BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.29.1401A, 24.29.1402, 24.29.1404, 24.29.1406, 24.29.1407, 24.29.1408, 24.29.1409, 24.29.1433, 24.29.1534, 24.29.1538, and 24.29.1616 and the repeal of ARM 24.29.1415 and 24.29.1432 pertaining to workers' compensation	))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On June 4, 2024, at 9:00 a.m., 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:

a. Join Zoom Meeting, https://mt-gov.zoom.us/j/88376081707
Meeting ID: 883 7608 1707, Passcode: 569883
-OR-

b. Dial by telephone, +1 406 444 9999 or +1 646 558 8656
Meeting ID: 883 7608 1707, Passcode: 569883

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., on May 28, 2024, to advise us of the nature of the accommodation that you need. Please contact the department at P.O. Box 1728, Helena, Montana 59624-1728; telephone (406) 444-5466; Montana Relay 711; or e-mail laborlegal@mt.gov.

3. <u>GENERAL STATEMENT OF REASONABLE NECESSITY</u>: There is necessity to substantially review and revise subchapter 14 of the workers' compensation rules to clarify, simplify, and increase usability of the rules. The proposed amendments eliminate duplication of statute, repeal inapplicable and invalid rules, and clarify departmental processes for all interested parties who use the workers' compensation rules. This rulemaking is in furtherance of Executive Order 1-2021 and efforts to reduce red tape in administrative rules. The proposed amendments also incorporate the statutorily required annual updates to the department's workers' compensation medical fee schedule, utilization and treatment guidelines, and prescription drug formulary.

4. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

24.29.1401A DEFINITIONS As used in subchapters 14 and 15, the following definitions apply:

(1) through (9) remain the same.

~~(10) "Department" means the Montana Department of Labor and Industry.~~

(11) through (20) remain the same but are renumbered (10) through (19).

~~(21) "Insurer" has the same meaning as provided by 39-71-116, MCA.~~

(22) remains the same but is renumbered (20).

~~(23) "Maintenance care" has the same meaning as provided by 39-71-116, MCA.~~

~~(24) "Medical stability", "maximum medical improvement", "maximum healing", or "maximum medical healing" has the same meaning as provided by 39-71-116, MCA.~~

(25) through (28) remain the same but are renumbered (21) through (24).

~~(29) "Palliative care" has the same meaning as provided by 39-71-116, MCA.~~

(30) remains the same but is renumbered (25).

~~(31) "Primary medical services" has the same meaning as provided by 39-71-116, MCA.~~

(32) through (35) remain the same but are renumbered (26) through (29).

~~(36) "Secondary medical services" has the same meaning as provided by 39-71-116, MCA.~~

(37) and (38) remain the same but are renumbered (30) and (31).

~~(39) "Treating physician" means:~~

~~(a) with respect to claims arising before July 1, 1993, the meaning provided by ARM 24.29.1511;~~

~~(b) with respect to claims arising on or after July 1, 1993, the meaning provided by 39-71-116, MCA.~~

(40) remains the same but is renumbered (32).

AUTH: 39-71-203, MCA
IMP: 39-71-116, 39-71-704, MCA

REASON: The proposed amendments striking sections (10), (21), (23), (24), (29), (31), (36), and (39)(b) are necessary because the definitions are duplicative of the statutory definitions in 39-71-116, MCA. Reasonable necessity exists to repeal the definition of "treating physician" in (39)(a) because the cross-reference to ARM 24.29.1511 is invalid as of that rule's repeal in 2019.

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) ~~As required by 39-71-704, MCA, charges submitted by providers must be the usual and customary charge billed for nonworkers' compensation patients.~~ Payment of medical claims must be made in accordance with the schedule of facility and professional medical fees adopted by the department.

(a) ~~For services provided on or after July 1, 2011, payment~~ Payment of medical claims must also be made in accordance with the utilization and treatment guidelines adopted by the department in ARM Title 24, chapter 29, subchapter 16.

