable, plus the handling and freight cost for the implantable. Handling and freight charges must be included in the implantable reimbursement and are not to be reimbursed separately.

(g) the following applies to patient transfers from an ASC to an acute care hospital:

(i) an ASC transferring a patient is paid the APC reimbursement.

(ii) the acute care hospital is paid the MS-DRG or the APC reimbursement, whichever is applicable.

(iii) facility transfers do not include costs related to transportation of a patient to initially obtain medical care. Such reimbursements are covered by ARM 24.29.1409.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 1055, Eff. 6/18/16; AMD, 2017 MAR p. 784, Eff. 6/10/17; AMD, 2018 MAR p. 1036, Eff. 5/26/18; AMD, 2019 MAR p. 848, Eff. 6/22/19; AMD, 2020 MAR p. 1021, Eff. 6/13/20; AMD , 2021 MAR p. 716, Eff. 6/12/21 AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2023 MAR p. 522, Eff. 6/10/23; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Subchapter 15
Nonfacility Service Rules

24.29.1501 Purpose (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2024 MAR p. 1066, Eff. 5/11/24.)

Rules 24.29.1502 and 24.29.1503 reserved

24.29.1504 Definitions (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; TRANS, to ARM 24.29.1401A, and AMD, 2008 MAR p. 2490, Eff. 12/1/08.

Rules 24.29.1505 through 24.29.1509 reserved

24.29.1510 Selection of Physician for Claims Arising From July 1, 1993 through June 30, 2013 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 2809, Eff. 12/1/93; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2013 MAR p. 1185, Eff. 7/12/13; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1511 Selection of Physician for Claims Arising Before July 1, 1993 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 2809, Eff. 12/1/93; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1512 Selection of Physician for Claims Arising on or After July 1, 2013

(1) Initial or repeated treatment in an emergency room or urgent care facility is not selection of a treating physician.

(2) The insurer must provide formal notification of the designated treating physician by e-mail, facsimile, or letter to:

(a) the injured worker;

(b) the current treating physician; and

(c) the designated treating physician. The effective date of the designation of treating physician is the date the insurer sends the notice of designation unless the physician declines within ten working days.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1513 Documentation Requirements

(1) 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) 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, the provider must provide to the insurer:

(a) CMS 1500;

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

(c) applicable treatment notes.

(4) Documentation, excluding (1)(b), is considered to be a service to the injured worker and no charge is allowed for the documentation required by this rule.

(5) The treating physician must report immediately to the insurer the date total disability ends or the date the injured worker is released to return to work.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2026 MAR, Notice No. 2025-110, Eff. 1/10/26.

Rule 24.29.1514 reserved

24.29.1515 Functional Improvement Status

(1) Functional improvement status must consist of objective medical findings of the claimant's functional status, and document the effect of interventions (positive, neutral, or negative) on functional goals. The functional improvement status can be sufficiently documented on the Medical Status Form. The Montana Utilization and Treatment Guidelines outline the standards for functional improvement.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2026 MAR, Notice No. 2025-110, Eff. 1/10/26

Rule 24.29.1516 reserved

24.29.1517 Prior Authorization for Certain Services (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, 39-71-743, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1518 reserved

24.29.1519 Second Opinions for Services Provided on or Before June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1520 reserved

24.29.1521 Medical Equipment and Supplies for Dates of Service Before January 1, 2008 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1522 Medical Equipment and Supplies Provided by a Nonfacility for Dates of Service on or After January 1, 2008 Through June 30, 2013 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2008 MAR p. 2490, Eff. 12/1/08; AMD, 2013 MAR p. 1185, Eff. 7/12/13 REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1523 Medical Equipment and Supplies

(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 durable medical equipment (such as by complex assembly, modification, or special fabrication), then the provider may charge a reasonable fee for those services. Unpacking an item or simple fitting may not be billed. Extensive fitting of devices may be billed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1524 and 24.29.1525 reserved

24.29.1526 Disallowed Procedures (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 2003 MAR p. 2870, Eff. 12/25/03; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1527 and 24.29.1528 reserved

24.29.1529 Prescription Drugs Fee Schedule

(1) In addition to the limitations on the payments for and dispensing of prescription drugs as set out by 39-71-727, MCA, the following apply:
   (a) the reimbursement rate for prescription drugs is based upon the rate in effect on the date the drug is dispensed.
   (b) reimbursement rates to retail pharmacies for brand-name drugs are limited to the lesser of:
      (i) the price charged for the prescription drug at the time of dispensing; or
      (ii) the average wholesale price (AWP), minus 10 percent, at the time of dispensing, plus a dispensing fee, not to exceed $3.00 per prescription drug.
   (c) reimbursement rates to retail pharmacies for generic-name drugs are limited to the lesser of:
      (i) the price charged for the prescription drug at the time of dispensing; or
      (ii) the AWP, minus 25 percent, at the time of dispensing, plus a dispensing fee, not to exceed $3.00 per prescription drug.
   (d) for the purposes of this rule, average wholesale prices must be updated monthly.

(2) If, prior to liability for a claim being accepted by the insurer, an injured worker has personally paid for prescription drugs, prescribed for a condition for which liability is subsequently accepted, the injured worker is entitled to a refund of the price paid by the injured worker for the prescription drug.
   (a) the insurer, when accepting liability for a condition for which a prescription drug has been prescribed, must, upon receiving a proper receipt, reimburse the injured worker the retail price paid.
   (b) after the injured worker has been reimbursed by the insurer, the pharmacy must, upon request by the insurer, reimburse the insurer for the difference in the amount paid by the injured worker and the amount provided by the fee schedule.

History: 39-71-203, MCA; IMP, 39-71-727, 39-71-743, MCA; NEW, 2007 MAR p. 1192, Eff. 8/24/07; AMD, 2007 MAR. p. 1676, Eff. 10/26/07; AMD, 2007 MAR p. 2011, Eff. 12/7/07.

Rule 24.29.1530 reserved

24.29.1531 Use of Fee Schedules for Services Provided from April 1, 1993 through June 30, 2002 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 2002 MAR p. 1758, Eff. 7/1/02; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1532 Use of Fee Schedules for Services Provided from July 1, 2002, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1533 Nonfacility Fee Schedule for Services Provided From January 1, 2008 through June 30, 2013 (REPEALED)

(1) This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2009 MAR p. 8, Eff. 1/16/09; AMD, 2009 MAR p. 2482, Eff. 12/25/09; AMD, 2013 MAR p. 1185, Eff. 7/12/13; REP, 2024 MAR p. 1066, Eff. 5/11/24.)

24.29.1534 Professional Fee Schedule

(1) 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 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. The fee schedules are comprised of the elements listed in 39-71-704, MCA, and the following:
   (a) the conversion factors established by the department in ARM 24.29.1538;
   (b) modifiers, listed on the department's website;
   (c) the Montana unique code, MT001, described in (9);
   (d) the Montana unique code, MT003, adopted and described in ARM 24.29.1433; and
   (e) the Montana unique code, MT009, for referral to a vocational rehabilitation counselor for on-site job evaluation with the injured worker to assist in returning him/her to work either to his/her time of injury job or a new job/position.

(2) The conversion factors, the Current Procedural Terminology (CPT) codes, and the relative value unit (RVU) 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 ResourceBased Relative Value Scale (RBRVS) then multiplying the RVU for that code by the conversion factor.

(3) The insurer shall pay 100 percent of the usual and customary charges for dental codes. The insurer shall pay a minimum of 75 percent of the usual and customary charges for dental codes D6010 through D6199.

(4) 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.

(5) The maximum fee that an insurer is required to pay for a particular procedure is listed on the department web site and was computed using the RVU in the total facility or nonfacility column of the RBRVS times the conversion factor, except as otherwise provided for in these rules.

(6) Professionals, including those who furnish services in a hospital, critical access hospital, ambulatory surgery center, or other facility setting must bill insurers using the CMS 1500, with the exception of physical therapy, occupational therapy, and speech therapy services provided on an outpatient basis and billed on a UB04. Dental providers may bill insurers using the American Dental Association (ADA) Dental Claim Form.

(7) Each provider is to limit services to those which can be performed within the provider's scope of license. For nonlicensed providers, the insurer is not required to reimburse above the related CPT codes for appropriate services.

(8) 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;
   (b) a report associated with nonphysician conferences required by the payor;
   (c) completion of a job description or job analysis form requested by the payor; or
   (d) written questions that require a written response from the provider.

(9) Where a service is listed as "by report," the fee charged may not exceed the usual and customary fee charged by the provider to nonworkers' compensation patients.

(10) It is the responsibility of the provider to use the proper procedure, service, and supply codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(11) Copies of the RBRVS are available from the publisher. Ordering information may be obtained from the department.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 1055, Eff. 6/18/16; AMD, 2017 MAR p. 784, Eff. 6/10/17; AMD, 2018 MAR p. 1036, Eff. 5/26/18; AMD, 2019 MAR p. 848, Eff. 6/22/19; AMD, 2020 MAR p. 1021, Eff. 6/13/20; AMD, 2021 MAR p. 716, Eff. 6/12/21; AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2026 MAR, Notice No. 2025-110, Eff. 1/10/26 .

Rule 24.29.1535 reserved

24.29.1536 Conversion Factors–Methodology for Services Provided from April 1, 1993, Through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1537 Special Monitoring and Adjustment of Physical Medicine Fees During the Period July 1, 2002 through December 31, 2003 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1538 Conversion Factors

(1) The conversion factors established by the department for goods and services, other than anesthesia services are:
   (a) $61.09 on or after July 1, 2025.
   (b) all prior conversion factors for services provided starting July 1, 2013, are available on the department's website.

(2) The conversion factors established by the department for anesthesia services are:
   (a) $71.78 on or after July 1, 2025.
   (b) all prior conversion factors for services provided starting July 1, 2013, are available on the department's website.

(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.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2009 MAR p. 8, Eff. 1/16/09; AMD, 2009 MAR p. 2482, Eff. 12/25/09; AMD, 2013 MAR p. 1185, Eff. 7/12/13; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 1055, Eff. 6/18/16; AMD, 2017 MAR p. 784, Eff. 6/10/17; AMD, 2018 MAR p. 1036, Eff. 5/26/18; AMD, 2019 MAR p. 848, Eff. 6/22/19; AMD, 2020 MAR p. 1021, Eff. 6/13/20; AMD, 2021 MAR p. 716, Eff. 6/12/21 ; AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2023 MAR p. 522, Eff. 6/10/23; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Rules 24.29.1539 and 24.29.1540 reserved

24.29.1541 Acupuncture Fees for Services Provided from April 1, 1993, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1542 through 24.29.1550 reserved

24.29.1551 Dental Specialty Area Fees for Services Provided from April 1, 1993, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1552 through 24.29.1560 reserved

24.29.1561 Physician Fees – Medicine for Services Provided from April 1, 1993, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1562 through 24.29.1565 reserved

24.29.1566 Physician Fees – Anesthesia Specialty Area for Services Provided from April 1, 1993, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1567 through 24.29.1570 reserved

24.29.1571 Chiropractic Fees for Services Provided from April 1, 1993 through June 30, 2002 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1993 MAR p. 1659, Eff. 8/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1572 Chiropractic Fees for Services Provided from July 1, 2002, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1573 Prior Authorization and Billing Limitations for Chiropractic Services Provided from July 1, 2002, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1574 Chiropractic Fee Schedule for Services Provided from January 1, 2008, through June 30, 2011(REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1575 Chiropractic–Prior Authorization and Billing Limitations for Services Provided from January 1, 2008, through June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1576 through 24.29.1580 reserved

24.29.1581 Provider Fees–Occupational and Physical Therapy Specialty Area for Services Provided from April 1, 1993 through June 30, 2002 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 1993 MAR p. 404, Eff. 4/1/93; AMD, 1994 MAR p. 680, Eff. 4/1/94; AMD, 2002 MAR p. 1758, Eff. 7/1/02; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1582 Provider Fees–Occupational and Physical Therapy Specialty Area for Services Provided from July 1, 2002 through September 30, 2003 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1583 Prior Authorization and Billing Limitations for Services Provided by Occupational Therapists and Physical Therapists From July 1, 2002, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2002 MAR p. 1758, Eff. 7/1/02; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1584 Provider Fees–Occupational and Physical Therapy Specialty Area for Services Provided from October 1, 2003, through December 31, 2007 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 260, Eff. 2/23/07; AMD, 2007 MAR p. 1670, Eff. 10/26/07; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1585 Occupational and Physical Therapy Fee Schedule for Services Provided from January 1, 2008, through June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2011 p. 1137, Eff. 6/24/11; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1586 Occupational and Physical Therapists–Prior Authorization and Billing Limitations for Services Provided from January 1, 2008, through June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-704, MCA; NEW, 2007 MAR p. 1670, Eff. 10/26/07; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2018 MAR p. 2527, Eff. 1/1/19

Rules 24.29.1587 through 24.29.1590 reserved

24.29.1591 Utilization and Treatment Guidelines (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 2420, Eff. 12/24/16; AMD, 2017 MAR p. 2185, Eff. 11/25/17; TRANS to ARM 24.29.1611 and AMD, 2018 MAR p. 2531, Eff. 1/1/19

Rule 24.29.1592 reserved

24.29.1593 Prior Authorization (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS to ARM 24.29.1621, 2018 MAR p. 2531, Eff. 1/1/19.

Rule 24.29.1594 reserved

24.29.1595 Independent Medical Review Process (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-224, 39-71-704, 39-71-2401, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS to ARM 24.29.1641 and AMD, 2018 MAR p. 2531, Eff. 1/1/19.

24.29.1596 Applicability of Utilization and Treatment Rules (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 p. MAR 1137, Eff. 6/24/11; TRANS to ARM 24.29.1604 and AMD, 2018 MAR p. 2531, Eff. 1/1/19.

Rules 24.29.1597 and 24.29.1598 reserved

24.29.1599 Applicability of Utilization and Treatment Guidelines for Managed Care Organizations or Preferred Provider Organizations (TRANSFERRED)

This rule has been transferred.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS to ARM 24.29.1609, 2018 MAR p. 2531, Eff. 1/1/19

Subchapter 16
Utilization and Treatment Guidelines

24.29.1601 Definitions

As used in this subchapter, the following definitions apply:

(1) "Claim" means an injury or occupational disease where:
  (a) liability has been accepted by the insurer; or
  (b) payment has been made by the insurer pursuant to:
    (i) 39-71-608, MCA;
    (ii) 39-71-615, MCA; or
    (iii) any other reservation of rights.

(2) "Evidence-based" means use of the best evidence available in making decisions about the care of the individual patient, gained from the scientific method of medical decision-making and includes use of techniques from science, engineering, and statistics, such as randomized controlled trials (RCTs), meta-analysis of medical literature, integration of individual clinical expertise with the best available external clinical evidence from systematic research, and a risk-benefit analysis of treatment (including lack of treatment).

(3) " Formulary" means the list of drugs for which prior authorization is generally not needed, as adopted and automatically updated pursuant to ARM 24.29.1616.

(4) "Formulary rules" means:
  (a) ARM 24.29.1601;
  (b) ARM 24.29.1607;
  (c) ARM 24.29.1616;
  (d) ARM 24.29.1624;
  (e) ARM 24.29.1631;
  (f) ARM 24.29.1645; and
  (g) ARM 24.29.1648.

(5) "Insurer" means compensation plan No. 1, plan No. 2, and plan No. 3.

(6) "Legacy claim" means a workers' compensation or occupational disease claim with an occurrence date before April 1, 2019 (7) "Medical director" means a person who is an employee of, or contractor to, the department, and who is responsible for the independent medical review of requests for treatment(s) or procedure(s), when those requests are denied, and whose

responsibility will also include other areas to be determined by the department. A person serving as a medical director must be a physician licensed by the state of Montana under Title 37, chapter 3, MCA.

(8) "Montana Guidelines" are the Montana utilization and treatment guidelines adopted by the department in ARM 24.29.1611.

(9) "ODG drug formulary" means the ODG Workers' Compensation Drug Formulary published by MCG Health, LLC.

(10) "PBM" mean the pharmacy benefits manager used by an insurer to help the insurer implement the formulary's use in the insurer's claims handling processes.

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

(12) "Prior authorization" means the interested party receives prior authorization (either verbally or in writing) from the insurer:

(a) to perform treatment for those cases identified by ARM 24.29.1621; or

(b) to obtain medications for those cases identified in the formulary rules as requiring prior authorization.

(13) "Rebuttable presumption" means that the Montana Guidelines, as adopted in ARM 24.29.1611, are presumed to be compensable medical treatment for an injured worker. The presumption can be rebutted by a preponderance of credible medical evidenced-based material and medical reasons to justify that the medical treatment(s) or procedure(s) that require prior authorization are reasonable and necessary care for the injured worker.

(14) "Refill" means the dispensing of additional medications after the initial number of doses authorized by a written prescription have been dispensed, where the prescription expressly indicates that a certain number of refills are allowed without the need for another written prescription.

(15) "Supportive services" means those treatments, therapies, and related services that are designed to safely, effectively, and compassionately assist an injured worker transition from an existing medication regimen.

(16) "Treating physician" has the same meaning as provided by 39-71-116, MCA.

(17) "Treatment" has the same meaning as provided by ARM 24.29.1401A.

(18) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint. A treatment plan includes a transition plan provided for in ARM 24.29.1631. A treatment plan must be made in accordance with the Montana Guidelines adopted in ARM 24.29.1611 and made in accordance with any insurer authorized treatments or procedures

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Rules 24.29.1602 through 24.29.1603 reserved

24.29.1604 Applicability of Utilization and Treatment Rules

(1) The following rules are subject to the applicability provisions of this rule:

(a) ARM 24.29.1611;

(b) ARM 24.29.1621;

(c) ARM 24.29.1641; and

(d) ARM 24.29.1609.

(2) The rules identified in (1) apply to:
(a)injuries that occurred on or before June 30, 2007, for any treatment rendered on or after July 1, 2011, except that the provisions of (3) apply; and
(b)injuries that occurred on or after July 1, 2007, for any treatment rendered on or after July 1, 2011.
(3) The presumption of compensability in the Montana utilization and treatment guidelines adopted by ARM 24.29.1611 does not apply to injuries occurring on or before June 30, 2007. However, treatment for these injuries made in accordance with the guidelines constitutes reasonable primary or secondary medical treatment, pursuant to 39-71-704, MCA, for any condition or diagnosis identified in the guidelines. Therefore, prior authorization is not required for treatment within the guidelines for these injuries unless prior authorization would otherwise be required under these rules.
(4) As used in this subchapter, the term "injuries" includes occupational diseases which were diagnosed as an occupational disease, or should have been diagnosed as an occupational disease, during the time period specified.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 p. MAR 1137, Eff. 6/24/11; TRANS from ARM 24.29.1596 and AMD, 2018 MAR p. 2531, Eff. 1/1/19.

Rules 24.29.1605 through 24.29.1606 reserved

24.29.1607 Applicability of Formulary Rules to Out-Patient Services

(1) The provisions of these formulary rules apply to all claims arising on or after April 1, 2019, but only with respect to outpatient services.
(2) For claims arising before April 1, 2019, which are referred to as "legacy claims," the rules in this subchapter will apply to prescriptions written on or after April 1, 2020, or 90 days after the insurer gives notice as provided in ARM 24.29.1631, whichever is later.
(3) The provisions of this subchapter, including the formulary adopted and automatically updated as provided in ARM 24.29.1616 apply as they are in effect on the date the prescription is written.
(4) Nothing in this subchapter excuses an insurer from providing medications that constitute primary medical services required to be furnished by 39-71-704, MCA.
(5) Nothing in this subchapter requires an insurer to use the services of a PBM.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19.

24.29.1609 Applicability of Utilization and Treatment Guidelines for Managed Care Organizations or Preferred Provider Organizations

(1) Managed care organizations or preferred provider organizations providing any treatment for primary and secondary medical services to an injured worker shall use the Montana Guidelines. This rule does not alter or change how managed care organizations or preferred provider organizations are paid pursuant to 39-71-704, MCA.
(2) The provisions of this rule apply to medical services provided, or proposed to be provided, on or after July 1, 2011.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS from ARM 24.29.1599, 2018 MAR p. 2531, Eff. 1/1/19.

Rule 24.29.1610 reserved

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 on the department's website. The Montana Guidelines incorporated by reference apply as follows:

(a) for medical services provided on or after January 10, 2026: "Montana Utilization and Treatment Guidelines, 9th edition, 2025"; and

(b) all prior Utilization and Treatment Guidelines starting July 1, 2011, are available on the department's website or by contacting the department to request a copy.

(2) The utilization and treatment guidelines adopted in (1) are to be read in conjunction with the Centers for Disease Control publication, "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2022."

(3) When providing treatment for primary and secondary medical services to an injured worker, all health care providers shall use the Montana Guidelines adopted by reference in (1).

(a) in cases where treatment(s) or procedure(s) are recommended by the Montana Guidelines, and treatment is provided in accordance with the guidelines, prior authorization is unnecessary unless the Montana Guidelines specify otherwise.

(b) the department recognizes that medical treatment may include deviations from the Montana Guidelines as individual cases dictate. The provider or interested party shall follow the procedure for prior authorization under ARM 24.29.1621 for cases in which treatments or procedures are requested that are:

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

(ii) after maximum medical improvement; or

(iii) beyond the duration and frequency limits set out in the guidelines.

(c) an insurer is not responsible or liable for treatment(s) or procedure(s) as set out in (3)(b) unless:

(i) prior authorization is obtained from the insurer pursuant to 39-71-704, MCA, and in accordance with ARM 24.29.1621; or

(ii) the treatment(s) or procedure(s) were provided in a medical emergency.

(d) for those body parts not included in one of the guideline chapters, providers must apply and follow the general guideline principles that are found at the beginning of each chapter, and an insurer is liable for reasonable medical treatment.

(4) All insurers shall routinely and regularly review claims to ensure that care is consistent with the Montana Guidelines adopted by reference in (1) and (6).

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

(6) Effective April 1, 2019, the formulary adopted in ARM 24.29.1616 is considered to be a part of the Montana Guidelines.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; AMD, 2014 MAR p. 1513, Eff. 7/11/14; AMD, 2015 MAR p. 818, Eff. 6/26/15; AMD, 2016 MAR p. 2420, Eff. 12/24/16; AMD, 2017 MAR p. 2185, Eff. 11/25/17; TRANS from ARM 24.29.1591 and AMD, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2019 MAR p. 846, Eff. 6/22/19; AMD, 2021 MAR p. 761, Eff. 6/26/21 ; AMD, 2023 MAR p. 523, Eff. 6/10/23, AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2026 MAR, Notice No. 2025-110, Eff. 1/10/26.

Rules 24.29.1612 through 24.29.1615 reserved

24.29.1616 Incorporation by Reference And Updates to the Formulary

(1) The department will annually undertake formal rulemaking to select a formulary. The formulary may be any one of the following:
  (a) a formulary published by a commercial vendor;
  (b) a formulary published by another state for use in workers' compensation and occupational disease claims; or
  (c) a formulary specially developed by the department.
(2) The department adopts and incorporates by reference its formulary as follows:
  (a) for prescriptions written on or after July 1, 2025, the April 2025 edition of the ODG Drug formulary; and
  (b) all prior ODG drug formulary lists starting January 2019, are available on the department's website or by contacting the department to request a copy.
(3) Pursuant to 2-4-307, MCA, the automatic monthly updates of the annually adopted edition of the formulary are incorporated by reference without additional rulemaking, and are applicable as of the date the update is posted on the department's web site.
(4) The formulary is available on the department's website and from 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 at www.mcg.com/odg, and at ODG by MCG Health, 3006 Bee Caves Road, Suite A250, Austin, TX 78746.
(5) Archived versions of the formulary will be maintained by the department for five years from the date of the adoption of the formulary

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2019 MAR p. 2363, Eff. 12/28/19; AMD, 2020 MAR p. 2431, Eff. 12/25/20; AMD, 2021 MAR p. 761, Eff. 6/26/21 ; AMD, 2022 MAR p. 1075, Eff. 6/25/22; AMD, 2023 MAR p. 523, Eff. 6/10/23; AMD, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2024 MAR p. 1457, Eff. 7/1/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Rules 24.29.1617 through 24.29.1620 reserved

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) are after maximum medical improvement;
  (c) are beyond the duration and frequency limits set out in the guidelines; or
  (d) the guidelines require prior authorization before proceeding with the treatment.
(2) Prior authorization is not required for emergency procedures.
(3) When the guidelines explicitly require prior authorization for a treatment or modality, documentation need only include the clinical indications outlined in the guidelines to support that the treatment or modality is appropriate for the injured worker.
(4) When prior authorization is required because an interested party wishes to rebut the presumption of the guidelines, the interested party must submit to the insurer documentation to support the request and justification that the medical treatment(s) or procedure(s) are reasonable and necessary care for the injured worker. Documentation must consist of a preponderance of credible medical evidenced-based material and medical reasons to rebut the Montana Guidelines.

Documentation submitted to rebut the guidelines may include any information from the following list. However, nothing in this list is intended to imply that any given information is sufficient to rebut the guidelines. Rather, whether the presumption of the guidelines is rebutted can only be determined on a case-by-case basis. Submitted information may include:

(a) an explanation or documentation of how the patient's medical condition is different from the medical indications used in the Montana Guidelines that may have resulted in a negative recommendation or exclusion;

(b) an explanation or documentation of objective findings and functional improvements that would be the expected result of the treatment(s) or procedure(s), either from past experience or from an explanation about the mechanism of injury and the effect of the treatment(s) or procedure(s), and where improvement can be measured;

(c) an explanation or documentation of objective signs of functional restoration for treatment conducted thus far;

(d) an explanation or documentation of measurable goals and progress points expected from additional treatment;

(e) a statement of how the request will benefit both a short-term and long-term treatment plan; or

(f) any additional evidence-based utilization and treatment guidelines or studies that support the interested party's case.

(5) All prior authorization requests must be made at least 14 days prior to the date the service is scheduled.

(a) authorization is presumed to be given if not denied within 14 days.

(b) an insurer may notify the interested party of authorization by written confirmation, e-mail, or facsimile (fax).

(c) 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) If the insurer denies the prior authorization request, the denial must be in writing and must contain an explanation of why the justification is not sufficient.

(a) the denial must not be based solely on the fact that the medical treatment(s) or procedure(s) are not specifically addressed or recommended by the Montana Guidelines.

(b) if the written denial is five or fewer days before the expiration of the 14- day response period, the insurer must also notify the interested party of the denial by e-mail or facsimile (fax).

(7) When an insurer denies liability for an injury or occupational disease, and the insurer then later assumes liability for a particular condition, the insurer may not deny payment for the medical services provided for that condition during the period of denial based solely on failure to obtain prior authorization.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS from ARM 24.29.1593, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1622 through 24.29.1623 reserved

24.29.1624 Integration of Formulary With Montana Utilization and Treatment Guidelines – When Prior Authorization Is Required

(1) The formulary is considered to be a part of the Montana Guidelines established by the department.

(2) A medical provider is expected to write a prescription for medication in accordance with the Montana Guidelines, as adopted by ARM 24.29.1611, and in accordance with the formulary adopted by ARM 24.29.1616.

(3) Because the formulary is part of the Montana Guidelines, medical providers are required to prescribe in accordance with the provisions of the formulary unless the provider can sufficiently articulate sound medical reasoning to vary from the formulary.

