BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
OF THE STATE OF MONTANA

In the matter of the adoption of New Rules I through VII, the amendment of ARM 24.29.1401A, the amendment and transfer of ARM 24.29.1591, 24.29.1595, and 24.29.1596, and the transfer of ARM 24.29.1593 and 24.29.1599, pertaining to utilization and treatment guidelines, including a drug formulary, for workers' compensation	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AMENDMENT AND TRANSFER, AND TRANSFER

TO: All Concerned Persons

1. On November 9, 2018, at 10:00 a.m., the Department of Labor and Industry (department) will hold a public hearing in the basement auditorium at the DPHHS building, 111 North Sanders Street, Helena, Montana, to consider the proposed adoption, amendment, amendment and transfer, and transfer of the above-stated rules.

2. The 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 November 5, 2018, to advise us of the nature of the accommodation that you need. Please contact Cindy Zimmerman, Employment Relations Division, P.O. Box 8011, Helena, Montana 59604-8011; telephone (406) 444-1752; Montana TTD (406) 444-5549; facsimile (406) 444-4140; or e-mail Cindy.Zimmerman@mt.gov.

3. GENERAL STATEMENT OF REASONABLE NECESSITY: There is reasonable necessity to adopt, amend, amend and transfer, and transfer rules related to a workers' compensation prescription drug formulary that is to be part of the workers' compensation medical utilization and treatment guidelines in order to implement the provisions of Chapter 433, Laws of 2017 (Senate Bill 312). This statement of reasonable necessity applies to all the rule changes proposed within this Notice of Public Hearing.

The department has determined there is reasonable necessity to consolidate all of the medical utilization and treatment rules into a new subchapter 16 in ARM Title 24, chapter 29, in order to make the rules easier for users to locate in the ARM and in order to make it clear that the drug formulary rules being proposed are adopted as part of the overall workers' compensation medical utilization and treatment guidelines (U & T Guidelines) authorized by 39-71-704, MCA, and previously adopted by the department. A new subchapter is reasonably necessary to organize all the related U & T Guidelines in a logical and sequential manner.

Accordingly, there is reasonable necessity to transfer existing U & T Guideline rules to a new subchapter.

Following the enactment of Chap. 433, L. of 2017, the department undertook a survey of workers' compensation drug formularies and administrative rules adopted in various other states. The department consulted with a group of stakeholders (including insurers, medical providers, claims examiners, and representatives of injured workers) to evaluate whether the Montana workers' compensation system as a whole would be benefited by the adoption of a drug formulary, and if so, whether Montana should adopt a commercially available drug formulary, a formulary developed by another state, or develop its own formulary. After extensive discussion, the department developed a general consensus among its stakeholder group that it should adopt the commercial ODG formulary. The Labor-Management Advisory Council (LMAC) gave its approval to the department's choice as well.

In selecting the commercial ODG formulary, the department specifically considered whether the ODG formulary was evidence-based. The department received materials from a competitor of ODG that questioned whether the ODG formulary is evidence-based. In response to that material, the department analyzed how ODG rates the various types of medical studies it considers, and how ODG rates the quality of the studies it considers. After analysis, the department concluded that the ODG formulary appropriately uses high quality medical evidence as the basis for its formulary.

The department thereafter used a similar stakeholder group to review and evaluate the administrative rules used by other states to implement that state's drug formulary. Following general discussions of alternative administrative rule structures with the stakeholders, the department began drafting specific language to implement a drug formulary. As the department drafted specific language, the department consulted with its stakeholder groups and LMAC, refining the language in response to the input of those process participants.