(b) ~~For services provided on or after July 1, 2013, the~~ The department may assess a penalty on insurers for neglect or failure to use the correct fee schedule. It

is the insurer's responsibility to ensure that the correct fee schedule is used by a third-party agent.

~~(i) If the insurer does not properly process the entire medical bill using the correct fee schedule within 60 days of the receipt, the department may assess a $200.00 penalty for each occurrence. Each medical bill is an occurrence.~~

~~(ii) This fine may be increased $100.00 per subsequent occurrence up to a maximum of $1,000.00.~~

~~(iii) The department will not assess any penalty unless the provider submits adequate documentation that they attempted to resolve the bill with the insurer. If the insurer does not correct the error, the provider may forward the billing, explanation of benefits, if any, and documentation of contact and responses to the department.~~

~~(iv) The insurer has the burden of proof to notify the department either by e-mail, facsimile, or letter that the bill(s) in question have been processed using the correct Montana fee schedule.~~

~~(v) The amounts collected from the insurer must be deposited with the department to be used in the Workers' Compensation Administration Fund.~~

~~(vi) An insurer may contest a penalty assessed pursuant to 39-71-107(5)(b), MCA, in a hearing conducted according to department rules. A party may appeal the final agency order to the Workers' Compensation Court. The court shall review the order pursuant to the requirements of 2-4-704, MCA.~~

(c) remains the same.

(2) The insurer shall make timely payments of all medical bills for which liability is accepted. For services provided on or after July 1, 2013, the department may assess a penalty on an insurer that without good cause neglects or fails to pay undisputed medical bills on an accepted liability claim within 60 days of receipt of the bill(s). The insurer must document receipt date of the bill(s) or the receipt date will be three days after the bill(s) was sent by the provider.

~~(a) If the insurer does not pay the undisputed portions of a medical bill within 60 days of receipt, the department may assess a $200.00 penalty for each occurrence. Each medical bill is an occurrence.~~

~~(b) This fine may be increased $100.00 per subsequent occurrence up to a maximum of $1,000.00.~~

~~(c) The department will not assess any penalty unless the provider submits adequate documentation that they attempted to resolve the bill with the insurer. If the insurer does not pay the undisputed bill(s), the provider may forward the billing, explanation of benefits, if any, and documentation of contact and responses to the department.~~

~~(d) The insurer has the burden of proof to notify the department either by e-mail, facsimile, or letter that the bill(s) in question have been paid.~~

~~(e) The amounts collected from the insurer must be deposited with the department to be used in the Workers' Compensation Administration Fund.~~

~~(f) An insurer may contest a penalty assessed pursuant to 39-71-107(5)(c), MCA, in a hearing conducted according to department rules. A party may appeal the final agency order to the Workers' Compensation Court.~~

(3) ~~For services provided on or after July 1, 2013, the provider may charge 1 percent per month simple interest for unpaid balances on an undisputed medical bill~~

~~on a claim pursuant to 39-71-704, MCA. The interest will start accruing on the 31st day after receipt of the bill by the insurer. The insurer must document receipt date of the bill or the receipt date will be three days after the bill was sent by the provider. If there is no payment within 30 days, the provider may bill the insurer 1 percent per month on the unpaid balance.~~ For purposes of coding ~~billed amounts,~~ interest billing on unpaid charges, providers must bill the interest amount using the Montana unique code MT005 ~~is~~ established by this rule ~~and must be used by the provider to bill the interest amount~~.

~~(4) For services provided on or after July 1, 2013, the insurer may charge a 1 percent per month simple interest for overpayment made to a provider pursuant to 39-71-704, MCA. The interest will start accruing on the 31st day after receipt by the provider of the reimbursement request. The provider must document the receipt date of the reimbursement request or the receipt date will be three days after the request was sent by the insurer. If there is no payment within 30 days of the provider's receipt of a reimbursement request or if the provider has not made alternative arrangements for repaying the overpayment within 30 days, the insurer may charge the provider 1 percent per month simple interest on the balance.~~

(5) and (6) remain the same but are renumbered (4) and (5).