(4) Insurers shall pay for medications that are prescribed in a manner consistent with the formulary, subject to the medical provider furnishing documentation as required by ARM 24.29.1621. Payments for medications are subject to the provisions of 39-71-727, MCA.

(5) Pursuant to the formulary, prior authorization for an injury appropriate medication is not required as follows:

(a) the medication is listed as "Y" on the formulary; or

(b) the medication is listed as "N" on the formulary, and the prescription is:

(i) written within seven days of the occurrence of the workplace injury; and

(ii) limited to a maximum of a seven-day supply of the medication.

(6) Pursuant to the formulary, prior authorization for a medication is required as follows:

(a) except as provided by (5)(b), the medication is listed as "N" on the formulary;

(b) the medication is not listed on the formulary;

(c) the medication is experimental or investigational; or

(d) the medication is a compound, even if all the components of the compound are listed as "Y" medications on the formulary.

(7) The prior authorization process described in ARM 24.29.1621 applies to formulary matters, except that:

(a) the insurer shall respond within three business days of the receipt of a request for prior authorization being made to the insurer or the insurer's designee, by either approving or denying the request; and

(b) if the insurer fails to respond within three business days to a request for prior authorization, the prescription is deemed to be approved. An approval for a prescription medication made due to the lack of a timely response by the insurer does not apply to any refill that may be ordered.

(8) An insurer may delegate prior authorization decisions pertaining to the formulary to a PBM or other agent with which it contracts. An insurer has the legal responsibility for the decisions made by the PBM on behalf of the insurer.

(9) The delegation by an insurer of prior authorization decisions pertaining to the formulary to a PBM or other agent does not, in and of itself, violate the requirement of 39-71-107, MCA, that all claims be examined by a claims examiner in Montana.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-107, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19.

Rules 24.29.1625 through 24.29.1630 reserved

24.29.1631 Special Provisions for Transition of Legacy Claims – When Applicable

(1) The insurer shall notify in writing the injured worker and the treating physician (who, for the purposes of this rule, also includes any other prescribing medical provider) that a claim constitutes a legacy claim in which the insurer will enforce the applicability of these formulary rules.

(2) The notification required by (1) must include at least the following information:

(a) the name of the injured worker;

(b) the name of the treating physician or other prescribing medical provider;

(c) the name of each medication that is affected by the notice;

(d) the name and contact information of the claims examiner responsible for the injured worker's claim; and

(e) the date upon which the insurer will enforce the applicability of these formulary rules.

(3) This rule applies to a legacy claim on the latter of:

(a) April 1, 2020; or

(b) 90 days after the insurer provides notice as provided by (1).

(4) By not later than the applicability date of this rule pursuant to (3), the treating physician shall determine whether a transition plan is needed for an injured worker who is receiving:

(a) one or more drugs for which prior authorization is otherwise required; or

(b) drugs at a dosage level greater than recommended by the Montana Guidelines.

(5) The treating physician must state in writing whether the injured worker:

(a) should transition to "Y" status drugs or to medication dosages which are consistent with the recommendations of the Montana Guidelines; or

(b) should not undergo a transition from the existing medications because a transition is not medically appropriate.

(6) The treating physician must provide the basis for the medical provider's decision as required by ARM 24.29.1621. The explanation, and development of a transition plan as appropriate, constitutes a "by report" service (CPT code 99080).

(7) If the treating physician fails to provide the determination required in (5), by the date this rule becomes applicable to the claim pursuant to (3), these formulary rules will apply to prescriptions written for the injured worker.

(8) If the treating physician determines a transition from one or more drugs for which prior authorization required to a "Y" status drug is appropriate, or that a reduction in dosage is appropriate, the treating physician shall include in the worker's treatment plan a specific plan, including a projected time table or schedule, for transitioning the injured worker to care that is consistent with the Montana Guidelines.

(9) The treatment plan may, when determined by the treating physician to be medically necessary, include the provision of supportive services to the injured worker during the transition.

(10) Supportive services may be delivered in an out-patient or an in-patient setting, as appropriate, based upon the treating provider's transition plan. Supportive services that are reasonable and medically necessary constitute part of the primary medical services to which an injured worker with a legacy claim is entitled.

(11) Nothing in this rule prohibits the treating physician from proposing a treatment plan for transition prior to an insurer's authorization as provided in (1)

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19.

Rules 24.29.1631 through 24.29.1640 reserved

24.29.1641 Independent Medical Review Process

(1) An interested party who has requested and been denied authorization by the insurer for treatment, or an insurer, may request an independent medical review by the medical director designated by the department prior to mediation under 39-71-2401, MCA. If the independent medical review process is requested prior to mediation, the mediation process shall not proceed until completion of the independent medical review process.

(2) The interested party or insurer must submit its request for review to the department and must notify the other party of its request for review. Upon notice of a request for review, the insurer must submit a copy of the request for prior authorization, the denial, and any other relevant medical information to the department. The interested party and the insurer may also submit additional information to the department, if the information falls within the categories outlined in ARM 24.29.1621. Any new information submitted to the department must also be submitted to the other party.

(3) The medical director will review the medical records of the injured worker and other information relevant to the denial and issue a recommendation. For purposes of this rule, the medical director is the specific individual designated by the department to serve as the medical director with respect to a given set of disputed treatments or procedures. The medical director may seek consultation from other providers with specialties as would typically manage the medical condition at issue. If a consultation is sought and received, that provider's recommendation is also subject to the provisions of this rule.

(4) The medical director shall, within five days of receipt of the request for review, issue a written recommendation to the interested party and the insurer by mail, facsimile, or e-mail, or issue a notice that additional information or time is required to tender a recommendation along with an approximate date the recommendation will be issued, not to exceed 14 days from the date of receipt of the review request. If the medical director does not issue a recommendation within 14 days, the request for review is deemed denied and the parties may proceed to mediation.

(5) The medical director's review and recommendation is an informal alternative dispute resolution process without administrative or judicial authority and is not binding on the parties.

(a) the medical director's files and records are closed to all persons but the parties.

(b) the medical director may not be called to testify in any proceeding concerning the issues discussed in the independent medical review process.

(c) the medical director's recommendation and any information contained in the recommendation that is solely from the medical director are not admissible as evidence in any action subsequently brought in any court of law.

(d) the medical director's recommendation, including information contained in the recommendation, may be considered in mediation conducted under 39-71-2401, MCA.

(6) The insurer shall, within five days of receipt of the recommendation, notify the interested party if the previously denied treatment(s) or procedure(s) is authorized based on the medical director's recommendation.

(7) If the insurer does not authorize treatment after issuance of the medical director's recommendation, the interested party may file for mediation with the department pursuant to 39-71-2401, MCA.

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

(9) An expedited case review for medications is provided by ARM 24.29.1645.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-224, 39-71-704, 39-71-2401, MCA; NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS from ARM 24.29.1595 and AMD, 2018 MAR p. 2531, Eff. 1/1/19.

24.29.1645 Expedited Case Review for Prescription Medications by DLI Medical Director

(1) Expedited case review is available only when insurer declines to authorize further dispensing of an already prescribed medication and halting the supply of that medication appears likely to result in a medical emergency.

(2) A medical emergency occurs when all three of the following circumstances are present:

(a) the medical condition has a sudden onset;

(b) the medical condition manifests itself by acute symptoms of sufficient severity, including severe pain; and

(c) in the absence of immediate medical attention, the medical condition could reasonably be expected to result in:

(i) placing the injured worker's health or bodily functions in serious jeopardy; or

(ii) a serious dysfunction of any body organ or part of the injured worker.

(3) An expedited case review may be requested concurrently with a demand for mediation on the dispute concerning the medication.

(4) An expedited case review may only be requested within 14 days of the insurer's denial of, or refusal to authorize further dispensing of an already prescribed medication.

(5) A request for an expedited case review must be supported by such written information as the treating physician considers pertinent to the treating physician's opinion that a medical emergency is likely to occur as a result of the denial of the medication.

(6) The expedited medical review will be conducted within three business days of receipt by the department of a written request for an expedited medical review. The findings of the expedited medical review must be in writing and be based on the information provided by the treating physician, along with the reasoning given by the insurer or its agent for the denial.

(7) The findings of the medical director regarding whether or not a medical emergency is likely to occur as the result of not providing the further dispensing of medication as prescribed by the treating physician may be offered in evidence in mediation or the Workers' Compensation Court.

(8) If the findings of the medical director are that no medical emergency is likely to occur as a result of the insurer's denial, then the medical director shall further consider the matter of the denial under the independent medical review procedures provided for by ARM 24.29.1641.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19.

Rules 24.29.1646 through 24.29.1647 reserved

24.29.1648 Dispute Resolution for Formulary

(1) Disputes between the treating physician and the insurer regarding the formulary are subject to the same process available for other disputes regarding the Montana Guidelines, except as provided in ARM 24.29.1645.

(2) A dispute between the injured worker and the insurer regarding the use or application of the formulary constitutes a dispute concerning benefits, and may be resolved as provided by 39-71-2905, MCA.

History: 39-71-203, 39-71-704, MCA; IMP, 39-71-704, 39-71-2905, MCA; NEW, 2018 MAR p. 2531, Eff. 1/1/19.

Subchapter 17
Rehabilitation

24.29.1701 Rehabilitation Provider Designation (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, MCA; IMP, Sec. 39-71-1014, 39-71-1015, and 39-71-1023, MCA; NEW, 1987 MAR p. 1988, Eff. 10/30/87; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.1702 Rehabilitation Panels for Claims between July 1, 1987 and June 30, 1991 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-1015, 39-71-1016, 39-71-1017, 39-71-1018, 39-71-1019, MCA; NEW, 1987 MAR p. 1988, Eff. 10/30/87; AMD, 2013 MAR p. 841, Eff. 5/24/13; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1703 and 24.29.1704 reserved

24.29.1705 Local Job Pool Area Definition (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, MCA; IMP, Sec. 39-71-1011 and 39-71-1012, MCA; NEW, 1987 MAR p. 1988, Eff. 10/30/87; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1706 through 24.29.1709 reserved

24.29.1710 Auxiliary Rehabilitation Benefits

(1) A claimant may request auxiliary rehabilitation benefits and must obtain the insurer's authorization prior to incurring such expenses.
(2) Mileage and per diem expenses may be paid for up to five round trips in searching for new employment.
(3) Relocation expenses include actual expenses of moving by a commercial mover, or actual charges for rental of a truck or trailer by a commercial rental company and receipted fuel expenses.
(4) Auxiliary rehabilitation benefits do not include the expenses of long term commuting.
(5) The department may order the insurer to pay such other reasonable and necessary auxiliary rehabilitation benefits as it deems appropriate.

History: 39-71-203, MCA; IMP, 39-71-1025, MCA; NEW, 1987 MAR p. 1988, Eff. 10/30/87 AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1711 through 24.29.1720 reserved

24.29.1721 Payment of Rehabilitation Expenses from the Industrial Accident Rehabilitation Account for Claims Arising before July 1, 1991 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA (1987) (1989) and (1991); NEW, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2013 MAR p. 841, Eff. 5/24/13; REP, 2018 MAR p. 2527, Eff. 1/1/19.

24.29.1722 Payment Of Rehabilitation Expenses from the Industrial Accident Rehabilitation Account for Claims Arising on or After July 1, 1991 and before July 1, 1997 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1723 and 24.29.1724 reserved

24.29.1725 Information to be Included in the Rehabilitation Plan

(1) The rehabilitation plan must include the following information:

(a) plan objectives that summarize the type and duration of the training agreed to by the parties. It should include where the claimant will receive the training and identify any prerequisites and/or contingencies;

(b) a projection of expenditures to be made pursuant to the plan including the date the funds are needed and to whom the funds should be paid;

(c) a description of the claimant's responsibilities under the plan;

(d) a description of the insurer's responsibilities under the plan;

(e) a description of the vocational rehabilitation provider's responsibilities; and

(f) he signatures of both the claimant and the authorized insurer's representative.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/9; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.1726 reserved

24.29.1727 Department's Notice of Authorization or Denial of Use of Trust Funds (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1728 through 24.29.1730 reserved

24.29.1731 Allowable Rehabilitation Expenses (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chapter 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1732 reserved

24.29.1733 Disallowed Rehabilitation Expenses (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chapter 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2000 MAR p. 2701, Eff. 10/6/00; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1734 reserved

24.29.1735 Documentation Required (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chapter 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1736 reserved

24.29.1737 Insurer Responsibility to Provide Information to the Department (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.1738 through 24.29.1740 reserved

24.29.1741 Payment of Rehabilitation Expenses

(1) The insurer must pay for tuition, 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 optional expenses which are not required to complete the retraining plan.

(2) The insurer is not liable for tuition, fees, books or equipment costs incurred if the claimant fails to complete registration requirements or fails to properly withdraw from the agreed upon training program. The insurer is entitled to any refund of tuition or fees that may be paid by the retraining entity upon the early withdrawal of the claimant from the training program. In addition, the insurer is entitled to possession of books, tools or other equipment previously paid for by the insurer upon the pre-graduation withdrawal of the claimant from the agreed upon training program.

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.1742 through 24.29.1760 reserved

24.29.1761 Disputes over Rehabilitation Expenses (REPEALED)

This rule has been repealed .

History: 39-71-203, MCA; IMP, Title 39, chap. 71, part 10, MCA; NEW, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 18
Stay at Work/Return to Work

24.29.1801 Definitions

As used in this subchapter, the following definitions apply:
(1) "Injured worker" means an individual who has filed a claim for a workers' compensation injury or occupational disease and who does not meet the definition of a disabled worker.
(2) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, or the state fund under compensation plan No. 3, as defined in 39-71-116, MCA.
(3) "Medical status form" means the department reporting form completed by an injured worker's treating physician or designee, which documents an injured worker's medically necessary work restrictions and work abilities.
(4) "Outcome report form" means the department reporting form completed by an insurer or vocational rehabilitation counselor, which documents the results for the injured worker of SAW/RTW assistance.
(5) "Request" means a request for SAW/RTW assistance by letter, e-mail, or telephone call to the department or insurer. A request must include, at a minimum, the name of the injured worker, the requestor's name and requestor's telephone number. A note in a medical record does not constitute a request.
(6) "SAW/RTW" means stay at work/return to work.
(7) "Time-of-injury employer" means the employer under whose employment a worker was injured or developed an occupational disease.
(8) "Transitional employment" means work for the injured worker with the time-of-injury employer offered by the employer for a temporary period of time, and may include a reduction in hours, workplace modifications, and alternative job duties.
(9) "Vocational rehabilitation counselor" means a rehabilitation provider who possesses current certification from the Commission on Rehabilitation Counselor Certification, as defined in 39-71-1011, MCA.

History: 39-71-203, 39-71-1051, MCA; IMP, 39-71-105, 39-71-116, 39-71-1011, 39-71-1036, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12; AMD, 2018 MAR p. 2527, Eff. 1/1/19.

Rule 24.29.1802 reserved

24.29.1803 Applicability

(1) SAW/RTW assistance, pursuant to this subchapter, is applicable to workers who experience a work-related injury or occupational disease on or after July 1, 2012.

History: 39-71-203, 39-71-1051, MCA; IMP, 39-71-105, 39-71-1011, 39-71-1031, 39-71-1041, 39-71-1042, 39-71-1043, 39-71-1049, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12.

Rules 24.29.1804 through 24.29.1806 reserved

24.29.1807 Responsibilities of the Insurer

(1) Each insurer shall adopt a SAW/RTW policy and submit a current, complete copy of the policy to the department. The insurer shall provide the department with all SAW/RTW policy updates a minimum of ten business days in advance of implementation of policy change.
(2) The insurer shall designate a single point of contact with authority to coordinate all department requests for SAW/RTW assistance for injured workers and shall provide the department with written notice of the contact person's name or position title, telephone number, email address, and mailing address. When contact information changes, the insurer shall update the department a minimum of ten business days in advance of the change.
(3) When a request for SAW/RTW assistance is made directly to the insurer prior to the insurer's acceptance of liability for a claim, the insurer may elect to provide SAW/RTW assistance to the injured worker or it may refer the injured worker to the department for assistance.
(4) When a request for SAW/RTW assistance is made directly to the insurer and the insurer declines to provide SAW/RTW assistance the insurer shall notify the injured worker and the department in writing within three business days of a request for assistance.
(5) After the department has initiated SAW/RTW assistance to an injured worker, the insurer shall notify the department in writing within three business days of the insurer's acceptance or denial of liability for an injured worker's claim.
(6) For notice purposes, the department's contact information is:
    (a)via email, dlisawrtw@mt.gov;
    (b)via fax machine, (406) 444-4140;
    (c)via U.S. mail, SAW/RTW Assistance Program, P.O. Box 8011, Helena, MT 59604-8011; or
    (d)via the street address is Employment Standards Division, 301 S Park Avenue, Helena, Montana.
(7) Notice sent by U.S. mail must be postmarked within the three business days required by this rule.
(8) The insurer shall report the outcome of SAW/RTW assistance to the department, using the department outcome reporting form, within 30 business days of the earliest of:
    (a)the return to work start date;
    (b)the termination of SAW/RTW services; or
    (c)the injured worker's attainment of maximum medical improvement.

History: 39-71-203, 39-71-1051, MCA; IMP, 39-71-105, 39-71-1014, 39-71-1031, 39-71-1042, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12.

Rules 24.29.1808 through 24.29.1810 reserved

24.29.1811 Duties of the Department

(1) An injured worker is eligible for SAW/RTW assistance upon receipt by the department of a request for assistance from the injured worker, employer or health care provider.
(2) When the department is unable to identify the insurer within three business days of receiving a request for SAW/RTW assistance, the department shall provide assistance to the injured worker. When the department identifies the at-risk insurer after the department has initiated assistance, the department shall continue to provide SAW/RTW services to the injured worker when the insurer declines to provide SAW/RTW assistance or fails to respond to department notice of the initiation of services. The department shall provide services until it:
    (a)terminates SAW/RTW services to the injured worker upon notice of insurer denial of liability for the claim;

(b) terminates SAW/RTW services to the injured worker upon exhaustion of the maximum allowed provider fees, as provided in ARM 24.29.1815; or

(c) transfers responsibility for the delivery of SAW/RTW assistance to the insurer upon notice of the insurer's acceptance of liability for the claim.

(3) When the department provides SAW/RTW assistance, the department shall assign a vocational rehabilitation counselor to each eligible injured worker to provide services which may include, but are not limited to, the following:

(a) personal contact with injured worker to assess the worker's commitment and ability to stay at or return to work;

(b) identification of barriers to the injured worker staying at or returning to work;

(c) review of the injured worker's medical status form to ensure worker's understanding of work abilities and restrictions;

(d) personal contact with injured worker's employer to establish employer's ability to provide transitional employment that meets injured worker's abilities, as outlined by the medical status form;

(e) facilitation of communication between injured worker and employer regarding offer and acceptance of transitional employment;

(f) communication with injured worker's treating physician or designee regarding the assessment and approval of transitional employment when approval is not explicitly provided by medical status form;

(g) verification that duties assigned by employer to injured worker during transitional employment conform with abilities outlined by the medical status form;

(h) identification of concerns of the injured worker and employer and problem-solving throughout the process of establishing transitional employment; and

(i) monitoring injured worker's readiness and ability to return to time of injury job and providing appropriate interventions as needed.

(4) The department shall provide written notice to the injured worker, employer and insurer, if identified, when a vocational rehabilitation counselor is assigned by the department to provide SAW/RTW services to an injured worker. The notice shall be mailed within three business days of the assignment of a vocational rehabilitation counselor.

(5) The department shall provide written notice to the injured worker, employer and insurer of the completion of department-provided SAW/RTW assistance within three business days of the completion of services.

History: 39-71-203, 39-71-1051, MCA; IMP, 39-71-105, 39-71-1031, 39-71-1041, 39-71-1042, 39-71-1043, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12.

Rules 24.29.1812 through 24.29.1814 reserved

24.29.1815 Payment Schedule for Department-Provided SAW/RTW Assistance

(1) The department shall pay vocational rehabilitation counselors for SAW/RTW services in accordance with the following fee schedule:

(a) a maximum of $90 per hour for services provided, billed in 1/10 hour increments;

(b) travel time of four (4) hours or less at one-half the hourly rate;

(c) travel time over four (4) hours at two-thirds the hourly rate; and

(d) mileage, lodging and meals at the State of Montana per diem rate established pursuant to Title 2, chapter 18, part 5, MCA.

(2) The department shall pay a maximum of $2,000.00 per claim to a certified vocational rehabilitation counselor for SAW/RTW services, not including mileage, lodging and meals.
(3) When the department provides the assistance, the department may pay up to $2,000.00 to assist an employer in modifying the workplace or purchasing equipment required for the employer to provide transitional employment. Any such equipment or workplace modifications become the property of the employer. To apply for financial assistance, the employer must submit a written application to the department that includes, at a minimum, the following:
(a) a written recommendation from the department-designated vocational rehabilitation counselor, which specifically describes the required workplace modification or equipment;
(b) the estimated cost of the recommended workplace modification; and
(c) the estimated cost of the recommended equipment.
(4) The department may deny an employer's application for financial assistance when the department determines the application is incomplete or the request for assistance is unreasonable. The department will notify the employer as to whether the application is accepted or rejected, and the reasons for the action.

History: 39-71-203, 39-71-1049, 39-71-1051, MCA; IMP, 39-71-105, 39-71-1042, 39-71-1049, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12.

Rules 24.29.1816 through 24.29.1820 reserved

24.29.1821 Vocational Rehabilitation Counselor for Department-Provided SAW/RTW Assistance

(1) When the department provides SAW/RTW assistance, the department shall assign a vocational rehabilitation counselor to provide services to each eligible injured worker.
(2) The department shall select an appropriate vocational rehabilitation counselor for each injured worker, using the following criteria:
(a) geographical proximity to the injured worker's residence;
(b) ability to accept and promptly provide services to an injured worker; and
(c) specialized expertise and pertinent experience with the type of injury or challenges to returning to work faced by the injured worker.
(3) The vocational rehabilitation counselor shall notify the department of the services provided, the progress toward transitional employment, and assistance outcomes, as directed by the department.

History: 39-71-203, 39-71-1051, MCA; IMP, 39-71-105, 39-71-1043, MCA; NEW, 2012 MAR p. 1357, Eff. 7/13/12; AMD, 2018 MAR p. 2527, Eff. 1/1/19.

Subchapter 19 Reserved

Subchapter 20
Chiropractic Service Rules

24.29.2001 Treatment and Reporting (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-604 and 39-71-704, MCA; Eff. 12/31/72; AMD, 1990 MAR p. 2183, Eff. 12/14/90; REP, 1993 MAR p. 404, Eff. 4/1/93.

24.29.2002 Standards for Diagnosis for Services Provided on or before June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.2003 Workers' Compensation Does Pay for Certain Services Provided on or before June 30, 2011 (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-704, MCA; Eff. 12/31/72; AMD, 2011 MAR p. 1137, Eff. 6/24/11; REP, 2024 MAR p. 1066, Eff. 5/11/24

24.29.2004 Workers' Compensation Does Not Pay (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203 and 39-71-704, MCA; Eff. 12/31/72; REP, 2002 MAR p. 1758, Eff.7/1/02.

Subchapters 21 through 22 Reserved

Subchapter 23
Managed Care Organizations

24.29.2301 Purpose (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94;REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2302 reserved

24.29.2303 Definitions (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2304 through 24.29.2310 reserved

24.29.2311 Selection of Managed Care Organization and Treating Physician within a Managed Care Organization (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2312 through 24.29.2320 reserved

24.29.2321 Preliminary Application (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-224, 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2322 reserved

24.29.2323 Time, Place and Manner of Providing Services (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2324 and 24.29.2325 reserved

24.29.2326 Areas Served by the Managed Care Organization (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-1103 and 39-71-1105, MCA; IMP, 39-71-1103 and 39-71-1105, MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2327 and 24.29.2328 reserved

24.29.2329 Structure of Organization (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-1103 and 39-71-1105, MCA; IMP, 39-71-1103 and 3971-1105, MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; AMD, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2330 reserved

24.29.2331 Contents of the Managed Care Plan (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2332 through 24.29.2335 reserved

24.29.2336 Financial Ability of Organization (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2337 and 24.29.2338 reserved

24.29.2339 Approval of Preliminary Application (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94 REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2340 reserved

24.29.2341 Final Application (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-224, 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2342 through 24.29.2345 reserved

24.29.2346 Original Certification (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2347 through 24.29.2350 reserved

24.29.2351 Reporting Requirements (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-224, 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2352 through 24.29.2355 reserved

24.29.2356 Department May Inspect or Audit (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2357 through 24.29.2360 reserved

24.29.2361 Application to Renew Certification, Notice of Intent not to Renew Certification (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2362 through 24.29.2365 reserved

24.29.2366 Renewal Certification (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2367 through 24.29.2370 reserved

24.29.2371 Application to Modify Plan (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2372 reserved

24.29.2373 Addition and Termination of Members (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2374 and 24.29.2375 reserved

24.29.2376 Revocation or Suspension of Certification (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2377 and 24.29.2378 reserved

24.29.2379 Dispute Resolution (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203, 39-71-1103 and 39-71-1105 MCA; IMP, Sec. 39-71-1103 and 39-71-1105 MCA; NEW, 1994 MAR p. 420, Eff. 3/1/94 ; REP, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.2380 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.

History: 39-71-203, 39-71-1103, 39-71-1105, MCA; IMP, 39-71-1103, 39-71-1105, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapters 24 through 25 Reserved

Subchapter 26
Subsequent Injury Fund Rules

24.29.2601 Notification When Compensation to be Continued Beyond 104 Weeks (REPEALED)

This rule has been repealed.

History: 39-71-904, MCA; IMP, 39-71-904, MCA; Eff. 12/31/72; REP, 2010 MAR p. 2967, Eff. 12/24/10.

24.29.2602 Introduction (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-904, MCA; IMP, 39-71-901, 39-71-905, 39-71-907, 39-71-908, MCA; NEW, 2010 MAR p. 2967, Eff. 12/24/10; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.603 and 24.29.604 reserved

24.29.2605 Definitions

For the purposes of this subchapter, the following definitions apply:
(1) “Applicant” means a person with a disability who applies to the department for SIF certification.
(2) “Reemployment” means placement with the time-of-injury employer in a new or modified position, with or without accommodations made for the certified worker’s permanent impairment.
(3) “Referring agent” means a person or agency that assists an individual in preparing a SIF application.
(4) “SIF” means the subsequent injury fund, which is administered by the department.

History: 39-71-203, 39-71-904, MCA; IMP, 39-71-116, 39-71-901, 39-71-905, MCA; NEW, 2010 MAR p. 2967, Eff. 12/24/10; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2606 reserved

24.29.2607 Certification Process

(1) Application for certification requires the following documentation:
(a)a completed SIF application form signed by the applicant; and
(b)medical evidence of permanent impairment signed by a physician qualified to complete impairment ratings.
(2) When the department approves an application, the department shall notify the applicant and referring agent, if applicable, and provide the applicant with a letter of SIF certification.
(3) The department shall retain an incomplete application for a period of one year. When an application remains incomplete one year after submission, the department shall deny the application.

(4) When the department denies an application, the department shall issue an order informing the applicant and referring agent, if applicable.

