



**MONTANA
ADMINISTRATIVE
REGISTER**



DEPARTMENT OF LABOR AND INDUSTRY

NOTICE OF PROPOSED RULEMAKING

MAR NOTICE NO. 2026-88.1

Summary

2026 Updates to Medical Fee Schedules and Formulary

Hearing Date and Time

Thursday, May 28, 2026, at 9:00 a.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/81550905636>

Meeting ID: 815 5090 5636; Password: 0304343607

Dial by Telephone: +1 646 558 8656

Meeting ID: 815 5090 5636; Password: 0304343607

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 5, 2026, 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 21, 2026, at 5:00 p.m.

Contact

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

General Reasonable Necessity Statement

The proposed rule amendments are reasonably necessary to reflect the 2026 updates to the Medical Fee Schedules and Formulary.

Rulemaking Actions

AMEND

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

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~~ 2026" beginning July 1, ~~2025~~ 2026.
- (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 significant increases to Fair Market Rent rates for 2026. The average increase to HUD's Fair Market Rent rates for 2026 is 20%. It is reasonably necessary to update this rule as the 20% increase identified by HUD is a significant value change impacting fair market rental rates in Montana.

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~~ 2026, is ~~\$10,384~~ 10,623.
- (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~~ 2026, is ~~\$133~~ 136.
 - (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~~ 2026, is ~~\$100~~ 102.
 - (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

It is reasonably necessary to amend these rules to reflect the changes to the facility service rates. The changes to the rates were identified by the National Council on Compensation Insurance (NCCI). The NCCI calculated the Workers' Compensation Weighted Medical Price Index (WCWMI), an inflationary factor that accounts for both the medical price index and the producer price index. It was weighted using their medical call data to better match the mix of spend of workers' compensation. Reimbursement for the facility base rates will increase by 2.3%, according to the August 2025 WCWMI, published at the time of committee review.

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~~ 59.72 on or after July 1, ~~2025~~ 2026.

- (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~~ 68.20 on or after July 1, ~~2025~~ 2026.
 - (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 are reasonably necessary to update the maximum allowable reimbursements (MARs) in Montana's physician fee schedule. The proposed MARs reflect Medicare's 2025 Resource-Based Relative Value Scale (RBRVS). If adopted, the proposed physician fee schedule would be updated to reflect Medicare's 2026 RBRVS.

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~~ 2026, the April ~~2025~~ 2026 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 are reasonably necessary to incorporate by reference the updated applicable drug formulary effective July 1, 2026, as authorized by 39-71-704, 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 2026 of 20%.

Bill Sponsor Notification

The bill sponsor contact requirements do not apply.

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