MONTANA
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REGISTER

DEPARTMENT OF LABOR AND INDUSTRY

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-110.1

Summary

Updates to Workers' Compensation rules including removal of billing prohibition for medical status forms, implementation of House Bill 428, and annual update of the Utilization and Treatment Guidelines

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Hearing Date and Time

Thursday, November 6, 2025, at 1:00 p.m.

Virtual Hearing Information

A public hearing will be held via remote conferencing to consider the proposed changes to the agency's rules. There will be no in-person hearing. Interested parties may access the remote conferencing platform in the following ways:

Join Zoom Meeting: https://mt-gov.zoom.us/j/81672552694

Meeting ID: 816 7255 2694; Password: 1529968275

Dial by Telephone: +1 646 558 8656

Meeting ID: 816 7255 2694; Password: 1529968275

Comments

Concerned persons may present their data, views, or arguments at the hearing. Written data, views, or arguments may also be submitted at dli.mt.gov/rules or P.O. Box 1728, Helena, Montana 59624. Comments must be received by Friday, November 7, 2025, at 5:00 p.m.

Accommodations

The agency will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. Requests must be made by Thursday, October 30, 2025, at 5:00 p.m.

Contact

Department of Labor and Industry
(406) 444-5466
laborlegal@mt.gov
Montana Relay: 711

Rulemaking Actions

AMEND

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

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 ~~treatment plan~~ 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.

Authorizing statute(s): 39-71-203, MCA

Implementing statute(s): 39-71-704, MCA

Reasonable Necessity Statement

The proposed amendments to (3)(b) are necessary to provide consistent language with the proposed amendments to ARM 24.29.1515, described in the reasonable necessity statement below.

The proposed amendments to (4) are necessary to remove the prohibition on offering reimbursement for the medical status form which allows insurers to incentivize a provider's timely and accurate completion of the medical status form. A provider's timely and accurate completion of a medical status form helps facilitate safe and timely return-to-work efforts that benefit workers, employers, and insurers.

24.29.1515 FUNCTIONAL IMPROVEMENT STATUS

(1) Functional improvement status must ~~identify objective medical findings of the claimant's medical status, and note the effect of the medical services (positive, neutral, or negative), with respect to the goals of the treatment plan~~ consist of objective 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.

Authorizing statute(s): 39-71-203, MCA

Implementing statute(s): 39-71-704, 39-71-1036, MCA

Reasonable Necessity Statement

The proposed amendments are necessary because the 2025 Legislature passed House Bill 428, 2025 Mont. Laws Chapter 428, effective October 1, 2025, that amends the requirements for medical status forms found in 39-71-1036, MCA. To protect patient privacy, medical status forms are no longer required to contain a claimant's medical treatment plan or medications prescribed to a claimant. The proposed amendments are necessary because a medical status form is designed to communicate the claimant's functional status, improvement, and goals, and not a claimant's medical treatment plan.

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 Resource-Based 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~~, excluding the Medical Status Form~~.

(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.

Authorizing statute(s): 39-71-203, MCA

Implementing statute(s): 39-71-704, MCA

Reasonable Necessity Statement

The proposed amendments to (8)(d) are necessary to remove the prohibition on offering reimbursement for the medical status form, as described in the reasonable necessity statement for ARM 24.29.1513(4).

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 ~~July 1, 2023~~ [the effective date of this rule adoption]: "Montana Utilization and Treatment Guidelines, ~~8th~~ 9th edition, ~~2023~~ 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 (7).

(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.

Authorizing statute(s): 39-71-203, 39-71-704, MCA

Implementing statute(s): 39-71-704, MCA

Reasonable Necessity Statement

The proposed amendments to (1)(a) adopting the 2025 Montana Guidelines are necessary under the statutory mandate in 39-71-704, MCA. In addition to the comprehensive update to the shoulder injury chapter, the department is proposing updates to other chapters to make specific sections consistent with the Guidelines updated in 2023 and 2025. Specifically, the department is proposing updates to the psychologist licensure requirements for cognitive behavioral therapy, and language clarification in the positive patient response general guideline principle. Each proposed change in the 9th edition of the Montana Guidelines is available for review on the department's website.

Small Business Impact

The group or class of small businesses that will likely be affected by the proposed rule changes include small business insurance providers of workers' compensation coverage, and small-business medical providers that work as treating physicians for workers' compensation claimants, including physicians, physician assistants, chiropractors, osteopaths, dentists, and physical therapists.

The proposed rule changes will likely have a positive effect on small businesses because insurance providers can now provide an incentive for treating physicians to complete the medical status forms. The timely and accurate completion of medical status forms helps to facilitate safe and timely return-to-work efforts. Safe and timely return-to-work efforts contribute to cost-savings for insurance providers and medical providers in the workers' compensation context.

Bill Sponsor Notification

The bill sponsor contact requirements apply and have been fulfilled. The primary bill sponsor was contacted on April 15, 2025, by electronic mail.

Interested Persons

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

Rule Reviewer

Quinlan L. O'Connor

Approval

Sarah Swanson, Commissioner