MONTANA
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REGISTER

DEPARTMENT OF LABOR AND INDUSTRY

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2025-30.1

Summary

2025 Updates to Medical Fee Schedules and Formulary - Implementation of House Bill 143 and Senate Bill 109 of the 2025 Montana Legislature

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Hearing Date and Time

Thursday, May 29, 2025, at 9:00 a.m.

Virtual Hearing Information

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

Join Zoom Meeting: https://mt-gov.zoom.us/j/81908578685

Meeting ID: 819 0857 8685; Password: 876600

Dial by Telephone: +1 646 558 8656

Meeting ID: 819 0857 8685; Password: 876600

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, June 6, 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, May 22, 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:

24.29.617 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 ~~ARM 24.29.804~~ 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.

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

Implementing statute(s): 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, MCA

Reasonable Necessity Statement

The proposed amendment is necessary to correct a reference to a repealed rule, ARM 24.29.804, and provide reference to the proper statute, 39-71-107, MCA.

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 ~~ARM 24.29.804~~ 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 self-insurance 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.

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

Implementing statute(s): 39-71-403, 39-71-2101, 39-71-2102, 39-71-2103, 39-71-2106, MCA

Reasonable Necessity Statement

The proposed amendment is necessary to correct a reference to a repealed rule, ARM 24.29.804, and provide reference to the proper statute, 39-71-107, MCA.

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" for the period from April 1, 2018, through June 30, 2024; and~~

~~(b)~~(a) "Montana Workers Compensation Housing, Rent or Lodging Monthly Rates, ~~2024~~ 2025" beginning July 1, ~~2024~~ 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.

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

Implementing statute(s): 39-71-123, MCA

Reasonable Necessity Statement

The proposed repeal and replacement of (2)(a) is necessary because the U.S. Department of Housing and Urban Development (HUD) reported increases to Fair Market Rent rates for both 2024 and 2025. The average increase to HUD’s Fair Market Rent rates in 2024 was 8% and the

average increase for 2025 is 17%. The proposed adoption of new (2)(b) is necessary to simplify the rule and clarify that historical rates can be accessed online.

24.29.801 ACCIDENT REPORTING

(1) A ~~plan No. 1 or~~ 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.

Authorizing statute(s): 39-71-203, 39-71-307, MCA

Implementing statute(s): 39-71-307, 39-71-603, MCA

Reasonable Necessity Statement

The proposed amendments are necessary because plan No. 2 and plan No. 3 employers are required to file reports to the employers' insurer pursuant to 39-71-307(1), MCA. The rule mistakenly refers to plan No. 1 employers which are self-insured for workers' compensation purposes.

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" ~~means a provider~~ 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 those persons identified by 33-22-111, MCA, practicing within the scope of the providers' license.~~ 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 ~~24.29.1517~~ 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 treating physician must identify the scope of the referral in the treatment plan and provide guidance to the provider concerning the nature of the injury or occupational disease.

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

Implementing statute(s): 39-71-116, 39-71-704, MCA

Reasonable Necessity Statement

The proposed amendments to the definitions of "designated treating physician" and "physician" to include the statutory reference to 39-71-116, MCA, are necessary to provide clarity and consistency of definitions throughout these rules. The updated statutory references are also necessary because the 2025 Legislature passed House Bill 143, 2025 Montana Laws, Chapter 133, which has an immediate effective date upon passage and approval. House Bill 143 updates the statutory definition for "treating physician" under 39-71-116, MCA, and expands the ability of a physician assistant to serve as a treating physician under 39-71-116, MCA. The proposed rule amendment is further necessary because effective October 1, 2025, Senate Bill 109, 2025 Montana Legislature, further updates the definition of "treating physician" to include physical therapists.

The proposed amendment is necessary to correct the definition of "prior authorization" to remove a reference to a repealed rule, ARM 24.29.1517, and provide the correct reference to ARM 24.29.1621.

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, ~~2024~~ 2025, is ~~$10,141~~ $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, ~~2024~~ 2025, is ~~$130~~ $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, ~~2024~~ 2025, is ~~$98~~ $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.

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

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

Reasonable Necessity Statement

The proposed amendments to (11)(a)(i), (12)(a)(i) and (12)(b)(i) are necessary to update the base rates for services as part of the department's annually established medical fee schedules required by 39-71-704(2), MCA.

24.29.1538 CONVERSION FACTORS

(1) The conversion factors established by the department for goods and services, other than anesthesia services are:

(a) ~~$60.47~~ $61.09 on or after July 1, ~~2024~~ 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) ~~$65.73~~ $71.78 on or after July 1, ~~2024~~ 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.

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

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

Reasonable Necessity Statement

The proposed amendments to (1)(a) and (2)(a) are necessary to update the conversion factors as part of the department's annually established medical fee schedules required by 39-71-704(2), MCA.

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 ~~ARM 24.29.1401A~~ 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.

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

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

Reasonable Necessity Statement

The proposed amendment is necessary to correct the definition of “treating physician” from the cited rule to the proper statutory reference in 39-71-116, MCA. The proposed amendment is further necessary for consistency and to implement the 2025 Legislature’s House Bill 143 and Senate Bill 109 as described in the Reasonable Necessity Statement for ARM 24.29.1401A above.

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, ~~2024~~ 2025, the April ~~2024~~ 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.

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

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

Reasonable Necessity Statement

The proposed amendments to (2)(a) are necessary to update the department's commercial drug formulary which is adopted and must be annually updated under 39-71-704(3)(b), MCA. The automatic monthly update process for the department's commercial drug formulary is expressly adopted in 2-4-307(8), MCA.

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.

~~(2)~~(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.

~~(3)~~(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.

~~(4)~~(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.

~~(5)~~(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.

~~(6)~~(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.

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

Implementing statute(s): 39-71-717, MCA

Reasonable Necessity Statement

The proposed amendments adopting (2) are necessary to clarify the department's review of a petition to reopen medical benefits pursuant to 39-71-717, MCA. Reference to the statute, 39-71-717, MCA, is necessary because it contains more specific requirements for a petition to reopen medical benefits including the type of medical benefits that may be reopened, 39-71-717(1), MCA, and the statute of limitations for filing a petition to reopen, 37-71-717(5), MCA. The proposed amendments further clarify when the 60-day medical review period begins, as referenced in 39-71-717(8), MCA.

Small Business Impact

Pursuant to 2-4-111(1), MCA, the small businesses that will probably be affected by the proposed rule change to ARM 24.29.721 are all small-business housing providers including independent landlords, small rental and property management companies, and small hotels and motels. The agency has determined that the proposed rule change will have a positive significant and direct impact on small businesses because the proposed change to the rates is based on HUD's Fair Market Value average rate increase for 2025 of 17%.

Bill Sponsor Notification

The primary bill sponsors were contacted on April 15, 2025, and April 24, 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