There is reasonable necessity to adopt the proposed formulary rules, along with coordinating amendments and transfers in order to improve worker outcomes in the treatment of workplace injuries by using evidence-based guidelines for prescription drugs. No type or class of prescription drug is banned or prohibited by the formulary. Injury-appropriate prescription drugs that are listed as a "Y" on the formulary are presumptively medically appropriate for injured workers and are not subject to any prior authorization requirements. Prescription drugs that are not listed as a "Y" code on the formulary are subject to the prior approval of the insurer. The formulary rules require that a prescribing medical provider furnish appropriate information and clinical support to the insurer whenever the provider seeks prior authorization. Unless an insurer has suitable medical reasons not to authorize an "N" or unlisted medication, the insurer will presumably grant authorization. Insurers that unreasonably withhold prior authorization are subject to penalties and other sanctions as provided by the Workers' Compensation Act.

There is reasonable necessity to adopt by reference the commercial ODG drug formulary, based on the decision-making process described above. The ODG drug formulary is a commercially available drug formulary, designed specifically for workers' compensation matters, and is updated electronically on a monthly basis in order to be medically current. The drug formulary will be updated annually via the formal rulemaking process. The use of monthly updates and annual rulemaking is expressly provided for by 39-71-704(3)(b), MCA (2017), and is expressly authorized by 2-4-307(8), MCA (2017).

There is reasonable necessity to adopt rules that provide for an expedited dispute resolution process when the denial of a prescription medication is likely to lead to the injured worker suffering a medical emergency as a result of the denial. While other states sometimes allow the state regulatory agency to issue orders to continue a medication during dispute resolution, Montana law does not currently provide the department with that authority. Accordingly, the expedited medical review procedure provided in the rules is reasonably necessary to implement the statutory requirements for a speedy, effective dispute resolution process for formulary disputes.

There is reasonable necessity to adopt a phased adoption of the formulary rules for the following reason. The department anticipates that effective April 1, 2019, the formulary rules will apply to the treatment of workplace injuries occurring on and after that date. The department expects that the formulary rules will be adopted by December 31, 2018, thus giving medical providers and claims staff three months in which to become familiar with the formulary rules.

Workers' compensation claims relating to injuries occurring prior to April 1, 2019, are referred to in the rules (and the insurance industry) as "legacy claims." The formulary rules will not apply to legacy claims prior to April 1, 2020, and then only in cases where the insurer has given at least 90 days' notice to the injured worker and the prescribing medical providers that the insurer intends to begin to apply the formulary rules to the claim. The injured worker's medical provider(s) will be required to consider the effect of the proposed application of the formulary rules on the treatment of the injured worker. The medical provider may, if appropriate in light of the U & T Guidelines, decide whether it is appropriate to continue with the existing course of treatment or to transition the injured worker to a medical regimen that is consistent with the formulary and U & T Guidelines. Where appropriate, a transition plan may include providing the injured worker with supportive services in conjunction with a change of medications or dosages. The transition plan is designed to ensure that an injured worker with a long-term chronic injury is not suddenly "cut-off" from medications, and that a prescription medication dependency related to the injury is addressed in a medically appropriate manner.

From the beginning of its survey process to the present, the department has been meeting with stakeholders and other interested person for approximately 24 months in the development of its proposed new rules. The department concludes

that it has selected an approach to the adoption of a prescription drug formulary in a way that is reasonable and necessary to implement 39-71-704, MCA, as amended by Chap. 433, L. of 2017.

4. The rules proposed to be adopted provide as follows:

NEW RULE I 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) "Department" means the Department of Labor and Industry, Employment Relations Division.

(3) "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).

(4) " Formulary" means the list of drugs for which prior authorization is generally not needed, as adopted and automatically updated pursuant to [NEW RULE III].

(5) "Formulary rules" means:

(a) [NEW RULE I];

(b) [NEW RULE II];

(c) [NEW RULE III];

(d) [NEW RULE IV];

(e) [NEW RULE V];

(f) [NEW RULE VI]; and

(g) [NEW RULE VII].

(6) "Insurer" means compensation plan No. 1, plan No. 2, and plan No. 3.

(7) "Legacy claim" means a workers' compensation or occupational disease claim with an occurrence date before April 1, 2019.