History: 39-71-203, 39-71-904, MCA; IMP, 39-71-905, MCA; NEW, 2010 MAR p. 2967, Eff. 12/24/10 AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2608 and 24.29.2609 reserved

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 is a person with a disability. The applicant's disability may result from a congenital condition, trauma, or disease. The permanent impairment does not have to be caused by a workrelated injury or occupational disease;
   (b) the medical evidence of permanent impairment relates directly to the condition identified on the application form;
   (c) a physician has provided written documentation that the applicant is permanently impaired; and
   (d) a 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.

History: 39-71-203, 39-71-904, MCA; IMP, 39-71-905, MCA; NEW, 2010 MAR p. 2967, Eff. 12/24/10; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2611 through 24.29.2613 reserved

24.29.2614 Reimbursement Process

(1) An insurer seeking reimbursement shall send proof of 104 weeks of insurer payments for medical and indemnity benefits to the department. Documents must include:
   (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.

(2) After an insurer's right to SIF reimbursement has been established, 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.

(3) Each reimbursement request must state the amount of reimbursement claimed for medical and indemnity payments and include 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.

(4) The insurer shall notify the department at the outset of settlement negotiations involving an injured individual who is SIF-certified. The insurer waives the right to SIF reimbursement for the settlement by failing to notify the department at the outset of settlement negotiations. Attorney fees must be itemized separately from medical and/or indemnity benefits when a settlement is submitted for department approval.

(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 24.29.230, at the written request of either party.

History: 39-71-203, 39-71-904, MCA; IMP, 39-71-907, 39-71-908, 39-71-909, 39-71-912, 39-71-920, MCA; NEW, 2010 MAR p. 2967, Eff. 12/24/10; AMD, 2018 MAR p. 2527, Eff. 1/1/19 ; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 27
Silicosis Benefits

24.29.2701 Payment of Silicosis Benefits (REPEALED)

This rule has been repealed.

History: 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; NEW, 2000 MAR p. 862, Eff. 3/30/00; AMD, 2010 MAR p. 2967, Eff. 12/24/10; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 28
Uninsured Employers' Fund

24.29.2801 Uninsured Employers' Fund Distribution (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, MCA; NEW, 1987 MAR p. 1991, Eff. 10/30/87; REP, 1995 MAR p. 933, Eff. 7/1/95.

Rule 24.29.2802 reserved

24.29.2803 Definitions (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-504, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2002 MAR p. 1766, Eff. 6/28/02.

Rules 24.29.2804 through 24.29.2810 reserved

24.29.2811 Monthly Payments—UEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 2002 MAR p. 1766, Eff. 6/28/02; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2812 and 24.29.2813 reserved

24.29.2814 Determining the Amount of the Administrative Costs Balance—UEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; EMERG; REP, 2002 MAR p. 1766, Eff. 6/28/02.

Rules 24.29.2815 and 24.29.2816 reserved

24.29.2817 Determining Whether There is a Positive Fund Balance—UEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 2002 MAR p. 1766, Eff. 6/28/02.

Rules 24.29.2818 through 24.29.2820 reserved

24.29.2821 Monthly Calculations of Fund Balances and Transfers—UIEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.2822 and 24.29.2823 reserved

24.29.2824 Determining the Amount of the Administrative Costs Balance—UEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.2825 and 24.29.2826 reserved

24.29.2827 Determining Whether There is a Positive Fund Balance—UIEF (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rule 24.29.2828 reserved

24.29.2829 No Benefits Paid from the UIEF to Claimants (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rule 24.29.2830 reserved

24.29.2831 Penalty Calculations from Uninsured Employers

(1) The penalty is calculated using the highest tier (or pricing level) that could have been charged by the state fund during the uninsured period.

History: 39-71-203, MCA; IMP, 39-71-504, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 1995 MAR p. 1668, Eff. 9/1/95; AMD, 2006 MAR p. 2040, Eff. 8/25/06; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2832 and 24.29.2833 reserved

24.29.2834 Collection of Penalties and other Payments from Underinsured Employers (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.2835 and 24.29.2836 reserved

24.29.2837 Calculation of Penalty on Underinsured Employers (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-532, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 1995 MAR p. 1668, Eff. 9/1/95; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rule 24.29.2838 reserved

24.29.2839 Compromise of Penalties Assessed (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-506, MCA; NEW, 1995 MAR p. 1668, Eff. 9/1/95; AMD, 1998 MAR p. 2872, Eff. 11/1/98; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2840 reserved

24.29.2841 Claims for Benefits for Insolvent Periods

(1) Prior to July 1, 1987, 39-71-503 , MCA required the UEF to keep "proper reserves and surpluses." During the period January 13, 1981, to June 30, 1987, the UEF was insolvent. Based on the legal principle in workers' compensation that the statutes in effect at the time of an injury determine a claimant's entitlement to benefits, the UEF did not accept liability for any injuries that occurred during the period of insolvency.

History: 39-71-203, MCA; IMP, 39-71-503, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.2842 reserved

24.29.2843 Payment of Benefits

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

(2) The UEF will pay compensation 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) 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).

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-504, 39-71-510, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2844 and 24.29.2845 reserved

24.29.2846 Priority of Payment of Current Benefits (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-504, 39-71-510, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 2024 MAR p. 1066, Eff.5/11/24.

Rules 24.29.2847 and 24.29.2848 reserved

24.29.2849 Payment of Claims Where Liability is Disputed (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-504, 39-71-510, MCA; NEW, 1995 MAR p. 933, Eff. 7/1/95; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2850 reserved

24.29.2851 Limitation on Expenditures for Medical Benefits Payable by the UEF—Applicability (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-510, 39-71-704, 39-71-727, MCA; NEW, 2007 MAR p.1446, Eff. 9/21/07, Eff. 5/11/24.

Rules 24.29.2852 reserved

24.29.2853 Rights of Third-Party Providers after the UEF Reaches $100,000 Medical Benefit Expenditure Limitation—Applicability

(1) Pursuant to 39-71-508 and 39-71-743 , MCA, the injured worker is not liable to the provider of medical services for the difference between the amount payable to the provider pursuant to the fee schedules and the charges billed by the provider or for the services provided that are not reimbursed after the $100,000 expenditure limit is reached.

(2) This rule applies to claims arising on or after July 1, 2007.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-508, 39-71-510, 39-71-704, 39-71-727, 39-71-743, MCA; NEW, 2007 MAR p. 1446, Eff. 9/21/07; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.2854 reserved

24.29.2855 Rights of Third-Party Providers upon the UEF's Proportionate Reduction in Benefit Payments—Applicability (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-503, 39-71-508, 39-71-510, 39-71-704, 39-71-727, 39-71-743, MCA; NEW, 2007 MAR p. 1446, Eff. 9/21/07; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapters 29 through 30 Reserved

Subchapter 31
Reopening of Closed Medical Benefits

24.29.3101 Introduction - Applicability - Voluntary Payments

(1) Subchapter 31 addresses the reopening of medical benefits terminated by statute for certain claims that occurred on or after July 1, 2011.
(2) Nothing in subchapter 31 prohibits an insurer from making voluntary payments for medical benefits that have terminated by statute. An insurer that makes a voluntary payment for a medical benefit that has been terminated by 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.

History: 39-71-203, MCA; IMP, 39-71-105, 39-71-107, 39-71-704, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3102 reserved

24.29.3103 Definitions

As used in subchapter 31, the following definitions apply unless the context clearly indicates otherwise:
(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.
(2) “Dismissed” means the petition was found ineligible for medical review or has been withdrawn at the injured worker’s request.
(3) “Petition” means the department-provided form upon which a party requests that medical benefits terminated by statute be reopened.
(4) “Reopened” means medical benefits terminated by statute and which are now to be furnished by the insurer as recommended in the medical report.

History:39-71-203, MCA; IMP, 39-71-116, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2018 MAR p. 2527, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3104 reserved

24.29.3105 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 shall review a petition to reopen. If the petition is not complete or not compliant with 39-71-717, MCA, it will be returned to the petitioner. The date the department accepts a complete and compliant petition to reopen begins the 60-day medical review period.

(3) 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.
(4) 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.
(5) 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.
(6) 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.
(7) 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.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2024 MAR p. 1066, Eff. 5/11/24; AMD, 2025 MAR, Notice No. 2025-30, Eff. 7/1/25.

Rule 24.29.3106 reserved

24.29.3107 Timelines and Explanation of Status Classifications of a Petition (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2018 MAR p. 2527, Eff. 1/1/19.

Rules 24.29.3108 through 24.29.3110 reserved

24.29.3111 Petition for Reopening (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3112 and 24.29.3113 reserved

24.29.3114 Submission of Medical Records and Additional Information - Effect of Failure to Submit Medical Records or Additional Information (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2021 MAR p. 1210, Eff. 9/25/21; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3115 and 24.29.3116 reserved

24.29.3117 Joint Petition for Reopening (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2018 MAR p. 2527, Eff. 1/1/19; AMD, 2021 MAR p. 1210, Eff. 9/25/21; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3118 and 24.29.3120 reserved

24.29.3121 Review by Medical Director - Consent of Both Parties (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3122 and 24.29.3123 reserved

24.29.3124 Review by Medical Review Panel - Report and Recommendations (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 586, Eff. 2/6/16; AMD, 2018 MAR p. 2527, Eff. 1/1/19; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.3125 and 24.29.3126 reserved

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 in order to determine whether the previous recommendations should be changed.

(2) The department shall request the worker and the insurer deliver to the department claim records created since the prior medical review. The department's request shall specify a deadline by which claim records must be received by the department.

(3) The biennial review will be based on the claim records previously submitted and the records sent pursuant to (2). If a party does not timely send updated claim records, 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 claim records to the department with the initial petition:

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

(b) if 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 conduct a review as set forth in ARM 24.29.3105.

(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 claim records; or

(b) in cases where the original review was made solely by the medical director, only the medical director will review the updated claim records.

(6) Following completion of the periodic review, the medical director shall issue a report and make recommendations.

History: 39-71-203, MCA; IMP, 39-71-717, MCA; NEW, 2016 MAR p. 204, Eff. 2/6/16; AMD, 2021 MAR p. 1210, Eff. 9/25/21; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 32
Officers of Private Corporations Election

24.29.3201 Election not to be Bound – Corporate Officer (TRANSFERRED)

This rule has been transferred.

History: Sec. 39-71-410 MCA; IMP, Sec. 39-71-410 MCA; NEW, Eff. 5/5/74; AMD, Eff. 11/3/75; AMD, Eff. 1/3/77; AMD, 1984 MAR p. 983, Eff. 7/2/84; TRANS, to ARM 24.29.705, Eff. 7/2/84.

Subchapters 33 through 34 Reserved

Subchapter 35
Coverage Under State Compensation Insurance Fund

24.29.3501 Electing Coverage under Plan Three (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2303 MCA; IMP, Sec. 39-71-2303 MCA; NEW, 1982 MAR p. 1397, Eff. 7/16/82; REP, 1995 MAR p. 1953, Eff. 10/1/95.

24.29.3502 Election of Optional Coverages (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2303 MCA; IMP, Sec. 39-71-2303 MCA; NEW, 1982 MAR p. 1397, Eff. 7/16/82; REP, 1995 MAR p. 1953, Eff. 10/1/95.

24.29.3503 Election of Corporate Officers not to be Bound (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2303 MCA; IMP, Sec. 39-71-2303 MCA; NEW, 1982 MAR p. 1397; Eff. 7/16/82; AMD, 1986 MAR p. 49, Eff. 1/17/86; REP, 1995 MAR p. 1953, Eff. 10/1/95.

24.29.3504 Policy and Declarations (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2303 MCA; IMP, Sec. 39-71-2303 MCA; NEW, 1982 MAR p. 1397, Eff. 7/16/82; REP, 1995 MAR p. 1953, Eff. 10/1/95.

24.29.3505 Termination of Coverage (REPEALED)

This rule has been repealed.

History: Sec. 39-71-2303 MCA; IMP, Sec. 39-71-2303 MCA; NEW, 1982 MAR p. 1397, Eff. 7/16/82; REP, 1995 MAR p. 1953, Eff. 10/1/95.

Subchapter 36 Reserved

Subchapter 37
Trade Group Discounts

24.29.3701 Purpose (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rule 24.29.3702 reserved

24.29.3703 Definitions (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

24.29.3704 Plan of Operation (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3705 and 24.29.3706 reserved

24.29.3707 Organizational Structure (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3708 through 24.29.3710 reserved

24.29.3711 Certification of a Group (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3712 through 24.29.3720 reserved

24.29.3721 Annual Report (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3722 through 24.29.3725 reserved

24.29.3726 Decertification of a Group (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3727 through 24.29.3730 reserved

24.29.3731 Individual Applicants (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Rules 24.29.3732 through 24.29.3740 reserved

24.29.3741 Disputes (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-433, MCA; NEW, 1994 MAR p. 681, Eff. 4/1/94; REP, 1998 MAR p. 2872, Eff. 11/1/98.

Subchapter 38
Attorney Fees

24.29.3801 Attorney Fee Regulation (REPEALED)

This rule has been repealed.

History: Sec. 39-71-203 MCA; IMP, Sec. 39-71-613 MCA; NEW, Eff. 11/4/76; AMD, 1985 MAR p. 606, Eff. 6/1/85; AMD, 1986 MAR p. 458, Eff. 4/1/86; AMD, 1987 MAR p. 323, Eff. 4/1/87; REP, 1988 MAR p. 2390, Eff. 11/11/88.

24.29.3802 Attorney Fee Regulation

(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 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 department. The department shall return the contract to the attorney along with a notification that the contract has been approved or disapproved.

(2) Except as provided in (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) for cases that have been settled without an order of the workers' compensation judge or the supreme court, 20% of the amount of compensation payments claimant receives due to the efforts of the attorney.

(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).

(3) The fee schedule set forth in (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, but the total fee charged may not exceed the schedule set forth in (2) except as provided in (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.

(4) The following benefits shall not be considered as a basis for calculation of attorney fees:
(a) the amount of medical and hospital benefits received by the claimant unless the workers' compensation insurer has denied all liability, including medical and hospital benefits, or unless the insurer has denied the payment of certain medical and hospital costs and the attorney has been successful in obtaining such benefits for the claimant.
(b) benefits received by the claimant with the assistance of the attorney in filling out initial claim forms only.
(c) any undisputed portion of impairment benefits received by the claimant based on an impairment rating. (d) Benefits initiated or offered by the insurer when such initiation or offer is supported by documentation in the claimant's file and has not been the subject of a dispute with the claimant.
(e) any other benefits not obtained due to the actual, reasonable and necessary efforts of the attorney.

(5) Nothing prevents an attorney from charging a fee below the fee guidelines set forth in (3) and (4). An attorney may reduce the attorney's fee from what was originally established in the approved fee contract without the further approval of the department.

(6) For good cause shown, the department may approve a variance providing for fees in excess of the guidelines of fees as set forth in (3) and (4).
(a) to obtain approval of a variance, an attorney has the burden of providing clear and convincing evidence of entitlement to a greater fee by documenting the following factors in regard to the specific claimant and the specific case:
(i) the anticipated time and labor required to perform the legal service properly.
(ii) the novelty and difficulty of legal issues involved in the matter.
(iii) the fees customarily charged for similar legal services.
(iv) the possible total recovery if successful.
(v) the time limitations imposed by the client or circumstances of the case.
(vi) the nature and length of the attorney-client relationship.
(vii) the experience, skill and reputation of the attorney.
(viii) the ability of the client to pay for the legal services rendered.
(ix) the risk of no recovery.
(x) the market value of the lawyer's services at the time and place involved.
(b) if a variance requested under (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 24.29.230. (7) Attorney compensation shall be determined by the approved fee arrangement and shall be paid out of the funds received in settlement or recovery or other funds available to the claimant. Upon the occurrence of a hearing before the workers' compensation court or the supreme court, the workers' compensation court shall have exclusive jurisdiction for the award of attorney's fees on the claim against the insurer or employer, which shall be credited to the fee due from the claimant.

(8) In the event a dispute arises between any claimant and an attorney relative to attorney's fees in a workers' compensation claim, upon request of either the claimant or the attorney or upon notice of any party of a violation of 39-71-613, MCA, or this rule, the workers' compensation court shall review the matter and issue an order resolving the dispute. The fee contract must clearly identify the rights granted by this section.

(9) Attorneys subject to this rule must report to the department as required by ARM 24.29.4332.

(10) If an attorney violates a provision of 39-71-613, MCA, this rule, or an order fixing an attorney's fee, the attorney shall forfeit the right to any fee which the attorney may have collected or have been entitled to collect.

History: 39-71-203, MCA; IMP, 39-71-225, 39-71-613, 39-71-2905, MCA; NEW, 1988 MAR p. 2390, Eff. 11/11/88; AMD, 1995 MAR p. 675, Eff. 5/1/95; AMD, 2004 MAR p. 78, Eff. 1/16/04; AMD, 2013 MAR p. 841, Eff. 5/24/13; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Subchapter 39 Reserved

Subchapter 40
Plan Number Two Insurers Rules

24.29.4001 Security Deposits for Plan Number Two Insurers (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-2206, MCA; NEW, 1987 MAR p. 1992, Eff. 10/30/87; REP, 2000 MAR p. 2701, Eff. 10/6/00.

Subchapters 41 and 42 Reserved

Subchapter 43
Workers' Compensation Data Base System

24.29.4301 Purpose (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2003 MAR p. 2297, Eff. 10/17/03; AMD, 2006 MAR p. 546, Eff. 2/24/06; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rule 24.29.4302 reserved

24.29.4303 Definitions

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

(1) "Closed" or "closed claim" means a claim on which all medical and indemnity benefits have been paid, and there is no expectation of future liability.

(2) "Electronic data interchange", or "EDI" means computer-to-computer exchange of business information in a standard and structured format.

(3) "IAIABC" means the International Association of Industrial Accident Boards and Commissions, which is an international trade association that seeks to advance the administration of workers' compensation systems through education, research and information sharing. The IAIABC establishes standards for reporting industrial accidents.

(4) "Reporting parties" means any person, firm, corporation, or any other type of entity required by Title 39, chapter 71, part 2, MCA, to report information to the department.

(5) "Third-party administrator" means an entity who contracts to administer all or part of an insurer's or employer's workers' compensation business, which can include adjusting a claim on behalf of the insurer or employer.

(6) "Trading partner" means the entity which actually transmits the data to the department, excluding the intermediary channels that are used to get it to that final point, even if those channels include the legally responsible regulated party.
(7) "Workers' compensation subsequent report" means a report required to communicate payment information related to an indemnity claim, including both medical and indemnity benefits.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2003 MAR p. 2297, Eff. 10/17/03; AMD, 2006 MAR p. 546, Eff. 2/24/06; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4304 through 24.29.4306 reserved

24.29.4307 Claim File Records Maintenance and Retention

(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 or departmentapproved equivalent;
  (b)medical bills, or an electronic data record thereof;
  (c)benefit rate calculations, if applicable;
  (d)correspondence relating to the claim;
  (e)medical reports;
  (f) vocational rehabilitation reports;
  (g)payment record; and
  (h)official orders, whether those orders are from the department or a court.
(2) Copies of insurer files must be provided to the department at no cost.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2003 MAR p. 2297, Eff. 10/17/03; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4308 through 24.29.4310 reserved

24.29.4311 Forms Used for Reporting (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-205, 39-71-208, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2003 MAR p. 2297, Eff. 10/17/03; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4312 and 24.29.4313 reserved

24.29.4314 Reporting

(1) Reporting parties who report electronically 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.
  (b)electronic reporting for workers' compensation claims and insurance coverage information must be reported using a department-supported IAIABC 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.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2003 MAR p. 2297, Eff. 10/17/03; AMD, 2006 MAR p. 546, Eff. 2/24/06; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

24.29.4315 Insurer and Employer Reporting Requirements – Coverage and Cancellation Notification

(1) An insurer's electronic notice of insurance coverage or cancellation must contain the taxpayer identification number of the employer.
(2) An employer must provide its taxpayer identification number to its workers' compensation insurer.

History: 39-9-103, 39-71-203, 39-71-225, MCA; IMP, 39-9-201, 39-71-203, 39-71-225, 39-71-401, 39-71-504, 39-71-507, 39-71-2204, 39-71-2205, 39-71-2337, 39-71-2339, MCA; NEW, 2007 MAR p. 697, Eff. 5/25/07; AMD, 2007 MAR p. 1028, Eff. 7/27/07.

Rule 24.29.4316 reserved

24.29.4317 Reports Produced by the Department (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-205, 39-71-209, 39-71-224, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2003 MAR p. 2297, Eff. 10/17/03; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4318 through 24.29.4320 reserved

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 injury or of an occupational disease.
(2) All insurers and the UEF are required to submit a first report of injury and occupational disease to the department within 14 days of notification by the department that a previously submitted report contains a data error.
(3) All insurers are required to submit to the department a workers' compensation subsequent report for every indemnity claim within 14 days of the occurrence of any one of the following triggering events:
(a)each six-month anniversary of the injury or occupational disease, while the claim is open;
(b)notification by the department that a previously submitted report contains a data error; or
(c)a request by the department for a report.
(4) Upon closure of a claim, the workers' compensation subsequent report may be filed either within 14 days of the time the claim is closed or at the next six month anniversary of the injury or occupational disease.
(5) The department will identify transmission errors and notify the trading partner via the electronic acknowledgment record. The trading partner must correct the identified errors and resubmit the record within 14 days of receiving the acknowledgment record.

History: 39-71-203, MCA; IMP, 39-71-225, 39-71-307, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2000 MAR p. 2701, Eff. 10/6/00; AMD, 2003 MAR p. 2297, Eff. 10/17/03; AMD, 2006 MAR p. 546, Eff. 2/24/06; AMD 2024 MAR p. 1066, Eff. 5/11/24.

24.29.4322 Transitional Rule for Injury and Occupation Disease Information Reporting Requirements (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; REP, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4323 through 24.29.4328 reserved

24.29.4329 Verification and Additional Information (REPEALED)

This rule has been repealed.

History: 39-71-203, MCA; IMP, 39-71-203, 39-71-225, 39-71-304, MCA; NEW, 1994 MAR p. 2630, Eff. 10/1/94; AMD, 2003 MAR p. 2297, Eff. 10/17/03, Eff. 5/11/24

Rules 24.29.4330 through 24.29.4331 reserved

24.29.4332 Claimant Legal Fees and Costs Reporting Requirements

(1) All attorneys that represent claimants shall report, on a per-claim basis, the amount of legal fees and costs received for each claim where:
  (a)the attorney has an approved fee agreement; and
  (b)the attorney actually receives a fee from the claimant or on behalf of a claimant.
(2) An initial legal fee report must be reported to the department within 14 days of the date the attorney actually receives the first fee payment for each claim. If an attorney represents a claimant on multiple claims, the fees and costs for all claims need only be reported on one of the claims.
(3) Subsequent legal fee reports must be reported within 14 days of each six-month anniversary of the injury or occupational disease for as long as there exists the potential for fee payments.
(4) Once the potential for fee payments no longer exists, a final legal fee report must be filed at any time prior to or within 14 days of the next six-month anniversary of the injury or occupational disease.
(5) The claimant attorney must also submit a legal fee report upon:
  (a)notification by the department that a previously submitted report contains an error; or
  (b)a request by the department for a report.
(6) A claimant attorney must report to the department, in the form prescribed by the department, the following information:
  (a)the total amount of legal fees paid to date by the claimant or on behalf of a claimant, including the amount of attorney fees received pursuant to a settlement; and
  (b)the total amount of attorney costs paid or reimbursed to date by the claimant. For purposes of this rule, attorney costs include but are not limited to:
    (i) deposition costs;
    (ii) witness fees and mileage;
    (iii) expert witness fees;
    (iv) documented photocopy expenses;
    (v) documented long-distance telephone expenses;
    (vi) documented postage expenses; and (vii) the amount of attorney fees received pursuant to a settlement.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1995 MAR p. 675, Eff. 5/1/95; AMD, 2006 MAR p. 546, Eff. 2/24/06; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4333 through 24.29.4334 reserved

24.29.4335 Insurer Legal Fees Reporting Requirements

(1) All insurers shall report, on a per-claim basis, the amount of the insurer's legal fees and costs, including fees paid to expert witnesses that have been paid to date by the insurer, associated with each indemnity claim. That information must be reported on the subsequent report required by ARM 24.29.4321.

(2) If an insurer uses in-house counsel, and the insurer does not allocate the cost of in-house counsel directly to specific claims, the insurer shall report as required by ARM 24.29.4336.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1995 MAR p. 675, Eff. 5/1/95; AMD, 2006 MAR p. 546, Eff. 2/24/06.

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.

(2) 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) the dollar amount that represents the following information about the cost of in-house legal staff:

(i) total compensation (salary and cost of benefits and employer contributions) of all attorneys who provide counsel on indemnity claims;

(ii) total compensation of support staff (such as secretaries, paralegals, and assistants) working for those attorneys; and

(iii) overhead costs attributable to the legal staff, such as a proportionate share of rent or building expense and administrative costs, such as payroll and accounting; and

(b) a percentage figure that reasonably approximates the percentage of time spent by the attorneys providing advice, counsel or representation on indemnity claims.

History: 39-71-203, MCA; IMP, 39-71-225, MCA; NEW, 1995 MAR p. 856, Eff. 5/1/95; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

Rules 24.29.4337 through 24.29.4338 reserved

24.29.4339 Verification of Consultant and Legal Fee Reporting

(1) For the purpose of verifying the accuracy of the data reported, the department may periodically verify 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.

(2) At least 14 days' advance notice will be given to the reporting party. A reporting party is responsible for full cooperation with the department.

History: 39-71-203, MCA; IMP, 39-71-225, 39-71-304, MCA; NEW, 1995 MAR p. 675, Eff. 5/1/95; AMD, 2024 MAR p. 1066, Eff. 5/11/24.

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Chapter 35
Independent Contractors

Subchapter 1
Independent Contractor Exemption Certificate

24.35.101 Definitions

For the purposes of ARM Title 24, chapter 35, the following definitions apply:

(1) "Employment status" means the employment relationship between an individual and a hiring agent.

(2) "Fixed business location" means a principle place of business for any trade, occupation, profession,or business that is designated by the owner as the physical location where customers are directedfor any physical contacts with the business and is the actual location where the majority of thebusiness work is regularly performed. More than a place to store inventory or product samples, afixed business location is where a person engages in work intended for commerce.

(3) "Hiring agent" means the entity that hires an individual to perform services. A hiring agent may be an "employer" as defined in 39-3-201, MCA; 39-51-202, MCA; 39-71-117, MCA; or other legal entity as defined by an "employing unit" in 39-51-201, MCA.

(4) "Incomplete application" means an application submitted for an exemption as an independent contractor that fails to qualify for a minimum of 15 points due to insufficient, missing, unverifiable, or incorrect information; or due to failure to submit an essential component, such as a signed and notarized waiver or required fee.

(5) "Independent Contractor Central Unit" or "ICCU" means the individuals or group responsible for making employment status decisions for the entire department and other agencies that elect to participate in the ICCU.

(6) "Party" means a person or entity designated by the department as plaintiff or respondent in an ICCU decision-making proceeding. The department, the claimant, employer(s), hiring agent(s), ICEC holders, insurer(s), or agencies of state government may be a party to an ICCU decisionmaking proceeding or appeal of an ICCU decision to the Workers' Compensation Court.

(7) "Revoked" and "revocation" mean that an ICEC is no longer in force or effect.

(8) "Suspended" and "suspension" mean that a person's ICEC is not applicable to a particular job or to a series of jobs for a particular hiring agent.