~~(7) For claims arising before July 1, 1993, no fee or charge is payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.~~

(8) and (9) remain the same but are renumbered (6) and (7).

~~(10) For injured workers who are receiving benefits from the Uninsured Employers' Fund pursuant to 39-71-503, MCA, the provisions of this rule are subject to 39-71-510, MCA.~~

AUTH: 39-71-203, MCA
IMP: 39-71-107, 39-71-203, 39-71-510, 39-71-704, MCA

REASON: The proposed amendment striking a portion of (1) is necessary because it duplicates 39-71-704(2)(a), MCA. Reasonable necessity exists to update the implementation statutes to clarify the authority for monetary penalties as set forth in this rule. Reasonable necessity exists to strike the penalty portions of (1) and (2) because, to the extent they are not duplicative of statute, they set forth business process which need not be stated in rule. Reasonable necessity exists to strike the majority of (3) and (4) because they are duplicative of 39-71-704(6)-(7), MCA. Reasonable necessity exists to strike (7) as it applies to date of injury before 1993, over 30 years ago. Reasonable necessity exists to strike (10) because it is not necessary to state in rule that statute supersedes rule.

24.29.1404 DISPUTED MEDICAL CLAIMS (1) ~~After mediation, disputes between an insurer and a medical service provider arising over the amount of a fee for medical services are resolved by a hearing before the department upon written application of a party to the dispute or the injured worker.~~ The following issues are considered to be disputes arising over the amount of a fee for medical services:

(a) through (d) remain the same.

~~(2) All other disputes arising over medical claims, including travel expense reimbursement to injured workers, shall be brought before a department mediator as provided in part 24 of the Workers' Compensation Act.~~

(3) and (4) remain the same but are renumbered (2) and (3).

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

REASON: The proposed amendment striking a portion of (1) is necessary to align the rule with 39-71-704(10), MCA, which specifies that disputes between insurers and providers, after mediation, proceed directly to the Workers' Compensation Court for resolution, rather than through a departmental contested case hearing. Reasonable necessity exists to strike (2) because it is unnecessary to state in rule that disputes regarding benefits proceed through the normal course.

24.29.1406 FACILITY BILLS (1) remains the same.

(2) The providers and payers shall use, when possible, electronic billing for the billing and reimbursement process ~~in order to facilitate rapid transmission of data, lessen the opportunity for errors, and lessen system costs~~.

(3) It is the responsibility of the facility to use the proper service 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.~~

~~(4) Except as provided in (3), insurers must make timely payments of facility bills. In cases where there is no dispute over liability for the condition, the insurer must, within 30 days of receipt of a facility's charges, pay the charges according to the rates established by these rules.~~

(5) remains the same but is renumbered (4).

AUTH: 39-71-203, MCA
IMP: 39-71-105, 39-71-107, 39-71-203, 39-71-704, MCA

REASON: The proposed amendments striking portions of (2) and (3) are necessity because extra wording is not needed. Reasonable necessity exists to strike (4) because it duplicates 39-71-704(6)(a), MCA.

24.29.1407 PROSTHETIC APPLIANCES (1) remains the same.

~~(2) For services provided on or after July 1, 2011, claims must be paid in accordance with the utilization and treatment guidelines adopted by the department in ARM 24.29.1591.~~

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: The proposed amendment striking (2) is necessary because the Utilization and Treatment Guidelines requirements are listed in ARM 24.29.1611, and the guidelines do not direct payment of claims.

24.29.1408 SUSPENSION ALLOWED (1) An insurer may suspend compensation payments under 39-71-607, MCA, for not more than 30 days pending the receipt of medical information, if:

(a) the insurer submits to the department a detailed written statement indicating that the insurer is having difficulty in receiving medical information relating to a claimant's condition; ~~and~~

(b) and (c) remain the same.