(8) "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.

(9) "Montana Guidelines" are the Montana utilization and treatment guidelines adopted by the department in [ARM 24.29.1611].

(10) "ODG drug formulary" means the ODG Workers' Compensation Drug Formulary, established as Appendix A to the ODG Treatment in Workers' Comp publication, published by MCG Health, LLC.

(11) "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.

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

(13) "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.

(14) "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.

(15) "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.

(16) "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.

(17) "Treating physician" has the same meaning as provided by ARM 24.29.1401A.

(18) "Treatment" has the same meaning as provided by ARM 24.29.1401A.

(19) "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 [NEW RULE V]. 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.

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

NEW RULE II APPLICABILITY OF FORMULARY RULES TO OUT-PATIENT SERVICES (1) The provisions of these formulary rules apply to all claims arising on or after April 1, 2019, but only with respect to outpatient services.

(2) For claims arising before April 1, 2019, which are referred to as "legacy claims," the rules in [this subchapter] will apply to prescriptions written on or after April 1, 2020, or 90 days after the insurer gives notice as provided in [NEW RULE V], whichever is later.

(3) The provisions of [this subchapter], including the formulary adopted and automatically updated as provided in [NEW RULE III] apply as they are in effect on the date the prescription is written.

(4) Nothing in [this subchapter] excuses an insurer from providing medications that constitute primary medical services required to be furnished by 39-71-704, MCA.

(5) Nothing in [this subchapter] requires an insurer to use the services of a PBM.

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

NEW RULE III 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 the October 2018 edition of the ODG Drug Formulary as its formulary.

(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 from:

(a) the department's web site, at http://erd.dli.mt.gov/work-comp-claims/medical-regulations, at no charge;

(b) the department at Employment Relations Division, Medical Regulations, P.O. Box 8011, Helena, MT 59624-8011, at the costs of reproduction and postage for a printed .pdf version; and

(c) 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 via the internet 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.

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

NEW RULE IV INTEGRATION OF FORMULARY WITH MONTANA UTILIZATION AND TREATMENT GUIDELINES – WHEN PRIOR AUTHORIZATION IS REQUIRED (1) The formulary is considered to be a part of the Montana Guidelines established by the department.

(2) A medical provider is expected to write a prescription for medication in accordance with the Montana Guidelines, as adopted by [ARM 24.29.1611], and in accordance with the formulary adopted by [NEW RULE III].

(3) Because the formulary is part of the Montana Guidelines, medical providers are required to prescribe in accordance with the provisions of the formulary unless the provider can sufficiently articulate sound medical reasoning to vary from the formulary.

(4) Insurers shall pay for medications that are prescribed in a manner consistent with the formulary, subject to the medical provider furnishing documentation as required by [ARM 24.29.1621]. Payments for medications are subject to the provisions of 39-71-727, MCA.

(5) Pursuant to the formulary, prior authorization for an injury appropriate medication is not required as follows:

(a) the medication is listed as "Y" on the formulary; or

(b) the medication is listed as "N" on the formulary, and the prescription is:

(i) written within seven days of the occurrence of the workplace injury; and

(ii) limited to a maximum of a seven-day supply of the medication.

(6) Pursuant to the formulary, prior authorization for a medication is required as follows:

(a) except as provided by (5)(b), the medication is listed as "N" on the formulary;

(b) the medication is not listed on the formulary;

(c) the medication is experimental or investigational; or

(d) the medication is a compound, even if all the components of the compound are listed as "Y" medications on the formulary.

(7) The prior authorization process described in [ARM 24.29.1621] applies to formulary matters, except that:

(a) the insurer shall respond within three business days of a request for prior authorization being made to the insurer or the insurer's designee, by either approving or denying the request; and

(b) if the insurer fails to respond within three business days to a request for prior authorization, the prescription is deemed to be approved. An approval for a prescription medication made due to the lack of a timely response by the insurer does not apply to any refill that may be ordered.