History: 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-51-201, 39-51-204, 39-71-105, 39-71-409, 39-71-417, 39-71-418, MCA; NEW, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2061, Eff. 8/24/24.

Rules 24.35.102 through 24.35.110 reserved

24.35.111 Application for Independent Contractor Exemption Certificate

(1) The applicant for an ICEC shall submit:
(a)a completed ICEC application on a department-approved form bearing the applicant's signature;
(b)a fee, as required by ARM 24.35.121; and
(c)an executed waiver conforming to the requirements of ARM 24.35.113.

(2) The department shall approve or deny an ICEC application within 30 days of receipt and notify the applicant in writing.

(3) he department shall retain an incomplete or denied application for a period of six months from the date of receipt and allow the applicant the opportunity to supplement supporting documentation or submit missing components. Upon the written request of applicant, the department shall re-evaluate an application, taking into consideration the supplemental information submitted by applicant. Incomplete applications that have not been approved within six months of receipt by the department will remain denied.

History: 39-71-417, MCA; IMP, 39-71-417, MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96; AMD, 1998 MAR p. 2880, Eff. 11/1/98; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2061, Eff. 8/24/24; AMD, 2026 MAR, Notice No. 2025-508, Eff. 2/7/26.

24.35.112 Independent Contractor Exemption Certificate Application

(1) On the form provided by the department, the applicant shall provide all information designated as required. The applicant must state, under oath, the veracity of all information on and attached to the form.

(2) The applicant shall also submit supporting documentation to prove applicant's qualification for an ICEC. The department has the discretion to assess the reliability of the documentation and award points for each item of proof as outlined by this rule. Each item of documentation submitted may count toward points in more than one category. No more than two items of proof may be submitted under each category. To qualify for an ICEC, an applicant's documentation must be awarded a minimum of 15 points by the department for each independently established trade, occupation, profession, or business listed on the ICEC application.

(a) the department may award up to ten points for proof that the applicant has current workers' compensation, unemployment insurance, and Department of Revenue accounts for employees in each independently established trade, occupation, profession, or business. The department may award up to six points for proof of two insurance policies or accounts and may award up to three points for proof of one insurance policy or account.

(b) The department may award up to six points for each of the following proofs for each independently established trade, occupation, profession, or business:

(i) contract or memo of understanding that demonstrates applicant's independent contractor status. If the applicant can end a contract at any time without incurring any liability for failing to complete the project that is the subject of the contract, the department cannot award points for the contract under this rule. Separate contracts with different hiring agents may qualify for a maximum of six points. Each contract must include:

(A) payment based on a completed project;
(B) beginning and ending dates of the contract;
(C) liability for failure to complete the project;
(D) identification of who provides the materials and supplies;
(E) signatures by both parties; and
(F) defined body of work, complete project, or end result;

(ii) signed and dated list of equipment and tools owned or controlled by the applicant with approximate values. The equipment or tool list may be documented by a rental or lease agreement, county documents verifying the business equipment tax paid, or other means;

(iii) commercial general liability insurance policy or bonding;

(iv) most recent business tax forms filed within the past three years;

(v) IRS Form 1099s (miscellaneous income) from multiple hiring agents or two quarterly self-employment tax payments (IRS form 1040ES) within the past three years;
(vi) trucking company lease agreement; or
(vii) certification for Indian Preference by a federally recognized Indian tribe under the laws of that tribe.

(c) the department may award up to three points for each of the following proofs for each independently established trade, occupation, profession, or business:
(i) partnership or limited liability partnership agreement signed and dated by all partners that demonstrates:
(A) intent to form the partnership;
(B) contribution by all partners;
(C) a proprietary interest and right of control by the application; and
(D) the sharing of profit/loss;
(ii) current business license or building permit;
(iii) certificate of registration for the business entity issued by the Montana Secretary of State;
(iv) articles of incorporation, annual report, articles of organization, or other documentation that verifies the applicant is an officer in a corporation, a manager in a manager-managed limited liability company, or a member of a member-managed limited liability company;
(v) proof of ownership, home occupation license, rental or lease agreement with a statement that the property may be used for business or commercial use, or proof of IRS filing for use of home as a business;
(vi) educational certification for unlicensed occupations relevant to the trade, occupation, or profession for which the applicant seeks the ICEC;
(vii) current professional license relevant to the trade, occupation, or profession for which the applicant seeks the ICEC;
(viii) membership in a relevant professional association or affiliation;
(ix) current motor carrier (MC) authority number in applicant's personal or business name;
(x) business bank account; or
(xi) copies of advertising in a newspaper, phone book, web site on the internet, or other venue.

(d) the department may award up to one-and-one-half points for each of the following proofs for each independently established trade, occupation, profession, or business:
(i) federal employer identification number (EIN);
(ii) Dunn and Bradstreet number;
(iii) telephone or utility bill(s) in the business name;
(iv) credit card(s) or purchase account(s) in the business name;
(v) preprinted business invoices, business cards, or brochures;
(vi) proof of order(s) for printed hats, shirts, or other promotional items for the business;
(vii) proof of business advertising using a vehicle sign, yard sign, bulletin boards, or posted flyers;
(viii) invoices billed to the business name or a bid proposal or estimate, either of which must include the address and phone number of the recipient;
(ix) vehicle registration(s) in the business name; or
(x) international fuel tax account number (IFTA) in the applicant's personal or business name.

(e) the applicant may submit any other supporting documentation. The department has discretion to assess the reliability of and determine the point value of any documentation not listed in this rule.

History: 39-3-202, 39-3-403, 39-51-301, 39-71-203, 39-71-417, MCA; IMP, 39-3-201, 39-3-402, 39-51-201, 39-51-204, 39-71-417, 39-71-418, 39-71-419, MCA; NEW, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2063, Eff. 8/24/24; AMD, 2026 MAR, Notice No. 2025-508, Eff. 2/7/26 .

24.35.113 Independent Contractor Exemption Certificate Waiver

(1) To execute a waiver, the applicant shall complete the department-approved waiver form. The waiver form must be signed by the applicant and under oath. The applicant shall represent on the waiver form that:
   (a) the applicant is engaged in each independently established trade, occupation, profession, or business that is specifically identified on the application form;
   (b) the applicant is responsible for all taxes related to the applicant's work as an independent contractor;
   (c) the applicant controls the details of how services are performed, both under contract and in fact, and the hiring agent retains only the control necessary to ensure the bargained for end result; and
   (d) the applicant understands and agrees that if the ICEC is granted, the applicant is not eligible for and waives the right to workers' compensation or occupational disease benefits for an injury or occupational disease related to work performed as an independent contractor in each independently established trade, occupation, profession, or business for which the ICEC is granted

History: 39-3-202, 39-3-403, 39-51-301, 39-71-203, 39-71-417, MCA; IMP, 39-3-201, 39-3-402, 39-51-201, 39-51-204, 39-71-417, 39-71-418, 39-71-419, MCA; NEW, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2063, Eff. 8/24/24; AMD, 2026 MAR, Notice No. 2025-508, Eff. 2/7/26.

Rules 24.35.114 through 24.35.115 reserved

24.35.116 Renewal of Independent Contractor Exemption (REPEALED)

This rule has been repealed.

History: 39-71-203 and 39-71-401, MCA; IMP, 39-71-120 and 39-71-401, MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96; REP, 2005 MAR p. 1511, Eff. 8/12/05.

24.35.117 ICEC Renewal, Declaration, and Waiver

(1) About two months prior to its expiration, the department will remind an ICEC holder of the expiration date of their ICEC.
(2) To renew an ICEC, the ICEC holder shall submit the following:
   (a) signed ICEC renewal application on the department-approved form that indicates any changes in independent contractor status;
   (b) certification that previously submitted documentation remains valid;
   (c) additional documentation supporting independent contractor status, as needed;
   (d) a fee, as required by ARM 24.35.121; and
   (e) an executed waiver on the department-approved form.
(3) The department will verify documentation on file and evaluate all new documentation submitted by the ICEC holder. The department will assign point values to documentation, in accordance with ARM 24.35.112.
(4) The department has discretion to assess the reliability of and determine the point value of any documentation not listed in ARM 24.35.112.

(5) If the department is unable to verify any documentation needed to support independent contractor status, the department will notify the ICEC holder in writing within 30 days of receipt of the renewal application.
(6) To qualify for an ICEC renewal, the ICEC holder's documentation must be awarded a minimum of 15 points by the department for each independently established trade, occupation, profession, or business listed on the ICEC renewal application.
(7) An ICEC renewal issued by the department remains in effect for a two-year period unless the department revokes or suspends the ICEC or the ICEC holder requests in writing that the department cancel the ICEC.
(8) An ICEC holder may update the information on file with the department at any time during a current independent contractor exemption certificate period by requesting in person, over the phone, by e-mail, or in writing the revision of business name(s), business structure, phone number(s), or mailing address.
(9) An ICEC holder may add or change trade(s), occupation(s), profession(s), or business(es) to an ICEC, by submitting a complete application and meeting the requirements of statute and rule. When an addition is made pursuant to this section (9), the expiration date of the ICEC is not changed.

History: 39-51-301, 39-51-302, 39-71-203, 39-71-409, 39-71-417, MCA; IMP, 39-51-201, 39-51-204, 39-71-105, 39-71-409, 39-71-417, 39-71-418, MCA; NEW, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2061, Eff. 8/24/24; AMD, 2026 MAR, Notice No. 2025-508, Eff. 2/7/26.

Rules 24.35.118 through 24.35.120 reserved

24.35.121 Application and Renewal Fee for Independent Contractor Exemption Certificate

(1) A nonrefundable fee of $125 must be submitted with each initial application, each application for reinstatement of a revoked ICEC, and each renewal application.
(2) ICECs are issued for a two-year period.
(3) The department may charge a $10 fee for the reissuance of a current certificate.

History: 39-71-203, 39-71-401, MCA; IMP, 39-71-401, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96; AMD, 1998 MAR p. 2880, Eff. 11/1/98; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 967, Eff. 6/17/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18.

Rules 24.35.122 through 24.35.130 reserved

24.35.131 Suspension or Revocation of Independent Contractor Exemption Certificate

(1) The department may revoke an ICEC when the department determines it is necessary to do so. The following are examples when the department may revoke an ICEC:
  (a) the department is unable to locate the certificate holder or mail sent to the certificate holder at the address on file with the department is returned;
  (b) the certificate holder fails to cooperate with the department, including without limitation:
    (i) failure to provide information to the department upon request;
    (ii) failure to complete a worker relationship questionnaire upon request; or
    (iii) failure to notify the department of changes in contact information;
  (c) when revocation is required by law, for example for non-payment of child support pursuant to Title 40, chapter 5, part 7, MCA; or
  (d) any reason the department determines sufficiently egregious to warrant revocation of the ICEC.

(2) A person with a suspended ICEC as applied to a particular hiring agent may apply for reinstatement of the ICEC by submitting proof to the department of the ICEC holder's independent contractor status in relation to the identified hiring agent. The department shall investigate prior to reinstatement of an ICEC to ascertain that independent contractor status is established in fact.

(3) A person whose ICEC has been cancelled by the ICEC holder or revoked by the department may apply for a new ICEC pursuant to ARM 24.35.111.

History: 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-51-201, 39-51-204, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18.

Rule 24.35.132 reserved

24.35.133 Notice of Suspension or Revocation of Independent Contractor Exemption Certificate

(1) When the department suspends or revokes an ICEC, the certificate holder's waiver of workers' compensation benefits is no longer effective upon departmental notice to the hiring agent(s).

(2) A hiring agent is considered to have been given notice of the suspension of an ICEC on the date a written notice is personally delivered to the hiring agent, or three days after the department mails a written notice to the hiring agent, whichever is earlier.

(3) Regarding a revocation, if the department has contact information for a given hiring agent, that hiring agent is considered to have been given notice of the revocation of an ICEC on the date a written notice is personally delivered to the hiring agent, or three days after the department mails a written notice to the hiring agent, whichever is earlier.

(a)hiring agents unknown to the department or potential future hiring agents are deemed to have notice that an ICEC is revoked at the earlier of when:

(i) the department posts notice of the revoked ICEC at its web site; or

(ii) the hiring agent has actual knowledge of the department's revocation of the ICEC.

History: 39-71-203, 39-71-417, 39-71-418, MCA; IMP, 39-71-418, MCA; NEW, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2024 MAR p. 2061, Eff. 8/24/24 .

Rules 24.35.134 through 24.35.140 reserved

24.35.141 Guidelines for Determining Whether an Independent Contractor Exemption Certificate Is Needed (REPEALED)

This rule has been repealed.

History: 39-71-203, 39-71-417, MCA; IMP, 39-71-417, MCA; NEW, 1996 MAR p. 1303, Eff. 5/10/96; TRANS, 1996 MAR p. 1863, Eff. 7/1/96; AMD, 1998 MAR p. 2880, Eff. 11/1/98; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; REP, 2018 MAR p. 720, Eff. 4/14/18.

Subchapter 2
Central Unit for Status Determinations

24.35.201 Definitions (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, MCA; IMP, 39-3-208, 39-3-209, 39-3-210, 39-51-201, 39-51-203, 39-71-120, 39-71-415, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; REP, 2010 MAR p. 1608, Eff. 7/16/10.

24.35.202 Decisions Regarding Employment Status

(1) Subject to ARM 24.35.203, the department shall apply a two-part test to determine whether an individual is an independent contractor or an employee. The department shall evaluate:
   (a)whether the individual is and shall continue to be free from control or direction over the performance of the services, both under contract and in fact; and
   (b)whether the individual is engaged in an independently established trade, occupation, profession, or business.
(2) Initial determinations regarding employment status may be issued by any unit of the department or by the Department of Revenue. Initial determinations are binding unless appealed to the ICCU by applicable law.
(3) ICCU decisions regarding employment status are binding on the department and on any other agency which elects to be included as a member of the department's ICCU, subject to the limitations contained in ARM 24.35.205(3). This does not include any agency which is merely appearing before the ICCU as a party in an employment status case, and has not elected to be included as a member of the ICCU.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-3-208, 39-3-209, 39-3-210, 39-51-201, 39-51-203, 39-71-415, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 2061, Eff. 8/24/24.

24.35.203 Determinations Where Exemption Certificate Mandatory

(1) Except as provided in ARM 24.35.204, when a worker is required by 39-71-417, MCA, to have an independent contractor exemption certificate and does not, the worker is conclusively determined to be an employee for purposes of wage and hour, unemployment insurance, workers' compensation, and income tax.
(2) When a worker holds an independent contractor exemption certificate and is working under that certificate as required by 39-71-417, MCA, the worker is conclusively determined to be an independent contractor for purposes of wage and hour, unemployment insurance, workers' compensation, and income tax.
(3) When worker status is conclusively determined pursuant to this rule, the ICCU may issue a decision based solely on information sufficient to determine that conclusive outcome.
(4) Notwithstanding the foregoing, the ICCU may, at its discretion, perform an investigation pursuant to ARM 24.35.202 or when a decision is needed for a program other than wage and hour, unemployment insurance, workers' compensation, or income tax. A decision may also be issued for the purposes of suspending revoking the certificate pursuant to ARM 24.35.131 or issuing penalties, or for other purposes as the ICCU deems necessary.

History: 39-3-202, 39-3-403, 39-51-301, 39-71-203, 39-71-417, MCA; IMP, 39-3-201, 39-3-402, 39-51-201, 39-51-204, 39-71-417, 39-71-418, 39-71-419, MCA; NEW, 2018 MAR p. 720, Eff. 4/14/18, 2022 MAR p. 284, Eff. 2/26/22.

24.35.204 Misrepresentations Regarding Independent Contractor Status

(1) For purposes of the implementation of 39-51-203(4) and 39-71-419(1)(e), MCA, and requirements in certain instances not to determine status based "solely" on the lack of an ICEC, if one or more category of 39-71-417(7)(d), MCA applies, the ICCU will evaluate the worker's status pursuant to 39-71-417(4), MCA.

History: 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-51-201, 39-51-203, 39-71-419, MCA; NEW, 2022 MAR p. 284, Eff. 2/26/22; AMD, 2024 MAR p. 2061, Eff. 8/24/24

24.35.205 Binding Nature of ICCU Decisions Regarding Employment Status

(1) Unless appealed following mediation per 39-71-415, MCA, ICCU decisions are binding on all parties regarding employment status issues under the jurisdiction of the department and any other agency electing to be included as a member of the ICCU. These decisions may affect a party's liability in unemployment insurance, the Uninsured Employer's Fund, wage and hour, human rights, and state income tax withholding matters.
(2) Neither the department nor any other agency electing to be included as a member of the ICCU may appeal the ICCU's employment status decision.
(3) When a party appeals the ICCU's employment status decision, the decision is not binding on any party until all appeal rights are exhausted.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-3-212, 39-51-1109, 39-71-415, 39-71-417, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18 ; AMD, 2022 MAR p. 152, Eff. 1/29/22.

24.35.206 Mediation and Appeal of Employment Status

(1) A party receiving an adverse ICCU decision may request mediation within 15 days of the date the decision was sent. The mediation request is effective upon department receipt.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 2-4-201, 39-3-216, 39-51-1109, 39-71-415, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; AMD, 2018 MAR p. 720, Eff. 4/14/18 ; AMD, 2022 MAR p. 152, Eff. 1/29/22.

24.35.207 Transfer of File (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 2-4-201, 39-3-216, 39-51-1109, 39-71-415, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10; REP, 2018 MAR p. 720, Eff. 4/14/18.

Rules 24.35.208 and 24.35.209 reserved

24.35.210 Hearing on Employment Status Issue (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203, MCA; IMP, 2-4-201, 2-4-611, 39-3-216, 39-51-1109 and 39-71-415, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; REP, 2003 MAR p. 2550, Eff. 11/14/03.

Rule 24.35.211 reserved

24.35.212 Appeal Referee's Findings of Fact, Conclusions of Law, and Decision on Employment Status (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203, MCA; IMP, 2-4-611, 2-4-623, 39-3-216, 39-51-1109 and 39-71-415, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; REP, 2003 MAR p. 2550, Eff. 11/14/03.

24.35.213 Appeal of Findings, Conclusions and Decision on Employment Status (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203, MCA; IMP, 2-4-611, 2-4-623, 39-3-216, 39-51-1109, 39-71-415, 39-71-504, 39-71-532 and 39-71-2401, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; REP, 2003 MAR p. 2550, Eff. 11/14/03.

Subchapter 3
Definitions Related to Independent Contractors

24.35.301 Definition of Independent Contractor (REPEALED)

This rule has been repealed.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302 and 39-71-203, MCA; IMP, 39-3-201, 39-51-201, 39-51-204, 39-71-120 and 39-71-401, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; REP, 2005 MAR p. 1511, Eff. 8/12/05.

24.35.302 Independent Contractor—Guidelines Regarding Evidence of Control

(1) An individual is an employee and not an independent contractor if the hiring agent controls or retains the right to control the way the individual renders services. The following factors serve as general guidelines when the department evaluates whether control exists:

(a) the individual is required to follow written or oral instructions concerning when, where, or how work is to be done. Although some individuals, because of skill or expertise, work without receiving instructions, they may still be employees if the employer has the right to give instructions on work performance;

(b) the success or continuation of a business depends in great part upon the services performed by the individual;

(c) the hiring agent directs the hiring, supervising, or payment of the individual's assistants;

(d) the relationship between the individual and the hiring agent is on a frequent, recurring basis, even if irregular or part time;

(e) the individual is required to perform services at certain established times;

(f) the work is performed on the business premises or jobsite of the hiring agent. This factor is especially important if the work could be performed elsewhere;

(g) the hiring agent requires, or has the right to require, the individual to perform services in a certain manner, or in a certain order or sequence;

(h) the hiring agent requires the individual to submit oral or written reports;

(i) the individual is paid based on the time spent doing the work rather than a payment for a completed project or end result;

(j) the individual is paid or reimbursed for travel or other business-related expenses;

(k) the hiring agent furnishes the facilities, tools, materials, or other equipment to the individual;

(l) the individual may be discharged at the will of the hiring agent, including the right to discharge for the failure to follow specified rules or methods. A union contract or statute which restricts the right of discharge does not indicate a lack of control;

(m) training is provided to the individual by the hiring agent;

(n) the individual does not realize a profit or suffer a loss as a result of the services performed;

(o) the individual is prohibited or restricted from working for others or is required to devote primary attention to the hiring agent;

(p) the individual has signed an overly broad noncompetition clause in a contract with a hiring agent; or

(q) other factors that indicate control of the individual by the hiring agent.

(2) The above factors are weighed and evaluated depending on the circumstance of each case. A combination of these factors may indicate control or the right to control. Service performed by an individual for pay is considered to be employment until it is shown to the satisfaction of the department that the individual is an independent contractor.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-3-201, 39-51-201, 39-51-203, 39-51-204, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10.

24.35.303 Independent Contractor—Guidelines Regarding Independently Established Business

(1) To be an independent contractor, an individual must be engaged in an independently established trade, occupation, profession, or business. The following factors serve as general guidelines when the department evaluates whether an independently established business exists:

(a) the individual has a place of business separate from the hiring agent's place of business;

(b) the individual supplies substantially all of the tools, equipment, supplies, or materials necessary to perform the services;

(c) the individual pays all expenses associated with performing the services, and are not reimbursed by the hiring agent;

(d) the individual has two or more effective contracts to perform services for several different hiring agents;

(e) the individual is paid based on a billing statement or invoice at completion of the services;

(f) the individual performs the services under a written contract that requires complete or partial payment after a certain amount of work is performed, and the contract terminates after a definite time period;

(g) the individual advertises services in telephone books, newspapers, or other media;

(h) the individual files federal or state business tax forms;

(i) the individual has the required customary licenses, registrations, or permits to maintain a business;

(j) the individual may realize a profit or suffer a loss from performing the services for the hiring agent. This factor may be shown if the individual:

(i) hires or pays assistants to perform the services;

(ii) performs the services at facilities owned or leased by the individual;

(iii) has continuing or recurring liabilities associated with performing the services; or

(iv) agrees to perform specific jobs for prices agreed upon in advance and pays expenses associated with the performance of the services;

(k) the individual has an independent contractor exemption certificate;

(l) the individual may not end the relationship at will without incurring liability. An independent contractor agrees to complete a specific job, is responsible for its completion, and may be subject to liability for failing to complete the job in accordance with agreed upon specification;

(m) the individual is not prohibited or restricted from working for others; or

(n) another factor that indicates the existence of an independently established trade, occupation, profession, or business.

(2) The department shall evaluate and weigh the above factors for each case. A combination of these factors may indicate that the individual is customarily engaged in an independently established trade, occupation, profession, or business. Service performed by an individual for pay is considered to be employment until it is shown to the satisfaction of the department that the individual is an independent contractor.

History: 39-3-202, 39-3-403, 39-51-301, 39-51-302, 39-71-203, 39-71-417, MCA; IMP, 39-3-201, 39-51-201, 39-51-203, 39-51-204, 39-71-417, 39-71-418, MCA; NEW, 1996 MAR p. 1676, Eff. 7/1/96; AMD, 2003 MAR p. 2550, Eff. 11/14/03; AMD, 2005 MAR p. 1511, Eff. 8/12/05; AMD, 2010 MAR p. 1608, Eff. 7/16/10.

Chapter 5
Office of the Workers' Compensation Judge (REPEALED)

Subchapter 1
Organizational Rule

24.5.101 Organizational Rule (REPEALED)s

Subchapter 2 Reserved

Subchapter 3
Procedural Rules

24.5.301 Petition for Trial (REPEALED)
24.5.302 Response to Petition (REPEALED)
24.5.303 Service and Filing (REPEALED)
24.5.304 Alternative Pleading (REPEALED)
24.5.305 Nature of Rules (REPEALED)
24.5.306 Brevity in Pleadings and Form of Paper Presented for Filing (REPEALED)
24.5.307 Third-Party Practice (REPEALED)
24.5.307A Joinder and Service of Alleged Uninsured Employers (REPEALED)
24.5.308 Joining Third Parties (REPEALED)
24.5.309 Intervention (REPEALED)
24.5.310 Time and Place of Trial Generally (REPEALED)
24.5.311 Emergency Trials (REPEALED)
24.5.312 Setting Time and Place of Trial by Stipulation or in Best Interests of the Court (REPEALED)
24.5.313 Recusal (REPEALED)
24.5.314 Adjudication of Interim Benefit Claims Under 39-71-610, MCA (REPEALED)
24.5.315 Pretrial Identification of Witnesses and Exhibits (REPEALED)
24.5.316 Motions (REPEALED)
24.5.317 Medical Records (REPEALED)
24.5.318 Pretrial Conference, Pretrial Order, and Exhibits (REPEALED)
24.5.319 Amended Pleadings (REPEALED)
24.5.320 Computation of Time (REPEALED)
Rule 24.5.321 reserved
24.5.322 Depositions (REPEALED)
24.5.323 Interrogatories (REPEALED)
24.5.324 Request for Production (REPEALED)
24.5.325 Limiting Discovery (REPEALED)
24.5.326 Failure to Make Discovery – Sanctions (REPEALED)
24.5.327 Default (REPEALED)
Rule 24.5.328 reserved
24.5.329 Summary Judgment (REPEALED)
24.5.330 Requests to Vacate, Put in Abeyance, or Reset Trial (REPEALED)
24.5.331 Subpoena (REPEALED)

24.5.332 Conduct of Trial (REPEALED)
24.5.333 Informal Disposition (REPEALED)
24.5.334 Settlement Conference or Mediation (REPEALED)
24.5.335 Bench Rulings (REPEALED)
24.5.336 Trial Briefs and Proposed Findings of Fact and Conclusions of Law (REPEALED)
24.5.337 Motion for Reconsideration (REPEALED)
Rules 24.5.338 and 24.5.339 reserved
24.5.340 Masters and Examiners – Procedure–Recommendations for Bench Orders (REPEALED)
Rule 24.5.341 reserved
24.5.342 Taxation of Costs (REPEALED)
24.5.343 Attorney Fees (REPEALED)
24.5.344 Petition for New Trial and/or Request for Amendment to Findings of Fact and Conclusions of Law (REPEALED)
24.5.345 Writ of Execution (REPEALED)
24.5.346 Stay of Judgment Pending Appeal (REPEALED)
Rule 24.5.347 reserved
24.5.348 Certification of Decisions, Appeals to Supreme Court (REPEALED)
24.5.349 Rules Compliance (REPEALED)
24.5.350 Appeals to Workers' Compensation Court Under Title 39, Chapters 71 and 72, MCA (REPEALED)
24.5.351 Declatory Rulings (REPEALED)
24.5.532 Reference to Montana Rules of Civil Procedure (REPEALED)
24.5.353 Withdrawal of Attorney (REPEALED)
Rules 24.5.354 through 24.5.358 reserved
24.5.359 Notice of Representation (REPEALED)
24.5.360 Review (REPEALED)

Chapter 5
Office of the Workers' Compensation Judge (REPEALED)

Subchapter 1
Organizational Rule

24.5.101 Organizational Rule (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, MCA; NEW, Eff. 7/1/75; ARM Pub. 6/30/79; AMD, Eff. 9/30/87; TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, Eff. 1/14/94; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, Eff. 3/31/02; AMD, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Subchapter 2 Reserved

Subchapter 3
Procedural Rules

24.5.301 Petition for Trial (REPEALED))

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, 39-71-2905, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.301, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2003 MAR p. 650, Eff. 4/11/03; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.302 Response to Petition (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.303 Service and Filing (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, 39-71-2903, 39-71-2905, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.303, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2002 MAR p. 93, Eff. 1/18/02; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.304 Alternative Pleading (REPEALED)

This rule has been repealed.