AUTH: 39-71-607, MCA
IMP: 39-71-607, MCA

REASON: The proposed amendment is necessary to simplify grammar.

24.29.1409 TRAVEL EXPENSE REIMBURSEMENT ~~(1) For claims arising before July 1, 1989, reimbursement for travel expenses shall be determined as follows:~~

~~(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider.~~

~~(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.~~

~~(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.~~

~~(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.~~

~~(e) Requests for travel reimbursement must be made within a reasonable time following the date(s) the travel was incurred.~~

~~(2) For claims arising during the period July 1, 1989, through June 30, 1993, reimbursement for travel expenses shall be determined as follows:~~

~~(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider. When the travel coincides in whole or in part with the injured worker's regular travel to or from the worker's employment, the coincident mileage may be subtracted from the reimbursable mileage. For each calendar month, the first 50 miles of automobile mileage is not reimbursable.~~

~~(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.~~

~~(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.~~

~~(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.~~

~~(e) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for reimbursement that are not submitted within 90 days may be denied by the insurer.~~

~~(3) For claims arising from July 1, 1993, through June 30, 2001, travel expenses are not reimbursed unless the travel is at the request of the insurer. Travel is "at the request of the insurer" when the insurer directs the claimant to: change treating physician; attend an independent medical examination; use a preferred provider; or be treated by a managed care organization. If travel expenses are to be reimbursed, then reimbursement shall be determined as follows:~~

~~(a) Personal automobile and private airplane mileage expenses shall be reimbursed at the current rates specified for state employees. Prior authorization from the insurer is required for the use of a private airplane. Total reimbursable automobile miles shall be determined according to the most direct highway route between the injured worker's residence and the provider. For each calendar month, the first 50 miles of automobile mileage is not reimbursable. In addition, travel within the community in which the worker resides shall not be reimbursed.~~

~~(b) Expenses for eligible meals shall be reimbursed at the meal rates established for state employees.~~

~~(c) Actual out-of-pocket receipted lodging expenses incurred by injured workers shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by an original receipt from a licensed lodging facility. If the injured worker stays in a nonreceiptable facility, or fails to obtain a receipt, the reimbursement is the amount set for state employees for nonreceipted lodging.~~

~~(d) Miscellaneous transportation expenses, such as taxi fares or parking fees, are reimbursable and must be supported by paid receipts.~~

~~(e) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for reimbursement that are not submitted within 90 days may be denied by the insurer.~~

~~(4)~~ (1) ~~For claims arising on or after July 1, 2001, payment~~ Payment of travel expense is subject to the following:

~~(a) Claims for reimbursement of travel expenses must be submitted within 90 days of the date the expenses are incurred, on a form furnished by the insurer. Claims for travel expense reimbursement that are not submitted within 90 days may be denied by the insurer. The insurer must notify the injured worker in writing that the request for travel expense reimbursement must be submitted within 90 days from the date the expense was incurred in order to be reimbursed. If the insurer fails to notify the claimant of the claimant's entitlement to travel expenses and 90 days have passed since the expense was incurred, the insurer must pay the travel.~~

(a) Claims for travel reimbursement must be submitted on a form provided by the insurer within 90 days of the date the expense was incurred. After 90 days, the insurer must make reimbursement, unless, during the 90 days that the reimbursement was available:

(i) the insurer has proof of providing written notice to the injured worker that travel reimbursement is available; and

(ii) the written notice stated that a travel reimbursement claim must be submitted to the insurer within 90 days of the worker incurring the expense.

(b) through (e) remain the same.

(f) Reimbursement for travel expenses shall be determined as follows:

(i) and (ii) remain the same.