(8) An insurer may delegate prior authorization decisions pertaining to the formulary to a PBM or other agent with which it contracts. An insurer has the legal responsibility for the decisions made by the PBM on behalf of the insurer.

(9) The delegation by an insurer of prior authorization decisions pertaining to the formulary to a PBM or other agent does not, in and of itself, violate the requirement of 39-71-107, MCA, that all claims be examined by a claims examiner in Montana.

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

<u>NEW RULE V SPECIAL PROVISIONS FOR TRANSITION OF LEGACY CLAIMS – WHEN APPLICABLE</u> (1) The insurer shall notify in writing the injured worker and the treating physician (who, for the purposes of this rule, also includes any other prescribing medical provider) that a claim constitutes a legacy claim in which the insurer will enforce the applicability of these formulary rules.

(2) The notification required by (1) must include at least the following information:

(a) the name of the injured worker;

(b) the name of the treating physician or other prescribing medical provider;

(c) the name of each medication that is affected by the notice;

(d) the name and contact information of the claims examiner responsible for the injured worker's claim; and

(e) the date upon which the insurer will enforce the applicability of these formulary rules.

(3) This rule applies to a legacy claim on the latter of:

(a) April 1, 2020; or

(b) 90 days after the insurer provides notice as provided by (1).

(4) By not later than the applicability date of this rule pursuant to (3), the treating physician shall determine whether a transition plan is needed for an injured worker who is receiving:

(a) one or more drugs for which prior authorization is otherwise required; or

(b) drugs at a dosage level greater than recommended by the Montana Guidelines.

(5) The treating physician must state in writing whether the injured worker:

(a) should transition to "Y" status drugs or to medication dosages which are consistent with the recommendations of the Montana Guidelines; or

(b) should not undergo a transition from the existing medications because a transition is not medically appropriate.

(6) The treating physician must provide the basis for the medical provider's decision as required by [ARM 24.29.1621]. The explanation, and development of a transition plan as appropriate, constitutes a "by report" service (CPT code 99080).

(7) If the treating physician fails to provide the determination required in (5), by the date this rule becomes applicable to the claim pursuant to (3), these formulary rules will apply to prescriptions written for the injured worker.

(8) If the treating physician determines a transition from one or more drugs for which prior authorization required to a "Y" status drug is appropriate, or that a reduction in dosage is appropriate, the treating physician shall include in the worker's treatment plan a specific plan, including a projected time table or schedule, for transitioning the injured worker to care that is consistent with the Montana Guidelines.

(9) The treatment plan may, when determined by the treating physician to be medically necessary, include the provision of supportive services to the injured worker during the transition.

(10) Supportive services may be delivered in an out-patient or an in-patient setting, as appropriate, based upon the treating provider's transition plan. Supportive services that are reasonable and medically necessary constitute part of the primary medical services to which an injured worker with a legacy claim is entitled.

(11) Nothing in this rule prohibits the treating physician from proposing a treatment plan for transition prior to an insurer's authorization as provided in (1).

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

NEW RULE VI EXPEDITED CASE REVIEW FOR PRESCRIPTION MEDICATIONS BY DLI MEDICAL DIRECTOR (1) Expedited case review is available only when insurer declines to authorize further dispensing of an already prescribed medication.

(2) Expedited case review is only applicable in cases of medical emergency. A medical emergency occurs when all three of the following circumstances are present:

(a) the medical condition has a sudden onset;

(b) the medical condition manifests itself by acute symptoms of sufficient severity, including severe pain; and

(c) in the absence of immediate medical attention, the medical condition could reasonably be expected to result in:

(i) placing the injured worker's health or bodily functions in serious jeopardy; or

(ii) a serious dysfunction of any body organ or part of the injured worker.

(3) An expedited case review may be requested concurrently with a demand for mediation on the dispute concerning the medication.

