HOUSE BILL NO. 622

INTRODUCED BY R. LYNCH

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING CHOICE OF TREATING PHYSICIAN FOR WORKERS' COMPENSATION TREATMENT; ALLOWING AN INSURER OR INJURED WORKER TO MAKE ONE DISPUTED CHANGE EACH UPON PAYMENT OF A CHANGE FEE; REQUIRING NOTICE OF A MEDIATION OPTION; REQUIRING A TREATING PHYSICIAN TO BE DESIGNATED IF AN INJURED WORKER IS UNABLE TO RETURN TO WORK WITHIN 1 MONTH OF BEING INJURED; PROVIDING A PENALTY FOR AN INSURER'S FAILURE TO PAY A CHANGE FEE; AMENDING SECTIONS 39-71-201 AND 39-71-1101, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

Section 1. Section 39-71-201, MCA, is amended to read:

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

(a) all fees and penalties provided in 39-71-107, 39-71-205, 39-71-223, 39-71-304, 39-71-307, 39-71-315, 39-71-316, 39-71-401(6), 39-71-1101, 39-71-2204, 39-71-2205, and 39-71-2337;

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

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

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

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from

assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

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

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

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

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

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

(i) one installment due on July 1; or

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

(d) If an employer fails to timely pay to the department the assessment under this section, the department may impose on the employer an administrative fine of $500 plus interest on the delinquent amount

at the annual interest rate of 12%. Administrative fines and interest must be deposited in the workers' compensation administration fund.

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

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

(i) one installment due on July 1; or

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

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

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

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

by the department by not later than April 30. The resulting rate, expressed as a percentage, is levied against the premium paid by each employer enrolled under compensation plan No. 2 or plan No. 3 in the next fiscal year.

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

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

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

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

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

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

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

(11) The administration fund must be debited with expenses incurred by the department in the general administration of the provisions of this chapter, including the salaries of its members, officers, and employees and

the travel expenses of the members, officers, and employees, as provided for in 2-18-501 through 2-18-503, incurred while on the business of the department either within or without the state.

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

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

Section 2. Section 39-71-1101, MCA, is amended to read:

"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~~ penalty. (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~~ A worker may choose a person who is listed in 39-71-116(41) for initial treatment. Subject to ~~subsection (2)~~ subsections (3) and (4), if the person listed under 39-71-116(41) chosen by the worker agrees to comply with the requirements of subsection (2), that person is the treating physician.

(2) ~~Any time after acceptance of liability by an insurer, the insurer may designate or approve a treating physician~~ A person listed under 39-71-116(41), whether chosen by the injured worker and approved by the insurer or designated by the insurer as provided in subsection (3) or (11), 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) (a) At any time after acceptance of liability by an insurer, the insurer may approve the injured worker's initial choice of a person listed under 39-71-116(41) and determine whether that person agrees to be a treating

physician as provided in subsection (2).

(b) If the insurer that has accepted liability disagrees with the injured worker's choice as provided in subsection (1), the insurer may redesignate a health care provider and notify the injured worker and the department of the redesignation. A redesignation under this subsection (3)(b) requires the insurer to pay to the department a $50 change fee.

(4) (a) After at least one visit to the insurer's choice of health care provider, as provided in subsection (3) or (11), an injured worker may continue treatment with that health care provider, return to the health care provider who provided initial treatment, or choose a separate health care provider. An injured worker who does not accept the insurer's designated choice of health care provider shall pay a $50 change fee and notify the department, unless the provisions of subsection (4)(b)(i) apply.

(b) (i) If the insurer approves the alternate health care provider selected by the injured worker under subsection (4)(a), the injured worker is not subject to the $50 change fee.

(ii) If the insurer does not approve the alternate health care provider selected by the injured worker and does not take the dispute to mediation, the insurer shall pay for the services of the alternate health care provider, and the injured worker shall pay a $50 change fee to the department.

(iii) If the injured worker is unable to return to work within 1 month after being injured and a treating physician has not been approved or designated by the insurer or treatment has not been initiated, the dispute over a health care provider must be taken to mediation.

(5) The department shall indicate in the notice of benefits required under 39-71-606 that an injured worker and the insurer each have one change of a health care provider for which a change fee may be required and that mediation is required, as provided in subsection (4)(b)(iii), if a dispute remains on the choice of health care provider or treating physician.

~~(3)~~(6) ~~The~~ After being appointed, a treating physician may refer ~~the~~ an injured worker to other health care providers for medical services, as provided in 39-71-704, for the treatment of ~~a~~ the 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)~~(7) The treating physician designated or approved by the insurer must be reimbursed at 110% of the department's fee schedule.

~~(5)~~(8) 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)~~(9) 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)~~(10) 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)~~ (7) through ~~(6)~~ (9) of this section apply to the medical service on the date on which the medical service was provided.

~~(8)~~(11) The insurer may direct the worker to a managed care organization or a preferred provider organization for designation of the treating physician.

~~(9)~~(12) ~~After~~ If 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 or preferred provider organization may not provide treatment unless authorized by the insurer or unless the injured worker has paid a change fee under subsection (4).

~~(10)~~(13) After the date that a worker ~~[whose injury is]~~ who is subject to the provisions of subsection ~~(9)~~ (12) 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~~ Subject to the provisions of subsection (4)(b)(ii), 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)~~(14) 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.

(15) An insurer that fails to pay a change fee as provided in subsection (3)(b) is subject to a $500 fine that must be deposited as provided in 39-71-201."

NEW SECTION. **Section 3. Effective date.** [This act] is effective July 1, 2015.

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