(iii) Actual out-of-pocket receipted lodging expenses incurred by the claimant shall be reimbursed up to the maximum amounts established for state employees. Lodging in those areas specifically designated as high cost cities shall be reimbursed at actual cost. Any claim for receipted or high cost lodging reimbursement must be accompanied by ~~an original~~ a receipt from a licensed lodging facility. If the claimant ~~stays in a nonreceiptable facility, or~~ fails to obtain a receipt, the reimbursement is the amount set for state employees ~~for nonreceipted lodging~~.

(iv) remains the same.

(5) remains the same but is renumbered (2).

~~(6) For occupational disease claims arising prior to July 1, 2005, if liability has not been accepted on the claim and the department schedules a medical examination as provided in 39-72-602, MCA, the insurer shall reimburse the claimant for the travel expenses incurred for the examination pursuant to this rule.~~

~~(7) The department shall make available to interested parties the specific information referenced in this rule concerning rates for transportation, meals, and lodging; meal time ranges; and designations of high cost cities. The department shall inform interested parties in a timely manner of all applicable updates to this information.~~

AUTH: 39-71-203, ~~39-72-203, 39-72-402,~~ MCA
IMP: 39-71-704, ~~39-72-602, 39-72-608,~~ MCA

REASON: The proposed amendments striking (1), (2), and (3) are necessary because the sections address historical claims dating before July 1, 2001. The proposed amendments striking (6) is necessary because it addresses claims dating before July 1, 2005. It is not necessary to maintain this information in rule, and historical information regarding workers' compensation claims can be accessed by

contacting the department. The proposed amendment striking (7) is necessary because it is duplicative of the statute requiring the department to determine travel reimbursement rates in rule, 39-71-704(1), MCA, and the statute requiring the department to maintain and update interested parties' lists, 2-4-302(2)(b), MCA. Furthermore, (7) is not necessary because the department's website is consistently updated with current and accurate information. Reasonable necessity exists to shorten (4)(a) to condense and make travel reimbursement clearer. There is reasonable necessity to update the authorizing and implementing statutes because the cited statutes have been repealed.

24.29.1433 FACILITY SERVICE RULES AND RATES ~~FOR SERVICES PROVIDED ON OR AFTER JULY 1, 2013~~ (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 ~~Employment Relations Division~~ 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) through (c) remain the same.

(d) All current and prior instruction sets for services provided starting July 1, 2013, are available on the department's website. ~~A copy of any instruction set for services provided starting July 1, 2013, through the present may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

(2) through (10) remain the same.

(11) The following applies to inpatient services provided at an acute care hospital:

(a) remains the same.

(i) The base rate effective July 1, ~~2023~~ 2024, is $~~10,011~~ 10,141.

(ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the base rates for services provided starting July 1, 2013, may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

(b) through (g) remain the same.

(12) The following applies to outpatient services provided at an acute care hospital or an ASC:

(a) remains the same.

(i) The base rate effective July 1, ~~2023~~ 2024, is $130.

(ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the base rates for services provided starting July 1, 2013, may be requested by email at~~

~~DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

(b) remains the same.

(i) The base rate effective July 1, ~~2023~~ 2024, is $98.

(ii) All prior base rates for services provided starting July 1, 2013, are available on the department's website. ~~A copy of the base rates for services provided starting July 1, 2013, may be requested by email at DLIERDBP&S@mt.gov; phone at 406-444-6543; or by mail at P.O. Box 8011 Helena, MT 59604.~~

(c) through (g) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: The proposed amendments to (11)(a)(i) and (12)(a)(i) are necessary to incorporate the base rates for services as part of the annually updated medical fee schedules to comply with the provisions of 39-71-704(2), MCA, that require the department to annually establish a medical fee schedule. The proposed amendments to (1)(d), (11)(a)(ii), (12)(a)(ii), and (12)(b)(ii) remove unnecessary and repetitive references to the department's contact information, all of which is available online.

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) and (b) remain the same.

(c) the Montana unique code, MT001, described in ~~(7)~~ (9);

(d) remains the same.

(e) the Montana unique code, MT009, for referral to a ~~CRC~~ 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) remains the same.