(4) An expedited case review may only be requested within 14 days of the insurer's denial of, or refusal to authorize further dispensing of an already prescribed medication.

(5) A request for an expedited case review must be supported by such written information as the treating physician considers pertinent to the treating physician's opinion that a medical emergency is likely to occur as a result of the denial of the medication.

(6) The expedited medical review will be conducted within three business days of receipt by the department of a written request for an expedited medical review. The findings of the expedited medical review must be in writing and be based on the information provided by the treating physician, along with the reasoning given by the insurer or its agent for the denial.

(7) If the findings of the medical director determine that a medical emergency is likely to occur as the result of not providing the further dispensing of medication as prescribed by the treating physician, those findings may be offered in evidence in mediation or the Workers' Compensation Court.

(8) If the findings of the medical director are that no medical emergency is likely to occur as a result of the insurer's denial, then the medical director shall further consider the matter of the denial under the independent medical review procedures provided for by [ARM 24.29.1641].

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

NEW RULE VII DISPUTE RESOLUTION FOR FORMULARY (1) Disputes between the treating physician and the insurer regarding the formulary are subject to

the same process available for other disputes regarding the Montana Guidelines, except as provided in [NEW RULE VI].

(2) A dispute between the injured worker and the insurer regarding the use or application of the formulary constitutes a dispute concerning benefits, and may be resolved as provided by 39-71-2905, MCA.

AUTH: 39-71-203, 39-71-704, MCA
IMP: 39-71-704, 39-71-2905, MCA

5. The rule proposed to be amended is as follows, stricken matter interlined, new matter underlined:

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

(1) through (13) remain the same.

~~(14) "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).~~

(15) through (23) remain the same, but are renumbered (14) through (22).

~~(24) "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.~~

(25) through (32) remain the same, but are renumbered (23) through (30).

~~(33)~~ (31) "Prior authorization" means~~:~~

~~(a) with respect to services provided on or before June 30, 2011,~~ that for those matters identified by ARM 24.29.1517 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~~; and~~

~~(b) with respect to services provided on or after July 1, 2011, the interested party receives prior authorization (either verbally or in writing) from the insurer to perform treatment for those cases identified by ARM 24.29.1593~~.

(34) remains the same, but is renumbered (32).

~~(35) "Rebuttable presumption" means that the Montana Guidelines, as adopted in ARM 24.29.1591, 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.~~

(36) through (41) remain the same, but are renumbered (33) through (38).

~~(42)~~ (39) "Treatment plan" means a written outline of how the provider intends to treat a specific condition or complaint.

~~(a) With respect to services provided on or before June 30, 2011, the~~ 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.

~~(b) With respect to services provided on or after July 1, 2011, a treatment plan must be made in accordance with the Montana Guidelines adopted in ARM 24.29.1591 and made in accordance with any insurer authorized treatments or procedures.~~

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

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

24.29.1591 (24.29.1611) UTILIZATION AND TREATMENT GUIDELINES

(1) through (3)(a) remain the same.

(b) The department recognizes that medical treatment may include deviations from the Montana Guidelines as individual cases dictate. The provider or interested party shall follow the procedure for prior authorization under ~~ARM 24.29.1593~~ [ARM 24.29.1621] for cases in which treatments or procedures are requested that are:

(i) through (c) remain the same.

(i) prior authorization is obtained from the insurer pursuant to 39-71-704, MCA, and in accordance with ~~ARM 24.29.1593~~ [ARM 24.29.1621]; or

(ii) through (d) remain the same.

(4) All insurers shall routinely and regularly review claims to ensure that care is consistent with the Montana Guidelines adopted by reference in (1) and (6).

(5) remains the same.

(6) Effective April 1, 2019, the formulary adopted in [NEW RULE III] is considered to be a part of the Montana Guidelines.

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

24.29.1595 (24.29.1641) INDEPENDENT MEDICAL REVIEW PROCESS

(1) remains the same.