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; PREV. Rule #, ARM 2.52.204; TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89; REP, 1994 MAR p. 27, Eff. 1/14/94.

24.5.305 Nature of Rules (REPEALED)

This rule has been repealed.

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1990 MAR p. 847, Eff. 5/1/90; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.306 Brevity In Pleadings and Form of Paper Presented for Filing (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-2401, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2002 MAR p. 93, Eff. 1/18/02; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.307 Third-Party Practice (REPEALED)

This rule has been repealed.

History: NEW, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2002 MAR p. 93, Eff. 1/18/02; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26

24.5.307A Joinder and Service of Alleged Uninsured Employers (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-2401, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2002 MAR p. 93, Eff. 1/18/02; REP, 2014 MAR p. 2829, Eff. 3/1/15.

24.5.308 Joining Third Parties (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-2401, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.308, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.309 Intervention (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.309, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.310 Time and Place of Trial Generally (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; AMD, 1987 MAR p. 1618, Eff. 9/25/87; TRANS, from ARM 2.52.310, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2003 MAR p. 650, Eff. 4/11/03; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.311 Emergency Trials (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.311, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.312 Setting Time and Place of Trial by Stipulation or in Best Interests of the Court (REPEALED)

This rule has been repealed.

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; PREV. Rule #, ARM 2.52.210; TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89; REP, 2003 MAR p.650, Eff. 4/11/03.

24.5.313 Recusal (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1998 MAR p. 1281, Eff. 5/15/98; REP, 2014 MAR p. 2829, Eff. 3/1/15.

24.5.314 Adjudication of Interim Benefit Claims Under 39-71-610, MCA (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-610, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.315 Pretrial Identification of Witnesses and Exhibits (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.316 Motions (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.316, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 921, Eff. 5/1/92; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.317 Medical Records (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.317, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2001 MAR p. 153A, Eff. 3/1/01; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.318 Pretrial Conference, Pretrial Order, and Exhibits (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.318, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2003 MAR p. 650, Eff. 4/11/03; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.319 Amended Pleadings (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.320 Computation of Time (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26

Rule 24.5.321 reserved

24.5.322 Depositions (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.322, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.323 Interrogatories (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.323, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 921, Eff. 5/1/92; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.324 Request for Production (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.324, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.325 Limiting Discovery (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.326, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.327 Default (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.330 Requests To Vacate, Put In Abeyance, or Reset Trial (REPEALED).

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.330, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.331 Subpoena (REPEALED)

Every subpoena must comply with M. R. Civ. P. 45.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.331, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2002 MAR p. 93, Eff. 1/18/02; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.332 Conduct of Trial (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.332, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.333 Informal Disposition (REPEALED)

This rule has been repealed..

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; PREV. Rule #, ARM 2.52.219; TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.334 Settlement Conference or Mediation (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.334, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.335 Bench Rulings (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.335, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.336 Trial Briefs and Proposed Findings of Fact and Conclusions of Law (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.336, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.337 Motion for Reconsideration (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1998 MAR p. 2167, Eff. 8/14/98; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Rules 24.5.338 and 24.5.339 reserved

24.5.340 Masters and Examiners – Procedure–Recommendations for Bench Orders (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.340, 1989 MAR p. 2117, Eff. 12/22/89; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Rule 24.5.341 reserved

24.5.342 Taxation of Costs (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1985 MAR p. 107, Eff. 2/1/85; AMD, 1986 MAR p. 774, Eff. 5/16/86; TRANS, from ARM 2.52.343, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.344 Petition for New Trial and/or Request for Amendment to Findings of Fact and Conclusions of Law (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; AMD, 1985 MAR p. 107, Eff. 2/1/85; AMD, 1986 MAR p. 774, Eff. 5/16/86; TRANS, from ARM 2.52.344, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1994 MAR p. 27, Eff. 1/14/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.345 Writ of Execution (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1992 MAR p. 922, Eff. 5/1/92; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.346 Stay of Judgment Pending Appeal (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1994 MAR p. 675, Eff. 4/1/95; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Rule 24.5.347 reserved

24.5.348 Certification of Decisions, Appeals to Supreme Court (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, 39-71-2904, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; AMD, 1987 MAR p. 1618, Eff. 9/25/87; TRANS, from ARM 2.52.348, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1992 MAR p. 922, Eff. 5/1/92; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2014 MAR p. 2829, Eff. 3/1/15; AMD, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.349 Rules Compliance (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.349, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.350 Appeals to Workers' Compensation Court Under Title 39, Chapters 71 and 72, MCA (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.350, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1990 MAR p. 847, Eff. 5/1/90; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 1996 MAR p. 557, Eff. 2/23/96; AMD, 1998 MAR p. 1281, Eff. 5/15/98; AMD, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.351 Declatory Rulings (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; TRANS, from ARM 2.52.351, 1989 MAR p. 2177, Eff. 12/22/89; AMD, 1994 MAR p. 675, Eff. 4/1/94; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.352 Reference to Montana Rules of Civil Procedure (REPEALED)

This rule has been repealed.

History: 2-4-201, 39-71-2901, 39-71-2903, 39-71-2905, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2000 MAR p. 1513, Eff. 6/16/00; AMD, 2014 MAR p. 2829, Eff. 3/1/15; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

24.5.353 Withdrawal of Attorney (REPEALED)

This rule has been repealed.

History: 2-4-201, MCA; IMP, 2-4-201, 39-71-2901, MCA; NEW, 2018 MAR p. 305, Eff. 3/15/18; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Rules 24.5.354 through 24.5.358 reserved

24.5.359 Notice of Representation (REPEALED)

This rule has been repealed.

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83, TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89, REP, 1990 MAR p. 847, Eff. 5/1/90.

24.5.360 Review (REPEALED)

This rule has been repealed.

History: Sec. 2-4-201, MCA; IMP, Sec. 2-4-201, 39-71-2901, MCA; NEW, 1983 MAR p. 1715, Eff. 11/26/83; PREV. Rule #, ARM 2.52.231; TRANS, from Admin., 1989 MAR p. 2177, Eff. 12/22/89; REP, 2026 MAR, Notice No. 2025-473, Eff. 1/10/26.

Chapter 9
Contractor Registration

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39-9-407. Repealed.
39-9-408. Repealed.
39-9-409. Repealed.
39-9-410. Repealed.

Chapter 9
Contractor Registration

Part 1
General Provisions

Part Cross-References
Independent contractor certification, 39-71-417.

39-9-101. Purpose.

It is the purpose of this chapter to ensure that all construction contractors and home inspectors are competing fairly and in compliance with state laws.

History: En. Sec. 1, Ch. 500, L. 1995; amd. Sec. 1, Ch. 548, L. 1997; amd. Sec. 2, Ch. 294, L. 2019.

39-9-102. Definitions.

As used in this chapter, the following definitions apply:

(1) "Construction contractor" means a person, firm, or corporation that:
   (a) in the pursuit of an independent business, offers to undertake, undertakes, or submits a bid to construct, alter, repair, add to, subtract from, improve, move, wreck, or demolish for another a building, highway, road, railroad, excavation, or other structure, project, development, or improvement attached to real estate, including the installation of carpeting or other floor covering, the erection of scaffolding or other structures or works, or the installation or repair of roofing or siding; or
   (b) in order to do work similar to that described in subsection (1)(a) upon the construction contractor's property, employs members of more than one trade on a single job or under a single building permit, except as otherwise provided.

(2) "Department" means the Department of Labor and Industry.

(3) "Home inspection" means a physical examination of a residential dwelling to identify major defects in various attributes of or attachments to the dwelling, including mechanical, electrical, and plumbing systems in addition to structural and other essential components. Home inspections are performed for compensation and employ visual observation and the testing of user controls but not mathematical or specialized engineering sciences.
   (a) the term does not mean a physical examination of a residential dwelling when the owner or a representative of the owner requests the examination by an individual who is licensed, certified, or registered in this state and who is acting within the scope of practice of the individual's profession or occupation.

(4) "Home inspection report" means a written document prepared by a home inspector for a client and issued to the client in exchange for compensation after a home inspection has been completed. The report must clearly identify and describe:
   (a) the inspected systems, structures, and other relevant components of the dwelling;
   (b) any major visible defects in the inspected systems, structures, and other relevant components of the dwelling; and
   (c) any recommendations for further evaluation of the property by other appropriate persons.

(5) "Home inspector" means a person who performs a home inspection for compensation.

History: En. Sec. 2, Ch. 500, L. 1995; amd. Sec. 2, Ch. 548, L. 1997; amd. Sec. 3, Ch. 294, L. 2019.

39-9-103. Rulemaking authority.

The department may adopt rules to implement this chapter.

History: En. Sec. 25, Ch. 500, L. 1995.

Part 2
Registration

39-9-201. Registration required – application.

(1) Each construction contractor shall register with the department.
(2) An applicant for registration as a construction contractor shall submit an application on a form to be provided by the department that must include the following information:
  (a) the applicant's social security number;
  (b) proof of compliance with workers' compensation laws;
  (c) the I.R.S. employer identification number, if any; and
  (d) the name and address of:
    (i) each partner if the applicant is a firm or partnership;
    (ii) the owner if the applicant is an individual proprietorship;
    (iii) the corporate officers and registered agent if the applicant is a corporation; or
    (iv) the manager of a manager-managed limited liability company or the members of a member-managed limited liability company and the registered agent if the applicant is a limited liability company.

History: En. Sec. 3, Ch. 500, L. 1995; amd. Sec. 3, Ch. 548, L. 1997; amd. Sec. 1, Ch. 133, L. 2005.

39-9-202. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 4, Ch. 500, L. 1995.

39-9-203. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 5, Ch. 500, L. 1995.

39-9-204. Certificate of registration – issuance – duration.

(1) The department shall issue to the applicant a certificate of registration upon compliance with the registration requirements of this chapter.
(2) The department shall place the expiration date on the certificate. The certificate is valid for 2 years.

History: En. Sec. 6, Ch. 500, L. 1995; amd. Sec. 4, Ch. 548, L. 1997.

39-9-205. When partnership or joint venture considered registered.

A partnership or joint venture is considered registered under this chapter if one of the general partners or venturers whose name under which the partnership or venture does business is registered.

History: En. Sec. 7, Ch. 500, L. 1995.

39-9-206. Fees – education program.

(1) The department shall charge fees to construction contractors and home inspectors for:
   (a)issuance, renewal, and reinstatement of certificates of registration; and
   (b)change of name, address, or business structure.
(2) The department shall set the fees by administrative rule. The fees must cover the full cost of issuing certificates, filing papers and notices, and administering and enforcing this chapter. The costs include reproduction, travel, per diem, and administrative and legal support costs.
(3) The fees charged in subsection (1)(a) may not exceed:
   (a)for a construction contractor:
      (i) $70 for the initial registration certificate; or
      (ii) $70 for the renewal or reinstatement of a registration certificate; or
   (b)for a home inspector, an amount determined in rule for the initial registration certificate or for the renewal or reinstatement of a registration certificate.
(4) The fees collected under this section must be deposited in a state special revenue account to the credit of the department for the administration and enforcement of this chapter and independent contractor certification provided for in Title 39, chapter 71, part 4.
(5) The department shall establish, cooperatively with representatives of the building industry and the home inspection industry, an industry and consumer information program, funded with 15% of the fees, to educate the building industry and home inspectors about the registration requirements and to educate the public regarding the hiring of building construction contractors and home inspectors.
(6) The fee for a joint application for a certificate of registration and an independent contractor exemption certificate may not exceed the total fee charged for a certificate of registration and an independent contractor exemption certificate that are obtained separately. The fee paid for the independent contractor exemption certificate may be used by the department to offset the cost of administering independent contractor certification provided for in Title 39, chapter 71, part 4.

History: En. Sec. 8, Ch. 500, L. 1995; amd. Sec. 5, Ch. 548, L. 1997; amd. Sec. 2, Ch. 133, L. 2005; amd. Sec. 4, Ch. 294, L. 2019.

39-9-207. Registration – limiting liability.

A person who, pursuant to an oral or written contract, engages a construction contractor or a home inspector who is registered under this chapter on the date of the contract is not liable as an employer for workers' compensation coverage under 39-71-405, for unemployment insurance coverage, or for wages and fringe benefits for:
(1) The registered construction contractor or home inspector;
(2) The employees of the registered construction contractor or home inspector; or
(3) Any subsequent subcontractor or the employees of any subsequent subcontractor engaged to fulfill a part of or all of the obligations of the oral or written contract of the registered construction contractor or home inspector listed in subsection (1).

History: En. Sec. 9, Ch. 500, L. 1995; amd. Sec. 6, Ch. 548, L. 1997; amd. Sec. 5, Ch. 294, L. 2019.

39-9-208. through 39-9-210 reserved.

39-9-211. Exemptions.

As related to construction contractors, this chapter does not apply:

(1) To an authorized representative of the United States government, the state of Montana, or any incorporated municipality, county, alternative form of local government, irrigation district, reclamation district, or other municipal or political corporation or subdivision of this state;

(2) To an officer of a court acting within the scope of office;

(3) To a public utility operating under the regulations of the public service commission or to a rural cooperative utility operating under Title 35, chapter 18, in construction, maintenance, or development work incidental to its own business;

(4) To the repair or operation incidental to the discovery or production of oil or gas or incidental to the drilling, testing, abandoning, or other operation of an oil or gas well or a surface or underground mine or mineral deposit;

(5) To the sale or installation of finished products, materials, or articles of merchandise that are not actually fabricated into and do not become a permanent fixed part of a structure;

(6) To the construction, alteration, improvement, or repair carried on within the limits and boundaries of a site or reservation under the exclusive legal jurisdiction of the federal government;

(7) To a person who only furnished materials, supplies, or equipment without fabricating them into or consuming them in the performance of the work of the construction contractor;

(8) To work or operation on one undertaking or project considered of a casual, minor, or inconsequential nature, by one or more contracts, the aggregate contract price of which, for labor and materials and all other items, is less than $2,500 a job. The exemption prescribed in this subsection does not apply when the work or construction is only a part of a larger or major operation, whether undertaken by the same or a different construction contractor, or in which a division of the operation is made into contracts of amounts of less than $2,500 a job for the purpose of evasion of this chapter or otherwise.

(9) To a farmer or rancher while engaged in a farming, dairying, agriculture, viticulture, horticulture, or stock or poultry operation;

(10) To an irrigation district or reclamation district;

(11) To an operation related to clearing or other work upon land in rural districts for fire prevention purposes;

(12) To an owner who contracts for work to be performed by a registered construction contractor, but this exemption does not apply to an owner who is otherwise covered by this chapter who constructs a residence on the owner's property with the intention and for the purpose of promptly selling the improved property;

(13) To an owner working on the owner's property, whether occupied by the owner or not, but this exemption does not apply to an owner who is otherwise covered by this chapter who constructs an improvement on the owner's property with the intention and for the purpose of promptly selling the improved property, unless the owner has continuously occupied the property as the owner's primary residence for at least the last 12 months;

(14) To owners of commercial properties who use their own employees to do maintenance, repair, and alteration work in or upon their own properties;

(15) To an architect, civil or professional engineer, or professional land surveyor, licensed in Montana and acting solely in a professional capacity;

(16) To an electrician or plumber, licensed in Montana, operating within the scope of the license;

(17) To a contract security company, licensed under Title 37, chapter 60, operating within the scope of the license;

(18) To a person who engages in the activities regulated as an employee of a registered construction contractor with wages as the sole compensation or as an employee with wages as the sole compensation;
(19) To a person or entity licensed under Title 50, chapter 39, to sell, install, or service fire suppression or fire protection equipment;
(20) To a water well contractor licensed under Title 37, chapter 43, performing the work of a water well contractor;
(21) To an enrolled tribal member or an association, business, corporation, or other entity, at least 51% of which is owned by an enrolled tribal member or members and whose business is conducted solely within the exterior boundaries of an Indian reservation;
(22) To a contractor engaged in the logging industry who builds forest access roads for the purpose of harvesting and transporting logs from forest to mill;
(23) To a person working on the person's own residence, if the residence is owned by a person other than the resident; or
(24) To an independent contractor who has no employees. However, an independent contractor may voluntarily elect to register under this chapter.

History: En. Sec. 10, Ch. 500, L. 1995; amd. Sec. 7, Ch. 548, L. 1997; amd. Sec. 6, Ch. 294, L. 2019.

39-9-212. Home inspector registration – penalty - rulemaking.

(1) A home inspector, whether as an individual or a partnership, corporation, or manager-managed or member-managed limited liability company, shall register with the department on forms provided by the department and pay a registration fee for each home inspector covered by the registration. The registration fee must be set by the department by rule as provided in 39-9-206.
(2) For a first-time registration, a home inspector shall document that each person working under the registration certificate as a home inspector:
  (a) has successfully completed a minimum of 40 hours of comprehensive home inspection instruction approved by the department or a passing grade on the national home inspector examination offered by the examination board of professional home inspectors or another national examination as provided by the department by rule;
  (b) is a member of a national home inspection association; and
  (c) is covered by liability insurance, a minimum of $100,000 coverage in errors and omissions insurance, and either workers' compensation coverage or, if the home inspector is self-employed with no other employees and does not have workers' compensation coverage, an independent contractor's exemption certificate.
(3) A home inspector renewing a registration shall provide documentation that each home inspector covered by the registration:
  (a) has completed 40 hours of continuing education over the prior 2 years;
  (b) is a member in a national home inspection association; and
  (c) is covered by liability insurance, a minimum of $100,000 in errors and omissions insurance, and either workers' compensation coverage or an independent contractor's exemption certificate if the home inspector is self-employed with no other employees.
(4) Failure to register and pay a registration fee may result in:
  (a) a fine as determined by the department by rule; and
  (b) removal of the home inspector's registration on the department's website used to list registered home inspectors. Upon payment of the registration fee, the department shall reinstate the listing and charge a fee for reinstatement as provided in 39-9-206.

(5) A fee or fine collected under this section must be deposited in a state special revenue account to the credit of the department for administration and enforcement of this chapter.
   (a)a penalty under this section does not apply to a violation that is determined to be an inadvertent error.
(6) The department may adopt rules to implement this section.

History: En. Sec. 1, Ch. 294, L. 2019.

39-9-213. Requirement - prohibitions.

(1) A home inspector shall issue a home inspection report to a client after completing a home inspection unless the client agrees in writing to release the home inspector from this obligation.
(2) A home inspector may not:
   (a)disclose information concerning the results of a home inspection without the written approval of the home inspector's client or the client's representative;
   (b)accept compensation from more than one party with a financial interest in the residential dwelling without written approval from all parties with a financial interest in the residential dwelling;
   (c)accept a commission or allowance, directly or indirectly, from another person or business entity associated with the client in connection with work for which the home inspector is responsible to the client;
   (d)refuse or otherwise fail to disclose promptly to a client information about any business interest or relationship of the home inspector that may affect the client in connection with a home inspection.

History: En. Sec. 4, Ch. 276, L. 1999; Sec. 30-14-1004, MCA 2017; redes. 39-9-213 by Sec. 11, Ch. 294, L. 2019.

Part 3
Business Practices

39-9-301. Business practices – penalty.

(1) Except as provided in 39-9-205, a person who has registered under one name as provided in this chapter may not engage in the business or act in the capacity of a construction contractor or a home inspector under any other name unless that name also is registered under this chapter.
(2) Use of a falsified registration number in connection with a solicitation or identification as a construction contractor or a home inspector is prohibited.
(3) A partner, associate, agent, salesperson, solicitor, officer, or employee of a construction contractor or a home inspector shall use a true name and address at all times while engaged in the business or capacity of a construction contractor or a home inspector or in activities related to a construction contractor or a home inspector.
(4) A construction contractor may not:
   (a)hire a person as an independent contractor who does not have an independent contractor exemption certificate if required by 39-71-417;
   (b)hire a person as an independent contractor if the department has suspended, revoked, or denied the person's independent contractor's exemption certificate;
   (c)hire an independent contractor to work in a trade, business, occupation, or profession not listed on the independent contractor's registration;
   (d)allow an independent contractor to perform work not in the trade, business, occupation, or profession listed on the independent contractor exemption certificate; or

(e) classify an employee as an independent contractor if the person does not have an independent contractor exemption certificate required by 39-71-417.

(5) (a) The finding of a violation of this section by the department at a hearing held in accordance with the Montana Administrative Procedure Act subjects the person who commits the violation to a penalty of not more than $5,000, as determined by the department. The required hearing may be held by telephone or by videoconference. A penalty collected under this section must be deposited in the state special revenue account to the credit of the department for administration and enforcement of this chapter.

(b) penalties under this section do not apply to a violation that is determined to be an inadvertent error.

History: En. Sec. 11, Ch. 500, L. 1995; amd. Sec. 8, Ch. 548, L. 1997; amd. Sec. 7, Ch. 294, L. 2019; amd. Sec. 1, Ch. 505, L. 2023.

39-9-302. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 12, Ch. 500, L. 1995.

39-9-303. Department to compile and update registration lists – availability – fee.

(1) The department shall compile a list of all construction contractors and home inspectors registered under this chapter and update the list of construction contractors at least bimonthly and the list of home inspectors as provided by rule. The list is public information and must be available to the public upon request for a reasonable fee or posted on the department's website.

(2) The department shall inform a person, firm, or corporation whether a construction contractor or a home inspector is registered. The department shall provide the information without charge, except for a reasonable fee for any copies made.

History: En. Sec. 13, Ch. 500, L. 1995; amd. Sec. 9, Ch. 548, L. 1997; amd. Sec. 8, Ch. 294, L. 2019.

39-9-304. Provisions exclusive – certain local authority not limited or abridged.

The provisions of this chapter relating to the registration or licensing of a person, firm, or corporation, including the requirement of a bond with the state of Montana named as obligee and the collection of a fee, are exclusive for registered construction contractors. A political subdivision of the state may not require or issue any registrations, licenses, or bonds for the same or a similar purpose. However, this section does not limit or abridge the authority of a local government to levy and collect a general and nondiscriminatory license fee levied upon all businesses. This section does not limit the authority of a local government with respect to contractors not required to be registered under this chapter.

History: En. Sec. 14, Ch. 500, L. 1995; amd. Sec. 9, Ch. 294, L. 2019.

Part 4
Infractions – Penalties

39-9-401. Violation – infraction – penalty – disposition.

(1) It is a violation of this chapter and an infraction for any construction contractor to:
   (a) perform work as a construction contractor without being registered as required by this chapter;
   (b) perform work as a construction contractor when the construction contractor's registration is suspended; or
   (c) transfer a valid registration to an unregistered construction contractor or allow an unregistered construction contractor to work under a registration issued to another construction contractor.

(2) A determination by the department of a violation of this section subjects the person who commits the violation to a penalty of up to $500, as determined by the department. A person who has been determined to have violated this section may request that a hearing be held in accordance with the Montana Administrative Procedure Act. The hearing may be held by telephone or videoconference. An appeal of the hearing decision must be made in the same manner as prescribed in 39-51-2403.
   (a) a penalty under this section does not apply to a violation that is determined to be an inadvertent error.
   (b) a penalty collected under this section must be deposited in the uninsured employers' fund established in 39-71-503.
   (c) a penalty collected under this section must be deposited in the uninsured employers' fund established in 39-71-503.

History: En. Sec. 15, Ch. 500, L. 1995; amd. Sec. 10, Ch. 548, L. 1997; amd. Sec. 1, Ch. 377, L. 1999; amd. Sec. 6, Ch. 442, L. 1999.

39-9-402. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 16, Ch. 500, L. 1995.

39-9-403. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 5, Ch. 417, L. 1971; R.C.M. 1947, 41-2305; amd. Sec. 8, Ch. 90, L. 1995.

39-9-404. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 18, Ch. 500, L. 1995.

39-9-405. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 19, Ch. 500, L. 1995.

39-9-406. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 20, Ch. 500, L. 1995.

39-9-407. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 21, Ch. 500, L. 1995.

39-9-408. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 22, Ch. 500, L. 1995.

39-9-409. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 23, Ch. 500, L. 1995.

39-9-410. Repealed.

Sec. 14, Ch. 548, L. 1997.

History: En. Sec. 24, Ch. 500, L. 1995.

Chapter 33
Construction Contractors and Home Inspection

Subchapter 1
Registration of Construction Contractors

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Chapter 33
Contractor Contractors and Home Inspections

Subchapter 1
Registration of Construction Contractors

24.33.101 Contractor Registration Application Requirements (REPEALED)

This rule has been repealed.

History: 39-9-103, MCA; IMP, 39-9-102, 39-9-201, MCA; NEW, 2012 MAR p. 994, Eff. 5/11/12; REP, 2018 MAR p. 720, Eff. 4/14/18.

Rules 24.33.102 through 24.33.110 reserved

24.33.111 Additional Application Information (REPEALED)

This rule has been repealed.

History: 39-9-103, MCA; IMP, 39-9-201, MCA; NEW, 2012 MAR p. 994, Eff. 5/11/12; REP, 2024 MAR p. 1072, Eff. 5/11/24.

Rules 24.33.112 through 24.33.120 reserved

24.33.121 Construction Contractor Applications and Fees

(1) The fee for the issuance, renewal, or reinstatement of a construction contractor certificate of registration is $70. The fee is not refundable. If a business changes, adds, or removes an FEIN, a new application and $70 application fee must be submitted.
(2) An incomplete application will be deemed denied after 30 days. An applicant may submit required, missing information for consideration of the application within 180 days of initial application. After that time, the applicant must pay another application fee.
(3) The department may verify any application information, or other requirements of registration, as it deems necessary.

History: 39-9-103, MCA; IMP, 39-9-206, MCA; NEW, 1995 MAR p. 2146, Eff. 10/13/95; AMD, 1998 MAR p. 2877, Eff. 11/1/98; AMD, 2005 MAR p. 967, Eff. 6/17/05; AMD, 2012 MAR p. 994, Eff. 5/11/12; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 1072, Eff. 5/11/24.

Rules 24.33.122 through 24.33.130 reserved

24.33.131 Evidence of Compliance With Laws (REPEALED)

This rule has been repealed.

History: NEW, 1995 MAR p. 2146, Eff. 10/13/95; AMD, 1998 MAR p. 2877, Eff. 11/1/98; AMD, 2012 MAR p. 994, Eff. 5/11/12; AMD, 2018 MAR p. 720, Eff. 4/14/18; REP, 2024 MAR p. 1072, Eff. 5/11/24.

Rules 24.33.132 through 24.33.134 reserved

24.33.135 Suspension of construction contractor registration

(1) A contractor registration may be suspended in circumstances which the department deems necessary. These circumstances include, without limitation, the following:
(a)false statements regarding any aspect of the construction contractor registration application;

(b) suspension is required by law, for example, based on non-payment of child support pursuant to Title 40, chapter 5, part 7, MCA;
(c) failure to comply with any law or rule pertaining to construction contractors, including compliance with the Workers' Compensation Act.

History: 39-9-103, MCA; IMP, 39-9-204, 39-9-301, 39-9-401, MCA; NEW, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 1072, Eff. 5/11/24.

Rules 24.33.136 through 24.33.140 reserved

24.33.141 Acceptable Forms of Security (REPEALED)

This rule has been repealed.