(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.

(3) and (4) remain the same but are renumbered (4) and (5).

~~(5)~~ (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.

(6) through (10) remain the same but are renumbered (7) through (11).

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: The proposed new (4) and proposed amendments to renumbered (7) are necessary to establish a Montana-specific dental fee schedule to maintain Montana's status quo for dental procedures; allow insurers and dental providers to negotiate fees; and clarify and simplify the processing of dental claims for all interested parties. According to data from the National Council on Compensation Insurance (NCCI), Montana's established dental rates in 2020 were lower than both the regional and countrywide averages for dental rates. NCCI 2020 data shows that Montana's dental rates were an average of $207 lower than nine regional states' dental rates and an average of $233 lower than countrywide dental rates. The department compared Montana's dental fee schedule amounts to the actual average amounts paid by workers' compensation insurers for dental services, and 70% of insurers paid more for dental services than the fee schedule amount in recent service years. Allowing providers to use the American Dental Association (ADA) Dental Claim Form will simplify and clarify workers' compensation billing for providers and insurers. Establishing a Montana-specific dental fee schedule and adopting use of the ADA Dental Claim Form are intended to simplify the processing of dental claims, and hopefully reduce delays and increase access to dental services for injured workers.

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 on or after July 1, ~~2023~~ 2024.

(b) remains the same.

(2) The conversion factors established by the department for anesthesia services are:

(a) $65.73 on or after July 1, ~~2023~~ 2024.

(b) and (3) remain the same.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: The proposed amendments to the conversion factors are necessary because the department must annually update the medical fee schedules adopted under 39-71-704(2), MCA. Although the amount of the conversion factors did not change between 2023 and 2024, it is necessary to update the effective date of the conversion factors to avoid confusion.

24.29.1616 INCORPORATION BY REFERENCE AND UPDATES TO THE FORMULARY (1) remains the same.

(2) The department adopts and incorporates by reference its formulary as follows:

(a) for prescriptions written on or after July 1, ~~2023~~ 2024, the April ~~2023~~ 2024 edition of the ODG Drug Formulary; and

(b) through (5) remain the same.

AUTH: 39-71-203, 39-71-704, MCA
IMP: 39-71-704, MCA

REASON: The proposed amendments are necessary because the department must annually update the commercial drug formulary adopted under 39-71-704(3)(b)(i) and (ii), MCA (2023). The automatic monthly update process is expressly provided for by 2-4-307(8), MCA.

5. The rules proposed to be repealed are as follows:

24.29.1415 IMPAIRMENT RATING DISPUTE PROCEDURE

AUTH: 39-71-203, MCA
IMP: 39-71-711, MCA

REASON: The proposed repeal is necessary because the rule applies to injuries that occurred prior to 1991, which is over 30 years ago. Historical information regarding workers' compensation claims can be accessed by contacting the department.

24.29.1432 FACILITY SERVICE RULES AND RATES FOR SERVICES PROVIDED FROM DECEMBER 1, 2008 THROUGH JUNE 30, 2013

AUTH: 39-71-203, MCA
IMP: 39-71-203, 39-71-704, MCA

REASON: The proposed repeal is necessary because the rule applies to injuries that occurred prior to 2013, and it is no longer necessary to address these specific rates in rule. Historical information regarding workers' compensation claims can be accessed by contacting the department.

6. 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 no later than 5:00 p.m., June 7, 2024.

7. An electronic copy of this notice of public hearing is available at dli.mt.gov/rules and sosmt.gov/ARM/register.

8. 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.

9. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

10. Pursuant to 2-4-111, MCA, the agency has determined that the rule changes proposed in this notice will not have a significant and direct impact upon small businesses.

11. Department staff has been designated to preside over and conduct this hearing.

/s/ QUINLAN L. O'CONNOR	/s/ SARAH SWANSON
Quinlan L. O'Connor	Sarah Swanson, Commissioner
Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State April 30, 2024.