(2) The interested party or insurer must submit its request for review to the department and must notify the other party of its request for review. Upon notice of a request for review, the insurer must submit a copy of the request for prior authorization, the denial, and any other relevant medical information to the department. The interested party and the insurer may also submit additional information to the department, if the information falls within the categories outlined in ~~ARM 24.29.1593~~ [ARM 24.29.1621]. Any new information submitted to the department must also be submitted to the other party.

(3) through (8) remain the same.

(9) An expedited case review for medications is provided by [NEW RULE VI].

AUTH: 39-71-203, 39-71-704, MCA
IMP: 39-71-224, 39-71-704, 39-71-2401, MCA

24.29.1596 (24.29.1604) APPLICABILITY OF UTILIZATION AND TREATMENT RULES (1) The following rules are subject to the applicability provisions of this rule:

(a) ~~ARM 24.29.1591~~ [ARM 24.29.1609];
(b) ~~ARM 24.29.1593~~ [ARM 24.29.1611];
(c) ~~ARM 24.29.1595~~ [ARM 24.29.1621]; and
(d) ~~ARM 24.29.1599~~ [ARM 24.29.1641].

(2) remains the same.

(3) The presumption of compensability in the Montana utilization and treatment guidelines adopted by ~~ARM 24.29.1591~~ [ARM 24.29.1611] does not apply to injuries occurring on or before June 30, 2007. However, treatment for these injuries made in accordance with the guidelines constitutes reasonable primary or secondary medical treatment, pursuant to 39-71-704, MCA, for any condition or diagnosis identified in the guidelines. Therefore, prior authorization is not required for treatment within the guidelines for these injuries unless prior authorization would otherwise be required under these rules.

(4) As used in ~~ARM Title 24, chapter 29, subchapters 14 and 15~~ this subchapter, the term "injuries" includes occupational diseases which were diagnosed as an occupational disease, or should have been diagnosed as an occupational disease, during the time period specified.

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

7. The rules proposed to be transferred are as follows:

24.29.1593 (24.29.1621) PRIOR AUTHORIZATION

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

24.29.1599 (24.29.1609) APPLICABILITY OF UTILIZATION AND TREATMENT GUIDELINES FOR MANAGED CARE ORGANIZATIONS OR PREFERRED PROVIDER ORGANIZATIONS

AUTH: 39-71-293, 39-71-704, MCA
IMP: 39-71-704, MCA

8. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Cindy Zimmerman, Employment Relations Division, P.O. Box 8011, Helena, Montana 59604-8011, by facsimile to (406) 444-4140, or by e-mail to Cindy.Zimmermant@mt.gov, and must be received no later than 5:00 p.m., November 16, 2018.

9. An electronic copy of this notice of public hearing is available through the department's web site at http://dli.mt.gov/events/calendar.asp, under the Calendar of Events, Administrative Rules Hearings Section. The department strives to make its electronic copy of this notice of public hearing conform to the official version of the notice, as published in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy, only the official text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that a person's difficulties in sending an e-mail do not excuse late submission of comments.

10. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request, which includes the name and e-mail or mailing address of the person to receive notices, and specifies the particular subject matter or matters regarding which the person wishes to receive notices. Such written request may be mailed or delivered to the Department of Labor and Industry, attention: Mark Cadwallader, 1315 E. Lockey Avenue, P.O. Box 1728, Helena, Montana 59624-1728, faxed to the department at (406) 444-1394, or e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency.

11. The bill sponsor contact requirements of 2-4-302, MCA, apply and were fulfilled on November 9, 2017, via letter.

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

13. The department's Office of Administrative Hearings has been designated to preside over and conduct this hearing.

/s/ Mark Cadwallader	/s/ Galen Hollenbaugh
Mark Cadwallader	Galen Hollenbaugh
Alternate Rule Reviewer	Commissioner
	Department of Labor and Industry

Certified to the Secretary of State October 9, 2018.