History: 39-3-702 and 39-9-103, MCA; IMP, 39-3-703 and 39-9-203, MCA; NEW, 1995 MAR p. 2146, Eff. 10/13/95; REP, 1998 MAR p. 2877, Eff. 11/1/98.

24.33.142 Reporting Certificate Changes

(1) Certificate holders must report all changes to a certificate in writing to the department within ten days of the change. Such reportable changes include, but are not limited to:
(a) address;
(b) name;
(c) change in status of certificate as stated pursuant to ARM 24.33.151(1);
(d) phone number;
(e) change to ownership;
(f) workers' compensation insurance carrier change or cancellation;
(g) business name; or
(h) any change in business officers, members, or partners which has been or must be reported in filings with the Secretary of State.
(2) If a change is not reported to the department within ten days, the certificate may be suspended.

History: 39-9-103, MCA; IMP, 39-9-201, 39-9-206, 39-9-301, 39-9-303, MCA; NEW, 2012 MAR p. 1148, Eff. 5/11/12; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 1072, Eff. 5/11/24.

Rules 24.33.143 through 24.33.150 reserved

24.33.151 Certificates of Registration

(1) Issued certificates will display one of the following statuses:
(a) "BID ONLY" means the contractor is registered only to bid construction work in Montana and cannot perform actual work until the contractor upgrades the certificate to one of the following statuses.
(b) "EMPLOYER" means the contractor carries workers' compensation coverage on employees and is registered to have employees.
(c) "LEASED EMPLOYEES ONLY" means the contractor uses employees of a professional employer organization, as defined at 39-8-102, MCA.
(d) "NO EMPLOYEES, MAY HIRE EXEMPT WORKERS ONLY" means the contractor does not carry workers' compensation coverage on any employees.
(2) Along with a certificate, each certificate holder will receive a construction contractor registration wallet card.

History: 39-9-103, MCA; IMP, 39-9-204, MCA; NEW, 2012 MAR p. 994, Eff. 5/11/12; AMD, 2018 MAR p. 720, Eff. 4/14/18; AMD, 2024 MAR p. 1072, Eff. 5/11/24.

Subchapter 4
Registration of Home Inspectors

24.33.401 Definitions

As used in this subchapter, the following definitions apply:
(1) "Day" means a calendar day.
(2) "Expiration of registration" means the registration was not timely renewed and is no longer active due to the passage of time.
(3) "Home inspection worker" means an individual who has demonstrated to the department that the individual is qualified to perform home inspection work.
(4) "Initial application" means the first time a home inspection business applies to the department for registration as a home inspector.
(5) "Registration" means the status held by a home inspection business after the home inspection business has successfully registered with the department.
(6) "Reinstatement of registration" means reactivation of a non-expired registration, following suspension of the registration by the department.
(7) "Renewal application" means an application by a registered home inspector to be registered for an additional two-year period after the home inspector has been properly registered via an initial application.
(8) "Roster" means the list of home inspection workers who have been identified by the home inspection business as employees. The roster may include an individual who is separately registered in their individual capacity as a home inspection business as provided by ARM 24.33.421, but who is authorized to work under the registration name and number of the registrant.
(9) "Suspension of registration" means the registration is no longer active as the result of an action taken by the department in response to conduct of the registrant.

History: 39-9-102, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.402 through 24.33.405 reserved

24.33.406 Fee Schedule

(1) The following fees are charged by the department for home inspection businesses:
(a)initial application $80.00
(b)renewal application 80.00
(c)reinstatement of suspended registration 40.00
(d)change of address no charge
(e)change of home inspection worker roster no charge
(2) All fees are nonrefundable.

History: 39-9-103, MCA; IMP, 39-9-206, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.407 through 24.33.410 reserved

24.33.411 Initial and Renewal Application for Home Inspection Registration

(1) In order to be registered by the department, a home inspection business shall complete a registration application and pay the registration fee as provided in ARM 24.33.406.
(2) An incomplete application will be deemed denied after 30 days. Within six months of the deemed denial, an applicant may submit the required information for consideration of the application. After six months, the applicant must reapply.
(3) Before a registration expires, a home inspection business may renew its registration by applying to the department and paying the required fee.
(4) Application contents are public record open to inspection, except for personally identifiable information protected from public disclosure.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.412 through 24.33.415 reserved

24.33.416 Approval of Applications

(1) An application may be made in person during regular business hours at the department's offices, submitted by mail, or electronically as specified by the department.
(2) The registration period is two years and expires on the two-year anniversary of the initial registration.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.417 through 24.33.420 reserved

24.33.421 Registration Required for Subcontractors and Independent Contractors

(1) A home inspection worker who engages in subcontracting with a home inspection business of another shall individually register as a home inspection business.
(2) A home inspection worker who is engaged as an employee of a registered home inspection business must be listed on the employer's roster and does not need to separately register as a home inspection business, if the home inspection worker never:
(a)subcontracts with a registered home inspection business owned by another; or
(b)independently offers her or his services to members of the public

History: 39-9-103, 39-9-212, 39-71-203, MCA; IMP, 39-9-212, 39-71-417, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.422 through 24.33.430 reserved

24.33.431 Home Inspector Examinations and Comprehensive Education Courses

(1) Any organization wishing to be approved by the department for the purposes of offering an examination under for registration must apply to the department for approval of its examination. The organization must demonstrate that its examination is psychometrically valid, and covers at least the following topics:

(a)roofing;
(b)exterior;
(c)interior;
(d)structural;
(e)electrical;
(f) plumbing;
(g)heating and cooling (HVAC);
(h)insulation;
(i) fireplace and chimney; and
(j) ethical business practices, professional standards, and reports.

(2) Any organization wishing to be approved by the department for the purposes of offering a comprehensive home inspection instruction for home inspectors consisting of at least 40 hours of instruction must apply to the department for recognition. The organization must demonstrate that its educational program is comprehensive and covers at least the topics required for examination in (1).

(3) Any organization wishing to be approved by the department for the purposes of offering a comprehensive home inspection instruction for home inspectors must also demonstrate that it conducts a valid assessment of students' knowledge and understanding of the subject matter being taught in order to demonstrate successful completion. The organization shall describe in detail how the assessment is made, and the criteria by which a student is deemed to have successfully completed the educational program.

(4) A list of organizations approved by the department to offer home inspector examinations is available by contacting the department's home inspection program, and can also be found at the department's web site.

(5) A list of formal home inspection educational programs approved by the department is available by contacting the department's home inspection program, and can also be found at the department's web site.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.432 through 24.33.440 reserved

24.33.441 Duty to Update Roster and Business Information - Suspension - Reinstatement of Registration

(1) A home inspection business shall provide to the department in writing, within ten days of the occurrence, changes to:
(a)the roster of home inspectors performing work for the home inspection business; and
(b)the business name, address, contact information, or type of business structure.

(2) A home inspection business that does not timely provide information to the department as required by (1) is subject to having its registration suspended.

(3) A home inspection business may reinstate a suspended registration by providing the department with any updated information as required by (1) and paying the reinstatement fee provided in ARM 24.33.406.

(4) As provided by 39-9-212, MCA, a home inspection business may not operate without being properly registered. Operating a home inspection business without proper registration may result in the imposition of a civil penalty as provided by ARM 24.33.471.
(a)the imposition of a civil penalty does not preclude the department from seeking injunctive relief.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.442 through 24.33.444 reserved

24.33.445 Renewal of Business Registration (REPEALED)

This rule has been repealed.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; REP, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.446 through 24.33.460 reserved

24.33.461 Recognition of Continuing Educations Courses

(1) Any sponsoring organization that requests continuing education credits be approved by the department for training must complete and submit a request on a form provided by the department.
(2) The department shall review the course submission and determine the number of credit hours to be awarded for completion of the course. Course topics must be germane to the skills needed for competency as a home inspection worker.
(3) An hour of credit is available for each 50 minutes of continuing education instruction.
(4) 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.
(5) Continuing education programs offered or recognized by the following associations are deemed to be accepted by the department:
    (a) American Society of Home Inspectors (ASHI);
    (b) International Association of Certified Home Inspectors (InterNACHI); and
    (c) department-approved comprehensive courses.
(6) The department will accept continuing education courses offered by any other content provider, where the course has been recognized or accepted by two or more states that require continuing education for home inspectors as a condition of renewal of authority to engage in home inspection in that state.
(7) A list of recognized continuing education sponsors and courses is available on the department's home inspector web page.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-212, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.462 through 24.33.470 reserved

24.33.471 Penalties - Civil Fines - Injunctive Relief

(1) The following schedule of penalties (civil fines) applies to the home inspector program:
   (a)failure to register:
      (i) first offense $ 250
      (ii) second offense 500
      (iii)third offense and subsequent offenses 1,000
   (b)use of a false name or a false identity:
      (i) first offense 1,000
      (ii) second offense 2,500
      (iii)third offense and subsequent offenses 5,000
(2) In the event of an inadvertent failure to register, or a de minimus violation to timely update information, the department may, in its sole discretion, reduce or waive a penalty.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-206, 39-9-212, 39-9-301, 39-9-401, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.472 through 24.33.474 reserved

24.33.475 Dispute Resolution Process

(1) A person receiving an adverse decision may request a hearing within 15 days from when the adverse decision is sent. This request does not prohibit efforts at conciliation or mediation.
(2) The hearing will be conducted as a contested case per Title 2, chapter 4, part 6, MCA.
(3) Because home inspector registration is not a licensing matter, the hearing may be conducted either formally or informally, at the election of the person requesting the hearing.

History: 39-9-103, 39-9-212, MCA; IMP, 2-4-603, 39-9-212, 39-9-401, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19 ; AMD, 2022 MAR p. 152, Eff. 1/29/22; AMD, 2024 MAR p. 1192, Eff. 5/25/24.

Rules 24.33.476 through 24.33.485 reserved

24.33.486 Education and Outreach Program (REPEALED)

This rule has been repealed.

History: 39-9-103, 39-9-212, MCA; IMP, 39-9-206, MCA; NEW, 2019 MAR p. 2121, Eff. 11/23/19; REP, 2024 MAR p. 1192, Eff. 5/25/24.

TAB 6

Title 39
Labor

Chapter 8
Professional Employer Organizations and Groups Licensing

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Title 39
Labor

Chapter 8
Professional Employer Organizations and Groups Licensing

Part 1
General Provisions

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39-8-101. Short title - purpose.

(1) This chapter may be cited as the "Montana Professional Employer Organizations and Groups Licensing Act".
(2) The legislature recognizes that there is a public need for professional employer services and finds it necessary in the interest of public health, safety, and welfare to establish standards for the operation, regulation, and licensing of professional employer organizations and groups in this state.

History: En. Sec. 1, Ch. 344, L. 1995.

39-8-102. Definitions.

As used in this chapter, unless the context indicates otherwise, the following definitions apply:
(1) "Applicant" means a person that seeks to be licensed under this chapter.
(2) "Client" means a person that obtains all or part of the person's workforce from another person through a professional employer arrangement.
(3) "Controlling person" means an individual who possesses the right to direct the management or policies of a professional employer organization or group through ownership of voting securities, by contract or otherwise.
(4) "Department" means the department of labor and industry.
(5) "Employee leasing arrangement" means an arrangement by contract or otherwise under which a professional employer organization hires its own employees and assigns the employees to work for another person to staff and manage, or to assist in staffing and managing, a facility, function, project, or enterprise on an ongoing basis.
(6) "Financial statements" means accounting information, consisting of balance sheets and income statements, that identifies the financial position of applicants or licensees through their operations.
(7) "Licensee" means a person licensed as a professional employer organization or group under this chapter.
(8) "Person" means an individual, association, company, firm, partnership, corporation, or limited liability company.
(9) (a) "Professional employer arrangement" means an arrangement by contract or otherwise under which:
    (i) a professional employer organization or group assigns employees to perform services for a client;
    (ii) the arrangement is or is intended to be ongoing rather than temporary in nature; and
    (iii) the employer responsibilities are shared by the professional employer organization or group and the client.

(b)the term does not include:

(i) services performed by a temporary service contractor;

(ii) arrangements under which a person shares employees with a commonly owned company within the meaning of section 414(b) and (c) of the Internal Revenue Code of 1986, as amended, if:

(A) that person's principal business activity is not entering into professional employer arrangements; and

(B) that person does not represent to the public that the person is a professional employer organization or group;

(iii) arrangements existing for employment of an independent contractor working under an independent contractor exemption certificate provided for in 39-71-417; and

(iv) arrangements by a health care facility, as defined in 50-5-101, to provide its own employees to perform services at and on behalf of another health care facility or at and on behalf of a private office of physicians, dentists, or other physical or mental health care workers licensed and regulated under Title 37.

(10) "Professional employer group" or "group" means at least two but not more than five professional employer organizations, each of which is majority-owned by the same person.

(11) (a) "Professional employer organization" means:

(i) a person that provides services of employees pursuant to one or more professional employer arrangements or to one or more employee leasing arrangements; or

(ii) a person that represents to the public that the person provides services pursuant to a professional employer arrangement.

(b)the term does not include a health care facility, as defined in 50-5-101, that provides its own employees to perform services at and on behalf of another health care facility or at and on behalf of a private office of physicians, dentists, or other physical or mental health care workers licensed and regulated under Title 37.

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

History: En. Sec. 2, Ch. 344, L. 1995; amd. Sec. 1, Ch. 149, L. 2003; amd. Sec. 1, Ch. 260, L. 2005; amd. Sec. 4, Ch. 448, L. 2005.

Part 2
Licensing

39-8-201. License required – exemption – rulemaking authority.

(1) On or after July 1, 1995, a person who acts as a professional employer organization or group by entering into a professional employer arrangement or an employee leasing arrangement with a client in this state without a license or who violates the provisions of this chapter may be subject to the penalties provided in 39-8-302.
(2) The provisions of this chapter do not apply to a labor organization, the state or its political subdivisions, the United States, or any programs or agencies of those entities.
(3) A license issued under this chapter remains the property of the department and may not be transferred.
(4) The department may adopt rules to implement the provisions of this chapter.

History: En. Sec. 3, Ch. 344, L. 1995.

39-8-202. Initial license application – application fee – standards – provisional license.

(1) An applicant for initial licensure as a professional employer organization or group shall file with the department a completed application on a form provided by the department.
(2) The application must be accompanied by a nonrefundable application fee and any material or information required by the department that demonstrates compliance with the requirements of this chapter. The application fee is:
   (a) $750 for a resident or nonresident unrestricted license; and
   (b) $500 for a restricted license.
(3) As a condition of licensure under this chapter, an applicant who is not a resident or who is domiciled outside the state must first be licensed as a professional employer organization or group in the state in which the applicant is a resident or is domiciled if licensing is required by that state.
(4) An applicant for licensure as a professional employer organization or group must meet one of the following applicable standards:
   (a) an individual must be 18 years of age or older.
   (b) a partnership or a limited partnership shall provide the names and home addresses of all partners, indicate whether each partner is a general or a limited partner, and include a copy of the partnership agreement or an affidavit signed by all partners acknowledging that a written partnership agreement does not exist.
   (c) a corporation shall state the names and home addresses of all officers, directors, and shareholders who own a 5% or greater interest in the corporation. A domestic or foreign corporation must have filed any required documents with the secretary of state and shall remain in good standing to conduct business pursuant to this chapter.
   (d) a limited liability company shall state the names and home addresses of those individuals who own a 5% or greater interest in the limited liability company. A domestic or foreign limited liability company must have filed any required documents with the secretary of state and shall remain in good standing to conduct business pursuant to this chapter.
   (e) a group:
      (i) must be authorized to act on behalf of the group;
      (ii) shall include for each professional employer organization within the group the information required in subsection (4); and

(iii) shall guarantee, on a form provided by the department and executed by each professional employer organization within the group, payment of all financial obligations with respect to wages, payroll-related taxes, insurance premiums, and employee benefits of each other member within the group.

(5) (a) An applicant shall also provide:

(i) the trade name or names under which the applicant conducts business, the business's taxpayer or employer identification number, the address of the business's principal place of business in the state, and the addresses of any other offices within the state through which the applicant intends to conduct business as a professional employer organization or group. If the applicant's principal place of business is located in another state, the address must be provided.

(ii) a list by jurisdiction of each name under which the applicant has operated in the preceding 5 years, including any alternative names, names of predecessors, and names of related business entities with common majority ownership, and detailed information on the background of each controlling person to the extent required by the department; and

(iii) other information requested by the department to show that the applicant and each controlling person are of good moral character, have business integrity, and are financially responsible. "Good moral character" means a personal history of honesty, trustworthiness, and fairness; a good reputation for fair dealings; and respect for the rights of others and for the laws of this state and nation.

(b)(i) as a prerequisite to the issuance of a license, the department shall require the applicant and any controlling person to submit fingerprints for the purpose of fingerprint checks by the Montana department of justice and the federal bureau of investigation.

(ii) the applicant and any controlling person shall sign a release of information to the department and are responsible to the department of justice for the payment of all fees associated with the criminal background check.

(iii) upon completion of the criminal background check, the department of justice shall forward all criminal justice information, as defined in 44-5-103, concerning the applicant or any controlling person that involves the conviction of a criminal offense in any jurisdiction to the department, as authorized in 44-5-303.

(iv) at the conclusion of any background check required by this section, the department must receive the criminal background check report but may not receive the fingerprint card of the applicant or of any controlling person. Upon receipt of the criminal background check report, the department of justice shall promptly destroy the fingerprint card of the applicant and of any controlling person.

(c) if an applicant or any controlling person has a history of criminal convictions, then pursuant to 37-1-203, the applicant or controlling person has the opportunity to demonstrate to the department that the applicant or controlling person is sufficiently rehabilitated to warrant the public trust, and if the department determines that the applicant or controlling person is not, the license may be denied.

(6) (a) except for an applicant who is granted a restricted license under subsection (9), an applicant shall maintain a tangible accounting net worth of not less than $50,000, evidenced by:

(i) providing financial statements that have been independently audited by a certified public accountant in accordance with generally accepted accounting principles; or

(ii) providing independently compiled financial statements and a $100,000 security deposit in a form that is acceptable to the department.

(b) if, after licensure, an applicant defaults in paying wages or payroll-related taxes or in meeting any liability arising pursuant to Title 39, chapter 71, or this chapter, the security deposit may be used to meet those obligations. The security deposit may not be used in determining the net worth of an applicant.

(c) (i) documents submitted to establish net worth must reflect net worth as of a date not more than 6 months prior to the date on which the application is submitted.

(ii) financial statements submitted must be attested by the president, chief financial officer, and at least one controlling person of the professional employer organization or group.

(iii) if an applicant is unable to meet the $50,000 net worth requirement, the applicant shall provide to the department a surety bond, a letter of credit, or marketable securities acceptable to the department in an amount of not less than $50,000 to cover the deficiency. If, after licensure, an applicant defaults in paying wages or payroll-related taxes or in meeting any liability arising pursuant to Title 39, chapter 71, or this chapter, the surety bond, letter of credit, or marketable securities provided to the department may be used to meet those obligations.

(7) The applicant shall maintain a positive working capital, as evidenced by financial statements.

(8) The department may provide by rule for the acceptance, in lieu of the requirements of subsections (6) and (7), of an affidavit provided by a bonded, independent, and qualified assurance organization that has been approved by the department certifying the qualifications of a professional employer organization or group seeking licensure under this chapter.

(9) The department may issue a restricted license for limited operation within this state to a professional employer organization or group that is a resident of or domiciled in another state if:

(a) the applicant's state of residence or domicile provides for licensing of professional employer organizations or groups and the applicant is licensed and in good standing in that state and that state grants a similar privilege for restricted licensing to professional employer organizations or groups that are residents of or domiciled in this state and that are licensed under this chapter;

(b) the applicant does not maintain an office, a sales force, or a sales representative in this state and does not solicit clients who are residents of or domiciled in this state; and

(c) the applicant does not have more than 100 leased employees working in this state.

(10) An applicant for a license shall appoint a recognized and approved entity as its registered agent to receive service of legal process issued against it in this state if a registered agent has not already been appointed.

(11) The department may issue a provisional license to an applicant that allows the applicant to operate in this state while the applicant's application is being processed by the department. The department may not charge a fee for a provisional license. The department may adopt rules to implement the provisions of this subsection.

(12) A license issued under 39-8-204 or this section may not be transferred.

History: En. Sec. 4, Ch. 344, L. 1995; amd. Sec. 2, Ch. 260, L. 2005; amd. Sec. 41, Ch. 416, L. 2005; amd. Sec. 1, Ch. 15, L. 2007; amd. Sec. 4, Ch. 112, L. 2009.

39-8-203. Denial of license application or renewal – hearing.

(1) The department shall deny a license application or an application to renew a license if:
   (a) the application is not fully completed or properly executed;
   (b) documents required to supplement the application are not included in the application packet or are inadequate;
   (c) the nonrefundable application or license fee is not submitted or is incorrectly submitted with the application packet;
   (d) the applicant or any person named in the application misrepresents material in the application;
   (e) the applicant is determined by the department to lack good moral character, business integrity, or financial responsibility; or
   (f) the department determines that the applicant has failed to meet or maintain any requirement of this chapter.

(2) Conviction of a crime within the last 7 years does not automatically bar an applicant from obtaining a license or bar a licensee from renewing a license. The department shall consider the type of crime committed, the crime's relevancy to the employee leasing industry, the length of time since the conviction, and any other factor considered relevant by the department.

(3) The department or its agent shall furnish the applicant with a written statement of the reason or reasons for denying the license or license renewal application.

(4) An applicant or licensee may request a hearing before the department within 30 days after receiving the written denial statement. The hearing and appeal must follow the procedures provided in Title 2, chapter 4, parts 6 and .

(5) During the hearing and appeal process, a licensee may continue to operate unless the circumstances warrant the ordering of immediate cessation of operations. If the renewal application is rejected, the licensee shall cease operations within this state 30 days after receiving written notification. A licensee who does not comply with the department's order to cease is subject to the penalties provided in 39-8-302.

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

(7) An applicant or licensee is ineligible to reapply for a license for 1 year following final department action denying the issuance of or renewal of a license. The 1-year restriction does not apply to an administrative denial or nonrenewal if the denial or nonrenewal was caused:
   (a) by an inadvertent error or omission on the application;
   (b) by experience that was insufficiently documented to the department at the time of the previous application;
   (c) by a failure to submit the required fees; or
   (d) when the applicant or licensee was determined to be ineligible because an individual no longer associated with the professional employer organization or group was determined to lack good moral character, business integrity, or financial responsibility.

History: En. Sec. 5, Ch. 344, L. 1995.

39-8-204. License renewal.

(1) A license issued under this chapter is valid for 1 year from the date of issuance unless suspended or revoked.
(2) An applicant for license renewal is subject to the requirements of 39-8-202(3) through (11).
(3) At least 30 days prior to the expiration of the license, the licensee shall submit an application for renewal of a license on a form prescribed by the department and accompanied by the license fee, as provided in 39-8-205.
(4) A late renewal application may not be processed prior to the expiration of the licensee's current license. A person engaged in an unlicensed activity is subject to the penalty established in 39-8-302.
(5) Denial of a renewal license is subject to review under the provisions of 39-8-203.

History: En. Sec. 6, Ch. 344, L. 1995; amd. Sec. 3, Ch. 260, L. 2005.

39-8-205. Renewal fees.

(1) The fee for the renewal of a resident or nonresident unrestricted license is $750.
(2) The fee for the renewal of a restricted license is $500.
(3) The application fee required in 39-8-202 does not apply to the renewal of an unrestricted license.
(4) Fees collected must be used by the department to implement this chapter.

History: En. Sec. 7, Ch. 344, L. 1995; amd. Sec. 2, Ch. 15, L. 2007.

39-8-206. License suspension, revocation, or nonrenewal.

(1) In addition to the penalty provided in 39-8-302, the department may suspend for up to 1 year, may permanently revoke, or may refuse to renew a license issued under this chapter if, after notice to the licensee, the department finds that any of the following exists:
  (a) a cause for which issuance of the license could have been refused had it been known to the department at the time of issuance;
  (b) a violation of an order of the department or noncompliance with any provision of this chapter;
  (c) procurement of or attempting to procure a license through misrepresentation or fraud;
  (d) failure to provide a written response to a written inquiry from the department or its agent within 30 days after receiving an inquiry; or
  (e) failure to meet or maintain any other requirement of this chapter.
(2) If a license is suspended, revoked, or not renewed, the department shall:
  (a) immediately notify by certified mail the licensee and the licensee's workers' compensation carrier; and
  (b) require the licensee to:
    (i) notify each client by certified mail, return receipt requested, of the suspension, revocation, or nonrenewal using language furnished by the department;
    (ii) notify each client in writing that the client shares joint and several liability, retroactive to the date of the client's entering into a contract with the licensee, for any wages, workers' compensation premiums, payroll-related taxes, and any benefits left unpaid by the professional employer organization or group; and
    (iii) provide the department with evidence of client notification.
(3) Upon notification, the licensee may appeal the decision of the department pursuant to the procedure provided in 39-8-203.

History: En. Sec. 8, Ch. 344, L. 1995; amd. Sec. 4, Ch. 260, L. 2005.

39-8-207. Requirements of licensee.

(1) A professional employer organization or group shall, by written contract with the client, establish the responsibilities and duties of each party. The contract must disclose to the client:
  (a) the services provided, the administrative fee, and the respective rights and obligations of the parties;
  (b) a statement providing that the professional employer organization or group:
    (i) reserves a right of direction and control over employees assigned to the client's location. The client may retain sufficient direction and control over employees necessary to conduct business and without which the client would be unable to conduct business, discharge fiduciary responsibilities, or comply with state licensing laws.
    (ii) assumes responsibility for the payment of wages of employees, workers' compensation premiums, payroll-related taxes, and employee benefits from its own accounts without regard to payments by the client; and
    (iii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right to accept or cancel the assignment of an employee.
  (c) a statement that, with respect to a worker supplied to a client by a professional employer organization or group, the client shares joint and several liability for any wages, workers' compensation premiums, and payroll-related taxes and for any benefits left unpaid by the professional employer organization or group and that, in the event that the licensee's license is suspended or revoked, this liability is retroactive to the client's entering into a contract with the licensee; and
  (d) a statement that the client is responsible for compliance with the Montana Safety Culture Act, Title 39, chapter 71, part 15.

(2) The professional employer organization or group shall:
  (a) give written notice of the general nature of the relationship between the professional employer organization or group and the client to each employee assigned to perform services at the client's place of work. The disclosure must provide that the professional employer organization:
    (i) reserves a right of direction and control over employees assigned to the client's location. The client may retain sufficient direction and control over employees necessary to conduct business and without which the client would be unable to conduct business, discharge fiduciary responsibilities, or comply with state licensing laws.
    (ii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right to accept or cancel the assignment of an employee.
  (b) submit to the department, within 90 days of the end of each calendar quarter, information certified by an independent certified public accountant demonstrating that all payroll-related taxes for the quarter have been paid. Upon a showing of reasonable cause, one 30-day extension may be granted for each quarter. The department, by rule, may waive the requirements of this subsection (2)(b) if the licensee provides to the department an affidavit from an organization of the type specified in 39-8-202(8).
  (c) maintain and make available for the department or its agent all records relating to the licensee's business conduct. Records must be maintained for 5 years after terminating a professional employer arrangement or employee leasing arrangement.
  (d) notify the department in writing within 20 days of a change of business address or a change in partners, directors, officers, members, or controlling persons designated in the license;

(e) notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group; and

(f) post the license issued in a conspicuous place in the principal place of business and display, in clear public view in each licensee's office, a notice stating that the professional employer organization or group is licensed and regulated by the department.

(3) (a) When a professional employer organization or group uses a professional employer arrangement with the client, both the professional employer organization or group and the client are the immediate employers of the workers subject to the arrangement for the purposes of the workers' compensation laws of this state.

(b) when a professional employer organization or group uses an employee leasing arrangement with the client, the professional employer organization or group is the immediate employer of the workers subject to the arrangement for the purposes of the workers' compensation laws of this state.

(4) A professional employer organization or group shall:

(a) pay wages and collect, report, and pay payroll-related taxes from its own accounts;

(b) pay unemployment taxes, pursuant to 39-51-1103, and provide, maintain, and secure all records and documents required of employers under the unemployment insurance laws of this state. For unemployment reporting purposes, each professional employer organization is the employing unit, as defined in 39-51-201, and shall keep separate records and submit quarterly wage lists for each of its clients.

(c) provide workers' compensation coverage for all employees and provide, maintain, and secure all records and documents required of employers under the workers' compensation laws of this state. A license may not be issued to a professional employer organization or group until the department receives proof of Montana workers' compensation coverage for the professional employer organization or group.

(5) A professional employer organization or group is an employer for sponsoring and maintaining employee benefit and welfare plans. The plans, if limited to employees of the professional employer organization or group, are not multiple employer welfare arrangements. This section does not preclude the client from providing benefits to employees coemployed by a professional organization or group.

(6) A professional employer organization or group shall disclose to the department, to each client, and to its employees information on any health or life fringe benefit program provided for its employees. The information must include:

(a) the type of benefits;

(b) the identity of each insurer providing each type of coverage;

(c) the amount of benefits for each type of coverage and to whom or on whose behalf the benefits will be paid;

(d) the policy limits on each insurance policy; and

(e) whether coverage is fully insured, partially insured, or fully self-funded.

(7) Disclosure required by this section may be made by any written means reasonably calculated to adequately inform the employees, including a summary plan description that meets the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq., as amended.

(8) (a)Subject to any contrary provisions of the contract between the client and the professional employer organization or group, the professional employer arrangement that exists between the parties must be interpreted for purposes of insurance, bonding, and employer liability pursuant to subsection (8)(b).

(b)the professional employer organization or group:

(i) is entitled, along with the client, to the exclusivity of the remedy under both the workers' compensation and employers' liability provisions of a workers' compensation policy or plan of either party; and

(ii) is not liable for the acts, errors, or omissions of a client or of an employee acting under the direction and control of a client, subject to the provisions of this chapter. Subject to the provisions of this chapter, a client is not liable for the acts, errors, or omissions of a professional employer organization or group or of any employee of a professional employer organization or group acting under the direction and control of the professional employer organization or group..

(9) A professional employer organization or group that applies for workers' compensation coverage shall also maintain and furnish to the insurer sufficient information to permit the calculation of an experience modification factor for each client employer, including but not limited to:

(a)the client employer's corporate or business name;

(b)the client employer's taxpayer or employer identification number;

(c)the client employer's risk identification number;

(d)a listing of all employees assigned to each client employer and the applicable classification code and payroll; and

(e)the client employer's first report of injury identifying the client employer and any other information necessary to permit the calculation of an experience modification factor for each client employer.

(10) An employee assigned to a client by a professional employer organization or group is considered the employee of the client for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, and liquor liability insurance carried by the client. An employee assigned to a client by a professional employer organization or group is not an employee of the professional employer organization or group for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, or liquor liability insurance carried by the professional employer organization or group unless the employee is included by reference in an employment arrangement contract, insurance contract, or bond.

(11) The sale of professional employer services pursuant to this chapter does not constitute the sale of insurance under Title 33 unless the professional employer organization or group:

(a)undertakes to indemnify another or pay or provide a specified or determinable amount of benefit based on determinable contingencies unless done through a licensed insurer or an employee welfare benefit plan as defined in 29 U.S.C. 1002(1);

(b)solicits, negotiates, effects, procures, delivers, renews, continues, or binds an insurance policy unless done through a licensed insurance producer; or

(c)is not exempt under 33-17-103(4).

(12) A sole proprietor or a working member of a partnership working under a professional employer arrangement may not receive unemployment insurance benefits unless the individual would otherwise be entitled to benefits if the professional employer arrangement did not exist.

(13) If the professional employer organization or group or the client complies with the provisions of 39-71-401 with respect to a worker under the professional employer arrangement, the professional employer organization or group and the client, with respect to those workers, are not uninsured employers, as defined in 39-71-501, and are not subject to the provisions of 39-71-508 or 39-71-515.

History: En. Sec. 9, Ch. 344, L. 1995; amd. Sec. 161, Ch. 42, L. 1997; amd. Sec. 62, Ch. 472, L. 1999; amd. Sec. 5, Ch. 260, L. 2005; amd. Sec. 3, Ch. 15, L. 2007.

Part 3
Disciplinary Provisions

39-8-301. Deceptive practices prohibited.

A professional employer organization or group may not:

(1) Make, issue, circulate, or cause to be made, issued, or circulated an estimate, illustration, circular, statement, advertisement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions, or terms of a professional employer arrangement or that is otherwise untrue, deceptive, or misleading;

(2) Enter into an agreement to commit or by concerted action commit an act of boycott, coercion, or intimidation that results in unreasonable restraint of or monopoly in the business of professional employer services;

(3) File with the department or other public official or make, publish, disseminate, circulate, or deliver to a person a false statement of financial condition with the intent to deceive;

(4) Knowingly:

(a) make a false entry of a material fact in a book, report, or statement of a person; or

(b) omit a material fact pertaining to the business of the person from a book, report, or statement of that person;

(5) Permit the use or filing of a name, trade name, fictitious name, or business identity that is the same as or similar to or that may be confused with the name, trade name, fictitious name, or business identity of an existing licensee, governmental agency, or nonprofit organization; or

(6) Commit any other practice determined by department rule to be deceptive.

History: En. Sec. 10, Ch. 344, L. 1995.

39-8-302. Disciplinary action against licensee – penalties.

(1) The department may deny a license application or may suspend, revoke, or refuse to renew an existing license for a person who:

(a) obtains or renews a license through bribery, fraud, or willful misrepresentation;

(b) engages in fraud, deceit, misrepresentation, or misconduct in:

(i) obtaining or providing workers' compensation or health coverage;

(ii) the classification of employees;

(iii) the reporting of employee wages for purposes of any payroll-related taxes or workers' compensation benefits; or

(iv) the operation of a professional employer organization or group;

(c) conducts business without a valid license;

(d) fails to maintain evidence of workers' compensation insurance coverage;

(e) transfers or attempts to transfer a license issued pursuant to this chapter; or

(f) violates the provisions of this chapter or a rule issued pursuant to this chapter.

(2) A person who fails to comply with the provisions of this chapter is guilty of a misdemeanor and, upon conviction, is subject to a fine of up to $1,000, imprisonment for not more than 1 year, or both.

History: En. Sec. 11, Ch. 344, L. 1995; amd. Sec. 6, Ch. 260, L. 2005.

39-8-303. Practice without license – investigation of complaint – injunction.

(1) The department shall investigate complaints concerning practice by an unlicensed person of activities for which a license is required under this chapter.
(2) The department may file an action to enjoin a person from practicing without a license as a professional employer organization or group.

History: En. Sec. 12, Ch. 344, L. 1995.

39-8-304. Violation of injunction – penalty.

A person who violates an injunction issued under 39-8-303 shall pay a civil penalty, as determined by the court, of not more than $5,000. Fifty percent of the penalty must be deposited in the general fund of the county in which the injunction is issued, and 50% must be deposited in the state general fund.

History: En. Sec. 13, Ch. 344, L. 1995.

39-8-305. Investigations – audits – reviews.

(1) The department or its agent may perform an investigation, audit, or review necessary to determine whether a person has violated any provision of this chapter or any rule promulgated by the department to implement this chapter.
(2) Except as provided in subsection (3), material compiled by the department or its agent in an investigation, audit, or review pursuant to this section is a public record and may be disclosed.
(3) Financial information, client lists, and lists of workers that are assigned by a professional employer organization or group and that are obtained by the department or its agent during an investigation, audit, or review are confidential and may not be published or be open to public inspection, except to public employees in the performance of their public duties.

History: En. Sec. 14, Ch. 344, L. 1995.

Part 4
Confidentiality – Applicability of Other Law

39-8-401. Disclosure of information.

(1) The department may not disclose to any person the records, statements, or documents received from an applicant, client, or professional employer organization or group, except:
   (a) information necessary for public employees in the performance of their public duties; or
   (b) in response to an order received by a court of competent jurisdiction upon a finding that the disclosure of the record, statement, or document is necessary because the merits of disclosure clearly exceed the demand for individual privacy.
(2) The department may publish or make available to the public reasonable statistical data or reports regarding professional employer organizations or groups if the data or reports protect the identity of an applicant, client, or professional employer organization or group.

History: En. Sec. 15, Ch. 344, L. 1995.

39-8-402. Other law.

(1) This chapter does not exempt a client of a professional employer organization or group or an employee assigned to a client by a professional employer organization or group from other local, state, or federal license or registration requirements.
(2) An employee who is licensed, registered, or certified under law and who is assigned to a client location is an employee of the client for purposes of the license, registration, or certification.
(3) Except as provided in a professional employer arrangement, a professional employer organization or group is not liable for the general debts, obligations, profit losses, business goodwill, or other damages of a client with which it has entered into a professional employer arrangement.

History: En. Sec. 16, Ch. 344, L. 1995.

39-8-403. Workers' compensation insurer requirements.

(1) An insurer that provides workers' compensation insurance to a professional employer organization shall base classifications and rates applicable to the payroll of a worker who is subject to either a professional employer arrangement or an employee leasing arrangement as though the worker has been a direct employee of the client employer. If an experience modification has been established for the client employer, that experience modification must be audited using the factors in subsection (3) and must be applied by the insurer to the premium for the client employer's workers.
(2) The insurer of a professional employer organization shall report to the workers' compensation advisory or rating organization of which the insurer is required to be a member under Title 33, chapter 16, part 10, all data by client, including payroll by classification and liabilities for each client during the term of the policy.
(3) An insurer shall audit policies issued to a professional employer organization within 90 days of the policy effective date and may conduct quarterly audits thereafter. The purpose of the audit is to determine whether all classifications, experience modification factors, and estimated payroll used with respect to the development of the premium charged are appropriate.
(4) All operations of a client, whether or not all or a portion of the client's operations are subject to a professional employer arrangement or employee leasing arrangement, must be insured by the same insurer.

History: En. Sec. 17, Ch. 344, L. 1995.

Chapter 38
Professional Employer Organizations

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Chapter 38
Professional Employer Organizations

Subchapter 1
Licensure

24.38.101 New Applications - Denials

(1) An applicant for initial licensure must submit all information and documentation required by statute and rule.

(2) An application that does not contain all required information and documentation is incomplete. Upon receipt of an incomplete application from a newly applying PEO, the department will notify the applicant in writing that the PEO has 90 days from the date that the original application was received to submit a completed application.

(a) If a complete application is not received within the 90-day deadline, the application will be denied.

(b) An extension of the application process may be requested in writing by a controlling person and will be evaluated on a case-by-case basis

History: 39-8-201, MCA; IMP, 39-8-202, 39-8-203, 39-8-207, MCA; NEW, 2014 MAR p. 684, Eff. 4/11/14 ; AMD, 2022 MAR p. 909, Eff. 6/11/22.

Rule 24.38.102 reserved

24.38.103 Provisional License

(1) A provisional license may be granted to applicants for initial licensure as set forth in this rule. A provisional license may be in effect solely during the period from granting until a decision to grant or deny a license is made.

(2) A provisional license may be granted only if:

(a) the department determines it is in the best interest of potentially affected clients and employees; and

(b) the initial application is pending and contains proof that, at minimum:

(i) the requirements of 39-8-207(1), (2), (4), and (6), MCA are met; or

(ii) the applicant is licensed as a PEO in another state.

History: 39-8-201, MCA; IMP, 39-8-202, MCA; NEW, 2022 MAR p. 909, Eff. 6/11/22.

24.38.105 Renewal Applications - Denials

(1) Except as set forth in (2), a complete renewal application must be submitted to the department at least 30 days prior to the license expiration.

(2) A renewal application submitted less than 30 days prior to license expiration must be accompanied by a request for extension. An incomplete renewal application submitted less than 30 days prior to license expiration is subject to summary denial.

(3) Request for extension will be considered on a case-by-case basis and will be granted in the department's sole discretion. At minimum, the request must contain:

(a) the specific length of extension sought; and

(b) the reason extension is necessary, including circumstances outside the requestor's control.

History: 39-8-201, MCA; IMP, 39-8-202, 39-8-203, 39-8-204, 39-8-206, MCA; NEW, 2014 MAR p. 684, Eff. 4/11/14 ; AMD, 2022 MAR p. 909, Eff. 6/11/22.

Rules 24.38.106 through 24.33.110 reserved

24.38.111 Suspension, Revocation, Nonrenewal - Appeal - Immediate Cessation of Operations

(1) The PEO may appeal the suspension, revocation, or nonrenewal by submitting a written request within 30 days of receiving the notice of suspension, revocation, or denial. The appeal must be submitted to dlierdpeo@mt.gov .

(2) When the suspension or revocation of a provisional or regular license is appealed, the department may order an immediate cessation of operations if:

(a)the PEO does not maintain a valid workers' compensation policy; or

(b)other circumstances determined by the department warrant immediate cessation of operations.

History: 39-8-201, MCA; IMP, 39-8-203, 39-8-204, 39-8-206, MCA; NEW, 2014 MAR p. 684, Eff. 4/11/14 ; AMD, 2022 MAR p. 909, Eff. 6/11/22.

Rule 24.38.124 reserved

24.38.125 Professional Employer Organizations

(1) PEOs must meet all recordkeeping and reporting obligations applicable to all other employers pursuant to the Unemployment Insurance Law.

(2) Concurrent with the report required by ARM 24.11.2711, PEOs must submit quarterly to unemployment insurance a report detailing:

(a)for each client:

(i) client name; and

(ii) client federal employer identification number;

(b)for each leased employee:

(i) name;

(ii) social security number; and

(iii)for each client for which the leased employee worked, the wages paid.

(3) Failure to submit filings pursuant to this rule may subject a PEO license to suspension, revocation, or refusal to renew.

History: 39-8-201, 39-51-301, MCA; IMP, 39-8-207, 39-8-302, 39-51-1219, MCA; NEW, 2022 MAR p. 909, Eff. 6/11/22.

TAB 7

Chapter 73
Silicosis Benefits

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Chapter 73
Silicosis Benefits

Part 1
General Provisions

Part Cross-References

39-73-101. Definitions.

(1) "Examining board" means a well-qualified physician or physicians, as designated by the department of labor and industry.
(2) The term "gainful occupation" may not be construed to mean occasional or intermittent light employment where the ability to do manual labor is not essential but means any person having an income from any other source exceeding $350 a month.
(3) "Payments" means money payments to persons having silicosis.
(4) "Silicosis" means a fibrotic condition of the lungs due to the inhalation of silica dust.

History: (1)thru (3)En. Sec. 1, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 1, Ch. 225, L. 1961; amd. Sec. 1, Ch. 360, L. 1971; amd. Sec. 38, Ch. 182, L. 1975; Sec. 71-1001, R.C.M. 1947; (4)En. Sec. 3, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 1, Ch. 68, L. 1945; amd. Sec. 1, Ch. 216, L. 1947; amd. Sec. 1, Ch. 192, L. 1949; amd. Sec. 1, Ch. 42, L. 1953; amd. Sec. 1, Ch. 252, L. 1955; amd. Sec. 1, Ch. 3, L. 1961; amd. Sec. 3, Ch. 225, L. 1961; amd. Sec. 1, Ch. 267, L. 1965; amd. Sec. 1, Ch. 125, L. 1967; amd. Sec. 1, Ch. 260, L. 1969; amd. Sec. 1, Ch. 105, L. 1971; amd. Sec. 2, Ch. 360, L. 1971; amd. Sec. 1, Ch. 504, L. 1973; Sec. 71-1003, R.C.M. 1947; R.C.M. 1947, 71-1001, 71-1003(part); amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 474, L. 2005; amd. Sec. 1, Ch. 232, L. 2007.

39-73-102. Administration – duties of department.

The department of labor and industry shall administer this chapter. The department shall:
(1) Formulate a plan and adopt rules for the operation of this chapter;
(2) Cooperate with the federal government in all matters of immediate concern pertaining to silicosis;
(3) Designate the procedure to be followed in securing a competent medical examination for the purposes of determining silicosis in each individual applicant;
(4) Designate suitable physicians or physician, well qualified to examine applicants for aid under this chapter;
(5) Pay the actual transportation expenses of any applicant from the applicant's place of residence in the state to the place of examination and return, from funds appropriated to the department for that purpose;
(6) Develop and cooperate with other agencies in developing measures for the prevention of silicosis.

History: En. Sec. 2, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 2, Ch. 225, L. 1961; amd. Sec. 39, Ch. 182, L. 1975; R.C.M. 1947, 71-1002; amd. Sec. 2, Ch. 370, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1553, Ch. 56, L. 2009.

Cross-References
Administrative rulemaking procedure, Title 2, ch. 4, parts 1 through 3.

39-73-103. Conformity with acts of federal government.

If the government of the United States makes grants to states in aid of and allowing payments to persons having silicosis, the department of labor and industry is authorized to administer the grants-in-aid and payments in addition to grants made by this chapter. The total payments to any individual under this chapter may not exceed $350 a month, exclusive of any grants made by congress.

History: En. Sec. 8, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 3, Ch. 216, L. 1947; amd. Sec. 3, Ch. 192, L. 1949; amd. Sec. 2, Ch. 204, L. 1953; amd. Sec. 3, Ch. 252, L. 1955; amd. Sec. 2, Ch. 3, L. 1961; amd. Sec. 8, Ch. 225, L. 1961; amd. Sec. 3, Ch. 267, L. 1965; amd. Sec. 3, Ch. 125, L. 1967; amd. Sec. 3, Ch. 260, L. 1969; amd. Sec. 3, Ch. 105, L. 1971; amd. Sec. 3, Ch. 504, L. 1973; R.C.M. 1947, 71-1008; amd. Sec. 1, Ch. 559, L. 1981; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 20, Ch. 214, L. 2001; amd. Sec. 2, Ch. 474, L. 2005; amd. Sec. 2, Ch. 232, L. 2007.

39-73-104. Eligibility requirements for benefits.

Payment must be made under this chapter to any person who:

(1) Has silicosis, as defined in 39-73-101, that results in the person's total disability so as to render it impossible for the person to follow continuously any substantially gainful occupation;

(2) Has resided in and been an inhabitant of the state of Montana for 10 years or more immediately preceding the date of the application;

(3) Is not receiving, with respect to any month for which the person would receive a payment under this chapter, compensation under 39-71-715 equal to the sum of $350.

History: En. Sec. 3, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 1, Ch. 68, L. 1945; amd. Sec. 1, Ch. 216, L. 1947; amd. Sec. 1, Ch. 192, L. 1949; amd. Sec. 1, Ch. 42, L. 1953; amd. Sec. 1, Ch. 252, L. 1955; amd. Sec. 1, Ch. 3, L. 1961; amd. Sec. 3, Ch. 225, L. 1961; amd. Sec. 1, Ch. 267, L. 1965; amd. Sec. 1, Ch. 125, L. 1967; amd. Sec. 1, Ch. 260, L. 1969; amd. Sec. 1, Ch. 105, L. 1971; amd. Sec. 2, Ch. 360, L. 1971; amd. Sec. 1, Ch. 504, L. 1973; R.C.M. 1947, 71-1003(part); amd. Sec. 2, Ch. 559, L. 1981; amd. Sec. 33, Ch. 416, L. 2005; amd. Sec. 3, Ch. 474, L. 2005; amd. Sec. 3, Ch. 232, L. 2007; amd. Sec. 58, Ch. 2, L. 2009; amd. Sec. 25, Ch. 112, L. 2009.

39-73-105. Application for payment.

Application for payment under this chapter must be made by the person seeking the payment to the department of labor and industry. The application must be in writing or reduced to writing in the manner and upon the form prescribed by the department. The application form may be filled in and written by a person authorized by the department. If the applicant is unable to sign the applicant's name on the application, a witnessed mark may be used.

History: En. Sec. 5, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 5, Ch. 225, L. 1961; amd. Sec. 40, Ch. 182, L. 1975; R.C.M. 1947, 71-1005; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1554, Ch. 56, L. 2009.

39-73-106. Investigation of applications.

(1) Whenever the department of labor and industry under this chapter receives an application for a payment, an investigation and record shall be promptly made of the validity of the claim. The object of such investigation shall be to ascertain whether or not the applicant is entitled to a payment under the provisions of this chapter and such other information as may be required by the rules of the department. The investigation of such applicant shall be conducted by representatives of the department. The physicians or physician designated by the department, as herein provided, shall constitute an examining board for such clinical, pathological, x-ray, and roentgen examinations as in the opinion of the examining board may be necessary to determine whether or not the applicant has silicosis, as herein defined. A certified report of such examination from the examining board of physicians or physician must be attached to the investigation report.

(2) Upon the completion of such investigation, the department shall determine whether or not the applicant is entitled to a payment under this chapter. The department shall then notify the applicant of its decision.

History: (1)En. Sec. 6, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 6, Ch. 225, L. 1961; amd. Sec. 41, Ch. 182, L. 1975; Sec. 71-1006, R.C.M. 1947; (2)En. Sec. 7, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 7, Ch. 225, L. 1961; amd. Sec. 42, Ch. 182, L. 1975; Sec. 71-1007, R.C.M. 1947; R.C.M. 1947, 71-1006, 71-1007; amd. Sec. 64, Ch. 613, L. 1989.

39-73-107. Amount of payments.

Subject to the provisions of this chapter and the deductions provided in this chapter, any person who has silicosis and who has, subject to the regulations and standards of the department of labor and industry, been determined by the department to be entitled to payment under this chapter for silicosis must be granted a payment by the department of $350 a month, subject to any additional appropriations. If the person is receiving payments under 39-71-715 that are less in the aggregate than $350, then the person is entitled to a payment under this chapter of the difference between the amount received under 39-71-715 and $350 a month. The legislature shall authorize additional appropriations that may be necessary to make the increased monthly payments provided in this section.

History: Ap. p. Sec. 3, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 1, Ch. 68, L. 1945; amd. Sec. 1, Ch. 216, L. 1947; amd. Sec. 1, Ch. 192, L. 1949; amd. Sec. 1, Ch. 42, L. 1953; amd. Sec. 1, Ch. 252, L. 1955; amd. Sec. 1, Ch. 3, L. 1961; amd. Sec. 3, Ch. 225, L. 1961; amd. Sec. 1, Ch. 267, L. 1965; amd. Sec. 1, Ch. 125, L. 1967; amd. Sec. 1, Ch. 260, L. 1969; amd. Sec. 1, Ch. 105, L. 1971; amd. Sec. 2, Ch. 360, L. 1971; amd. Sec. 1, Ch. 504, L. 1973; Sec. 71-1003, R.C.M. 1947; Ap. p. Sec. 4, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 2, Ch. 216, L. 1947; amd. Sec. 2, Ch. 192, L. 1949; amd. Sec. 1, Ch. 204, L. 1953; amd. Sec. 2, Ch. 252, L. 1955; amd. Sec. 1, Ch. 248, L. 1959; amd. Sec. 4, Ch. 225, L. 1961; amd. Sec. 2, Ch. 267, L. 1965; amd. Sec. 2, Ch. 125, L. 1967; amd. Sec. 2, Ch. 260, L. 1969; amd. Sec. 2, Ch. 105, L. 1971; amd. Sec. 2, Ch. 504, L. 1973; Sec. 71-1004, R.C.M. 1947; R.C.M. 1947, 71-1003(part), 71-1004; amd. Sec. 3, Ch. 559, L. 1981; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 21, Ch. 214, L. 2001; amd. Sec. 34, Ch. 416, L. 2005; amd. Sec. 4, Ch. 474, L. 2005; amd. Sec. 4, Ch. 232, L. 2007.

39-73-108. Payment of benefits when person entitled is in institution.

If a person who is entitled to benefits under this chapter is an inmate in any Montana state institution, benefits may not be paid to the person but must be paid to the person's beneficiary, if any, as defined in39-71-116.

History: En. Sec. 3, Part 9, Ch. 82, L. 1937, as added by Sec. 1, Ch. 5, L. 1941; amd. Sec. 1, Ch. 68, L. 1945; amd. Sec. 1, Ch. 216, L. 1947; amd. Sec. 1, Ch. 192, L. 1949; amd. Sec. 1, Ch. 42, L. 1953; amd. Sec. 1, Ch. 252, L. 1955; amd. Sec. 1, Ch. 3, L. 1961; amd. Sec. 3, Ch. 225, L. 1961; amd. Sec. 1, Ch. 267, L. 1965; amd. Sec. 1, Ch. 125, L. 1967; amd. Sec. 1, Ch. 260, L. 1969; amd. Sec. 1, Ch. 105, L. 1971; amd. Sec. 2, Ch. 360, L. 1971; amd. Sec. 1, Ch. 504, L. 1973; R.C.M. 1947, 71-1003(c); amd. Sec. 9, Ch. 480, L. 1991; amd. Sec. 1555, Ch. 56, L. 2009.

39-73-109. Payment of benefits to surviving spouse.

(1) Upon the death of a person receiving payments for silicosis under 39-73-104 or 39-73-108, the surviving spouse, as long as the spouse remains unmarried, is entitled to receive the payments granted to the deceased spouse.

(2) A person who otherwise is qualified to receive payments under subsection (1) but whose spouse died prior to March 14, 1974, is eligible to begin receiving $350 a month.

History: (1)En. 71-1010 by Sec. 1, Ch. 203, L. 1974; Sec. 71-1010, R.C.M. 1947; (2)En. 71-1010.1 by Sec. 1, Ch. 500, L. 1975; Sec. 71-1010.1, R.C.M. 1947; R.C.M. 1947, 71-1010, 71-1010.1; amd. Sec. 91, Ch. 397, L. 1979; amd. Sec. 22, Ch. 214, L. 2001; amd. Sec. 5, Ch. 474, L. 2005; amd. Sec. 5, Ch. 232, L. 2007.

39-73-110. Assistance not assignable or subject to legal process.

Except as otherwise provided in this chapter, assistance granted under this chapter is not transferable or assignable, at law or in equity, and none of the money paid or payable under this chapter is subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

History: En. Sec. 18, Part 1, Ch. 82, L. 1937; amd. Sec. 26, Ch. 121, L. 1974; R.C.M. 1947, 71-229.

39-73-111. Representative payee – appointment – duties.

(1) The department of labor and industry may appoint a representative payee to apply for and receive payment of silicosis benefits on behalf of a person eligible for the payments or the person's beneficiary if the department determines that the appointment is in the best interests of the person or the person's beneficiary. The representative payee may be a person, a corporation, a government agency, or an institution, including a nursing home or extended care facility providing care for the person or the person's beneficiary.

(2) To determine the best interests of the eligible person or the person's beneficiary for appointment of a representative payee, the department may consider:
   (a) a court determination of incompetence;
   (b) medical evidence;
   (c) relevant information from any person, corporation, government agency, or institution; and
   (d) other relevant information.

(3) The department shall:
   (a) determine the circumstances in which a representative payee may be appointed;
   (b) establish procedures for the appointment; and
   (c) establish the representative payee's responsibilities.

(4) The representative payee shall:
   (a) act as a trustee to the person eligible for silicosis payments or the person's beneficiary in handling payments received; and
   (b) maintain and expend the funds for the benefit and best interests of the eligible person or the person's beneficiary.

(5) The department's obligation under this chapter is fully discharged upon payment of benefits to the representative payee.

History: En. Sec. 1, Ch. 69, L. 1989; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1556, Ch. 56, L. 2009.

TAB 8

Title 50
Health and Safety

Part 1
Montana Occupational Safety and Health Act

50-71-101. Repealed.
50-71-102. Renumbered 50-71-204.
50-71-103. Repealed.
50-71-104. Repealed.
50-71-105. Repealed.
50-71-106. Repealed.
50-71-107. Repealed.
50-71-108. Repealed.
50-71-109. Repealed.
50-71-110. Repealed.
50-71-111. Short tile.
50-71-112. Definitions.
50-71-113. Administrative authority - funding.
50-71-114. Rulemaking - variances.
50-71-115. Applicability of standars - exceptions.
50-71-116. Duties of public sector employers and public sector employees.
50-71-117. Public sectoremployer records and reports.
50-71-118. Inspections.
50-71-119. Report of inspection - violations - penalty - appeal process.
50-71-120. Stop-work orders.
50-71-121. Injunctive relief.
50-71-122. Safety consultation services.
50-71-123. Retaliation prohibited.
50-71-124 through 50-71-127 reserved.
50-71-128. Occupational safety and health administration fund.

Part 2
Duties of Employer and Employee

50-71-201. Employer to provide safe workplace and to purchase, furnish, and require use of healthand safety items - safe practices.
50-71-202. Employer to provide and maintain safe place of employment.
50-71-203. Removal of or refusal to use health and safety items prohibited.
50-71-204. Definitions.

Part 3
Safety Rules and Orders (Repealed)

50-71-301. Repealed.
50-71-302. Repealed.
50-71-303. Repealed.
50-71-304 through 50-71-310 reserved.
50-71-311. Repealed.
50-71-312. Repealed
50-71-313. Repealed
50-71-314. Repealed
50-71-315. Repealed
50-71-316. Repealed
50-71-317 through 50-71-320 reserved.
50-71-321. Repealed
50-71-322. Repealed
50-71-323. Repealed
50-71-324. Repealed
50-71-325. Repealed
50-71-326. Repealed
50-71-327. Repealed
50-71-328 through 50-71-330 reserved.
50-71-331. Repealed
50-71-332. Repealed
50-71-333. Repealed
50-71-334. Repealed

Chapter 71
Occupational Safety and Health

Part 1
Montana Occupational Safety and Health Act

50-71-101. Repealed.

Sec. 22, Ch. 27, L. 2009.

History: En. Sec. 1, Ch. 341, L. 1969; R.C.M. 1947, 41-1708.

50-71-102. Renumbered 50-71-204.

Sec. 24(2), Ch. 27, L.2009.

50-71-103. Repealed.

Sec. 22, Ch. 27, L. 2009.

History: En. Sec. 24, Ch. 341, L. 1969; R.C.M. 1947, 41-1731; amd. Sec. 10, Ch. 514, L. 1995.

50-71-104. Repealed.

Sec. 24(2), Ch. 27, L.2009.

History: En. Sec. 25, Ch. 341, L. 1969; R.C.M. 1947, 41-1732.

50-71-105. Repealed.

Sec. 22, Ch. 27, L. 2009..

History: En. Sec. 6, Ch. 341, L. 1969; amd. Sec. 2, Ch. 182, L. 1975; R.C.M. 1947, 41-1713(part).

50-71-106. Repealed.

Sec. 22, Ch. 27, L. 2009.

History: En. Sec. 6, Ch. 341, L. 1969; amd. Sec. 2, Ch. 182, L. 1975; R.C.M. 1947, 41-1713(part); amd. Sec. 64, Ch. 613, L. 1989.

50-71-107. Repealed.

Sec. 22, Ch. 27, L. 2009..

History: En. Sec. 22, Ch. 341, L. 1969; amd. Sec. 18, Ch. 182, L. 1975; R.C.M. 1947, 41-1729(1); amd. Sec. 64, Ch. 613, L. 1989.

50-71-108. Repealed.

Sec. 22, Ch. 27, L. 2009..

History: En. Sec. 22, Ch. 341, L. 1969; amd. Sec. 18, Ch. 182, L. 1975; R.C.M. 1947, 41-1729(2); amd. Sec. 64, Ch. 613, L. 1989.

50-71-109. Repealed.

Repealed. Sec. 22, Ch. 27, L. 2009

History: En. Sec. 26, Ch. 341, L. 1969; amd. Sec. 19, Ch. 182, L. 1975; R.C.M. 1947, 41-1733; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 144, Ch. 418, L. 1995; amd. Sec. 331, Ch. 546, L. 1995.

50-71-110. Repealed.

Sec. 22, Ch. 27, L. 2009..

History: En. Sec. 23, Ch. 341, L. 1969; R.C.M. 1947, 41-1730.

50-71-111. Short title.

This part may be cited as the “Montana Occupational Safety and Health Act”.

History: En. Sec. 1, Ch. 27, L. 2009.

50-71-112. Definitions.

As used in this part, the following definitions apply:

(1) ”Department” means the department of labor and industry provided for in 2-15-1701.

(2) “Employee” has the meaning provided in 39-71-118.

(3) “Employer” has the meaning provided in 39-71-117.

(4) “Health” means protection against occupational illness.

(5) “Inspection” means an onsite review of a workplace by the department to determine compliance with standards adopted under this part.

(6) “Private sector employer” means any employer that is not a public sector employer. The term includes for-profit and not-for-profit employers.

(7) (a)“Public sector employee” means an employee of a public sector employer.
(b)the term does not include a contractor.

(8) “Public sector employer” means:
(a)a state agency;
(b)each county in the state;
(c)each municipality in the state;
(d)each school district or community college; and
(e)any other political subdivision of the state.

(9) “Safety” means protection against occupational injury or death.

(10) “Safety consultation services” has the meaning provided in 39-71-1503.

(11) “Standard” means a rule adopted by the department pursuant to this part that is designed to promote or ensure safety or health in the workplace.

(12) “State agency” means any branch of government, including a department, board, commission, office, bureau, institution, university system entity, or unit of state government recognized in the state budget.

(13) “Workplace” means any site or location where an employee performs work for the employee’s employer.

History: En. Sec. 2, Ch. 27, L. 2009.

50-71-113. Administrative authority – funding.

(1) The department has authority to administer the provisions of this part.

(2) In addition to administering the provisions of this part, the department may:
(a)promote occupational safety and health;
(b)educate employers and employees in occupational safety and health matters;
(c)conduct research regarding occupational safety and health data, topics, and techniques; and
(d)investigate occupational injuries, illnesses, and deaths involving public sector employees.

(3) The department may develop and operate a statewide employment safety program. The statewide employment safety program may include but is not limited to:
(a)a safety awareness component;
(b)an employee education component;
(c)an employer education component; and
(d)industry-specific initiatives.
(4) The activities of the department under the provisions of this part are funded by the occupational safety and health administration fund provided for in 50-71-128.
(5) The department may accept, receive, and administer gifts, grants, or other funds from public or private agencies and from the United States for the purpose of carrying out the provisions of this part. Funds received by the department under this subsection must be deposited into the fund provided for in 50-71-128.

History: En. Sec. 3, Ch. 27, L. 2009; amd. Sec. 4, Ch. 365, L. 2015.

50-71-114. Rulemaking – variances.

(1)The department may adopt appropriate standards for safety and health by administrative rule, including:
(a)any safety or health regulations promulgated by the federal occupational safety and health administration; and
(b)standards that are not inconsistent with federal safety and health regulation but that provide for a greater level of protection for employees.
(2) The department may adopt other rules that are reasonably necessary to implement this part.
(3) (a)The department may by rule:
(i) provide a procedure to grant a temporary variance from the particular provisions of a standard; and
(ii) permit the temporary use of other or different devices or methods than provided by the standard.
(b)a temporary variance may be granted only if the public sector employer:
(i) has an effective program for complying with the standard as quickly as is practicable;
(ii) is taking all available steps to safeguard public sector employees against the hazards covered by the standard; and
(iii)is unable to comply with the standard because:
(A) professional or technical personnel needed to implement compliance with the standard are temporarily unavailable;
(B) material or equipment needed to comply with the standard is temporarily unavailable; or
(C) necessary construction or alteration of facilities cannot be completed by the effective date of the standard.

History: En. Sec. 4, Ch. 27, L. 2009.

50-71-115. Applicability of standards – exceptions.

(1) The standards for safety and health and the enforcement rules adopted pursuant to this part apply to all public sector employers in this state and to public sector employees.
(2) The standards and enforcement rules adopted pursuant to this part do not apply to employment by:
(a)private sector employers;
(b)the federal government and its instrumentalities; or
(c)a federally recognized tribal government.

History: En. Sec. 5, Ch. 27, L. 2009; amd. Sec. 8, Ch. 240, L. 2021.

50-71-116. Duties of public sector employers and public sector employees.

(1) Each public sector employer shall:
   (a) furnish a place of employment that is free from recognized hazards that cause or are likely to cause death or serious physical harm to public sector employees;
   (b) adopt and use practices, means, methods, operations, and processes that are adequate to render the workplace safe; and
   (c) take appropriate actions necessary to protect the life, health, and safety of public sector employees.
(2) Each public sector employee shall comply with the safety and health standards, rules, and orders issued pursuant to this part as they apply to the public sector employee's own actions and conduct.

History: En. Sec. 6, Ch. 27, L. 2009.

50-71-117. Public sector employer records and reports.

(1) Each public sector employer shall maintain records of occupational injuries, illnesses, and deaths as the department may require by rule.
(2) The department may inspect those records or require that the public sector employer submit those records to the department for its review.
(3) Except as otherwise provided by rule, a public sector employer complies with the requirements of this section if the public sector employer completes and submits a first report of injury form to the department or to the public sector employer's worker's compensation insurer within 30 days of the public sector employer becoming aware of an occupational injury, illness, or death suffered by a public sector employee

History: En. Sec. 7, Ch. 27, L. 2009.

50-71-118. Inspections.

(1) The department may inspect all workplaces of any public sector employer for the purpose of determining whether the public sector employer is in compliance with the safety and health standards that apply to the employer and the employer's workplaces. A department employee conducting an inspection shall, upon request, present appropriate credentials to the public sector employer. The department shall invite a representative of the public sector employer and a representative of any labor organization that represents employees of the public sector employer who are working at the workplace that is to be inspected to accompany the department employee on the inspection. The labor organization representative must be on paid status while accompanying the department employee on the inspection.
(2) An inspection may be performed:
   (a) periodically without prior notice or scheduling;
   (b) at the request of the public sector employer;
   (c) as the result of a complaint of a violation of a safety or health standard at a public sector employer's workplace;
   (d) as part of a department investigation following a report of an occupational injury, illness, or death; or

(e) following the issuance of a citation, after the public sector employer has been given a reasonable opportunity to correct any violation of standards.

(3) A public sector employer may not interfere with a department inspection conducted pursuant to this section.

(4) The department may not unreasonably interfere with the operations of a public sector employer while conducting an inspection. An unscheduled inspection does not constitute unreasonable interference with the public sector employer's operations.

History: En. Sec. 8, Ch. 27, L. 2009.

50-71-119. Report of inspection – violations -- penalty – appeal process.

(1) (a) The department shall make a written report of each inspection conducted under 50-71-118.

(b) the inspection report must include a list of violations of standards that the inspector discovered during the inspection. A violation of a standard by a public sector employee is attributable to the public sector employer for the purposes of this part.

(c) the department shall provide a copy of the inspection report to the public sector employer and to a representative of a labor organization that represents public sector employees at the workplace that was inspected.

(d) the public sector employer shall post a copy of the list of hazards included in the inspection report at one or more visible locations at the workplace that is the subject of the inspection report. The posting must be in a location likely to be seen by employees at that workplace.

(2) The department may issue a written citation to the public sector employer for a violation of a standard. The citation must specify:

(a) the nature of the violation;

(b) the standard that was violated; and

(c) a timeframe within which the public sector employer is required to correct the violation.

(3) (a) The department may impose upon a public sector employer a monetary penalty of not more than $1,000 for each violation for which a citation has been issued.

(b) the department may, in its sole discretion, waive or reduce a penalty under this subsection (3) if the public sector employer timely corrects or cures the violation for which the penalty was imposed.

(c) monetary penalties collected pursuant to this subsection (3) must be deposited into the occupational safety and health administration fund provided for in 50-71-128.

(4) (a) A public sector employer may appeal a citation or a penalty.

(b) an appeal to the department must be in writing and made within 30 days of the issuance of the citation.

(c) the appeal of a citation or a penalty is conducted as a contested case under Title 2, chapter 4.

History: En. Sec. 9, Ch. 27, L. 2009; amd. Sec. 5, Ch. 365, L. 2015.

50-71-120. Stop-work orders.

(1) The department may order a public sector employer to immediately and temporarily stop work at a particular workplace if a department inspector who has personally observed the workplace and the hazards that are present determines that:

(a) the conditions or operations that are present at the workplace constitute a violation of a standard established by the department;

(b) the violation poses an immediate and substantial risk of serious bodily injury or death to a public sector employee or a member of the public; and
(c) the public sector employer or a public sector employee who is present at the workplace is unable or unwilling to:
(i) immediately correct the violation; or
(ii) suspend the unsafe operation until the violation is corrected.

(2) The temporary stop-work order must be in writing and specify:
(a) the location of the workplace;
(b) the specific standard that is being violated;
(c) the nature of the risk posed by the violation;
(d) the date and the time that the temporary stop-work order is issued; and
(e) the name, employment address, and work telephone number of the person issuing the temporary stop-work order.

(3) The temporary stop-work order is effective upon communication or delivery to any one of the following:
(a) the public sector employer's onsite supervisor at the workplace;
(b) the public sector employer's manager in charge of workplace operations; or
(c) the chief executive of the public sector employer.

(4) A copy of the temporary stop-work order must be promptly posted by the department at the workplace. A posted temporary stop-work order may not be removed by any person while it is in effect.

(5) A temporary stop-work order is effective for 72 hours unless:
(a) the violation is corrected to the satisfaction of the department; or
(b) the temporary stop-work order is stayed by order of a district court judge following actual notice to the department and the public sector employer.

(6) The violation of a temporary stop-work order or the unauthorized removal of a posted copy of a temporary stop-work order is punishable as a contempt of court.

(7) As used in this section, the term "serious bodily injury" has the same meaning as provided in 45-2-101.

History: En. Sec. 10, Ch. 27, L. 2009.

50-71-121. Injunctive relief.

In addition to any remedies available under this part, the department may institute and maintain in the name of the state an action for injunctive relief as provided in Title 27, chapter 19, to:

(1) immediately restrain a public sector employer and public sector employees from engaging in any activity for which the department has issued a temporary stop-work order pursuant to 50-71-120;
(2) enjoin a violation of this part;
(3) enjoin a violation of a rule, including a safety or health standard, adopted under this part; or
(4) require compliance with this part, including compliance with any rules adopted under this part.

History: En. Sec. 11, Ch. 27, L. 2009.

50-71-122. Safety consultation services.

The department may, in its sole discretion, provide onsite safety consultation services to public sector employers and private sector employers that request onsite safety consultation services.

History: En. Sec. 12, Ch. 27, L. 2009.

50-71-123. Retaliation prohibited.

A public sector employer may not retaliate against a public sector employee who:
(1) contacts the department with a complaint of a violation of a standard in the workplace;
(2) cooperates with the department in the performance of an inspection or an investigation; or
(3) testifies or cooperates with the department in any case arising out of:
(a) an inspection;
(b) an investigation;
(c) a citation;
(d) a temporary stop-work order; or
(e) a civil action seeking injunctive relief.

History: En. Sec. 13, Ch. 27, L. 2009.

50-71-122 through 50-71-127 reserved.

50-71-128. Occupational safety and health administration fund.

(1) (a) An occupational safety and health administration fund is established, out of which are to be paid upon lawful appropriation all costs incurred by the department on or after July 1, 2016, in administering Title 50, chapters 71, 72, and 73.
(b) the department shall collect and deposit in the state treasury to the credit of the occupational safety and health administration fund:
(i) all penalties assessed under 50-71-119;
(ii) all expenses recovered under 50-72-106 and 50-73-107;
(iii) all fees paid by an assessment on paid losses, plus administrative fines and interest provided by this section; and
(iv) any grants or funds from private entities or the federal government intended for use by the department in defraying occupational safety and health costs.
(2) For the purposes of this section, the term "paid losses" has the meaning provided in 39-71-201.
(3) Each plan No. 1 employer, plan No. 2 insurer subject to the provisions of this section, and plan No. 3, the state fund, shall file annually on March 1 in the form and containing the information required by the department a report of paid losses.
(4) Each employer enrolled under compensation plan No. 1, compensation plan No. 2, or compensation plan No. 3, the state fund, shall pay its proportionate share, as determined by the paid losses in the preceding calendar year, of all costs appropriated for the next fiscal year for the purposes of administering Title 50, chapters 71, 72, and 73.
(5) (a) Each employer enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 2% of the paid losses that were paid in the preceding calendar year by or on behalf of the plan No. 1 employer. Any entity, other than the department, that assumes the obligations of an employer enrolled under compensation plan No. 1 is considered to be the employer for the purposes of this section.

(b) an employer formerly enrolled under compensation plan No. 1 shall pay an assessment to fund administrative and regulatory costs. The assessment may be up to 2% of the paid losses that were paid in the preceding calendar year by or on behalf of the employer for claims arising out of the time when the employer was enrolled under compensation plan No. 1.

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

(i) one installment due on July 1; or

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

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

(6) (a) Each employer insured under compensation plan No. 2 or plan No. 3, the state fund, shall pay a premium surcharge to fund administrative and regulatory costs. The premium surcharge must be collected by each plan No. 2 insurer and by plan No. 3, the state fund, from each employer that it insures. The premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted to the insured employer and must be identified as "occupational safety and health regulatory assessment surcharge". The premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes. However, an insurer may cancel a workers' compensation policy for nonpayment of the premium surcharge. When collected, assessments may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as a separate cost imposed on insured employers.

(b)(i) the amount to be funded by the premium surcharge may be up to 2% of the paid losses that were paid in the preceding calendar year by or on behalf of all plan No. 2 insurers and may be up to 2% of paid losses for claims arising on or after July 1, 1990, for plan No. 3, the state fund, plus or minus any adjustments as provided by subsection (6)(f).

(ii) the amount determined under subsection (6)(b)(i) must be divided by the total premium paid by all employers enrolled under compensation plan No. 2 or plan No. 3, the state fund, during the preceding calendar year.

(iii) a single premium surcharge rate, applicable to all employers enrolled in compensation plan No. 2 or plan No. 3, the state fund, must be calculated annually by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3, the state fund, in the next fiscal year.

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

(d) the premium surcharge must be paid whenever the employer pays a premium to the insurer. Each insurer shall collect the premium surcharge levied against every employer that it insures. Each insurer shall pay to the department all money collected as a premium surcharge within

20 days of the end of the calendar quarter in which the money was collected. If an insurer fails to timely pay to the department the premium surcharge collected under this section, the department may impose on the insurer an administrative fine of $500 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the occupational safety and health administration fund.

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

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

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

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

(9) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of Title 50, chapters 71, 72, and 73, including the salaries of its members, officers, and employees and the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

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

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

History: **En. Sec. 8, Ch. 365, L. 2015.**

Part 2
Duties of Employer and Employee

50-71-201. Employer to provide safe workplace and to purchase, furnish, and require use of health and safety items – safe practices.

Each employer shall:
(1) furnish a place of employment that is safe for each of the employer's employees;
(2) with the exception of footwear, purchase, furnish, and require the use of health and safety devices, safeguards, protective safety clothing, or other health and safety items, including but not limited to air masks, hardhats, and protective gloves, that may be required by state or federal law, the employer, or the terms of an employment contract unless the terms of a collective bargaining agreement provide otherwise;
(3) adopt and use practices, means, methods, operations, and processes that are reasonably adequate to render the place of employment safe; and
(4) do any other thing reasonably necessary to protect the life, health, and safety of the employer's employees.

History: En. Sec. 3, Ch. 341, L. 1969; R.C.M. 1947, 41-1710; amd. Sec. 1, Ch. 298, L. 1991; amd. Sec. 1869, Ch. 56, L. 2009.

50-71-202. Employer to provide and maintain safe place of employment.

(1) An employer who is the owner or lessee of any real property in this state shall not construct or cause to be constructed or maintained any place of employment that is unsafe.
(2) Every employer who is the owner of a place of employment or lessee thereof shall repair and maintain the same as to render it safe.

History: En. Sec. 4, Ch. 341, L. 1969; R.C.M. 1947, 41-1711.

50-71-203. Removal of or refusal to use health and safety items prohibited.

A person may not:
(1) remove, displace, damage, destroy, carry off, or refuse to use any health and safety device, safeguard, protective clothing, or other health and safety item furnished for use by the person's employer;
(2) interfere with the use of any required health and safety device, safeguard, protective clothing, or other health and safety item by any other person;
(3) interfere with the use of a method or process adopted for the protection of an employee in the place of employment; or
(4) fail to do any other thing reasonably necessary to protect the life, health, and safety of employees..

History: En. Sec. 5, Ch. 341, L. 1969; R.C.M. 1947, 41-1712; amd. Sec. 2, Ch. 298, L. 1991; amd. Sec. 1870, Ch. 56, L. 2009.

50-71-204. Definitions.

Unless the context requires otherwise, in this part, the following definitions apply:
(1) "Employee" and "worker" have the meanings provided in 39-71-118.
(2) "Employer" has the meaning provided in 39-71-117.

History: En. Sec. 2, Ch. 341, L. 1969; amd. Sec. 1, Ch. 182, L. 1975; R.C.M. 1946, 41-1709; amd. Sec. 48, Ch. 613, L. 1989; amd. Sec. 17, Ch. 27, L. 2009; Sec. 50-71-102, MCA 2007; redes. 50-71-204 by Sec. 24(2), Ch. 27, L. 2009.

Part 3
Safety Rules and Orders (Repealed)

50-71-301. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 8, Ch. 341, L. 1969; amd. Sec. 4, Ch. 182, L. 1975; R.C.M. 1947, 41-1715; amd. Sec. 64, Ch. 613, L. 1989.

50-71-302. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 9, Ch. 341, L. 1969; amd. Sec. 5, Ch. 182, L. 1975; R.C.M. 1947, 41-1716; amd. Sec. 64, Ch. 613, L. 1989.

50-71-303. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 7, Ch. 341, L. 1969; amd. Sec. 3, Ch. 182, L. 1975; R.C.M. 1947, 41-1714; amd. Sec. 64, Ch. 613, L. 1989.

50-71-301. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 8, Ch. 341, L. 1969; amd. Sec. 4, Ch. 182, L. 1975; R.C.M. 1947, 41-1715; amd. Sec. 64, Ch. 613, L. 1989.

50-71-304 through 50-71-310 reserved.

50-71-311. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 20, Ch. 341, L. 1969; amd. Sec. 16, Ch. 182, L. 1975; R.C.M. 1947, 41-1727(part); amd. Sec. 64, Ch. 613, L. 1989.

50-71-312. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 20, Ch. 341, L. 1969; amd. Sec. 16, Ch. 182, L. 1975; R.C.M. 1947, 41-1727(part); amd. Sec. 64, Ch. 613, L. 1989.

50-71-313. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 20, Ch. 341, L. 1969; amd. Sec. 16, Ch. 182, L. 1975; R.C.M. 1947, 41-1727(part).

50-71-314. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 20, Ch. 341, L. 1969; amd. Sec. 16, Ch. 182, L. 1975; R.C.M. 1947, 41-1727(2); amd. Sec. 64, Ch. 613, L. 1989.

50-71-315. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 21, Ch. 341, L. 1969; amd. Sec. 17, Ch. 182, L. 1975; R.C.M. 1947, 41-1728(part); amd. Sec. 64, Ch. 613, L. 1989

50-71-316. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 21, Ch. 341, L. 1969; amd. Sec. 17, Ch. 182, L. 1975; R.C.M. 1947, 41-1728(part); amd. Sec. 64, Ch. 613, L. 1989.

50-71-317 through 50-71-320 reserved.

50-71-321. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 18, Ch. 341, L. 1969; amd. Sec. 14, Ch. 182, L. 1975; R.C.M. 1947, 41-1725; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 1, Ch. 307, L. 1997.

50-71-322. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 19, Ch. 341, L. 1969; amd. Sec. 15, Ch. 182, L. 1975; R.C.M. 1947, 41-1726; amd. Sec. 64, Ch. 613, L. 1989.

50-71-323. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 10, Ch. 341, L. 1969; amd. Sec. 6, Ch. 182, L. 1975; R.C.M. 1947, 41-1717; amd. Sec. 64, Ch. 613, L. 1989; amd. Sec. 11, Ch. 514, L. 1995.

50-71-324. Repealed.

SSec. 22, Ch. 27, L. 2009.

History: En. Sec. 12, Ch. 341, L. 1969; amd. Sec. 8, Ch. 182, L. 1975; R.C.M. 1947, 41-1719; amd. Sec. 64, Ch. 613, L. 1989.

50-71-325. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 11, Ch. 341, L. 1969; amd. Sec. 7, Ch. 182, L. 1975; R.C.M. 1947, 41-1718(1) thru (4); amd. Sec. 23, Ch. 37, L. 1979; amd. Sec. 1, Ch. 277, L. 1983; amd. Sec. 64, Ch. 613, L. 1989.

50-71-326. Repealed.

Sec. 22, Ch. 27, L. 2009.

History: En. Sec. 11, Ch. 341, L. 1969; amd. Sec. 7, Ch. 182, L. 1975; R.C.M. 1947, 41-1718(5); amd. Sec. 64, Ch. 613, L. 1989.

50-71-327. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 13, Ch. 341, L. 1969; amd. Sec. 9, Ch. 182, L. 1975; R.C.M. 1947, 41-1720; amd. Sec. 64, Ch. 613, L. 1989.

50-71-328 through 50-71-330 reserved.

50-71-331. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 15, Ch. 341, L. 1969; amd. Sec. 11, Ch. 182, L. 1975; R.C.M. 1947, 41-1722; amd. Sec. 64, Ch. 613, L. 1989.

50-71-332. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 16, Ch. 341, L. 1969; amd. Sec. 12, Ch. 182, L. 1975; R.C.M. 1947, 41-1723; amd. Sec. 64, Ch. 613, L. 1989.

50-71-333. Repealed.

Sec. 22, Ch. 27, L. 2009

History: En. Sec. 17, Ch. 341, L. 1969; amd. Sec. 13, Ch. 182, L. 1975; R.C.M. 1947, 41-1724; amd. Sec. 64, Ch. 613, L. 1989.

50-71-334. Repealed.

Sec. 22, Ch. 27, L. 2009.

History: En. Sec. 14, Ch. 341, L. 1969; amd. Sec. 10, Ch. 182, L. 1975; R.C.M. 1947, 41-1721; amd. Sec. 64, Ch. 613, L. 1989.