Montana Workers' Compensation Drug Formulary

Frequently Asked Questions

General Questions

Q: Why is the Department adopting a drug formulary for workers' compensation?
A: In May 2017, SB312 was passed by the Montana legislature authorizing the Montana Department of Labor & Industry to adopt a drug formulary by rule. The goals of implementing a workers' compensation drug formulary in Montana are to (1) reduce the number of potentially dangerous drug prescriptions and (2) improve worker outcomes by reducing disability duration and increasing return to work rates.

Q: Why did the Department choose to adopt the ODG formulary?
A: The Department reviewed and presented three formulary options to the Formulary Working Group (a comprehensive group of stakeholders comprised of both internal and external members, more information can be found at http://erd.dli.mt.gov/work-comp-claims/medical-regulations/formulary), including ODG (MCG Health, LLC), ACOEM (ReedGroup), and the Washington L&I Outpatient Formulary (State of Washington). Based on the information provided by representatives, the current and available literature, as well as internal research and discussion, the Department proposed that the ODG formulary would *best* meet the needs of Montana based on factors including (a) utilization of an evidence-based and transparent process, (b) ease of implementation and readability, (c) ease of access with no cost to stakeholders, (d) ability for stakeholder input, and (e) a consistent track record in other states. A full explanation of the Department's reasoning can be found at http://erd.dli.mt.gov/work-comp-claims/medical-regulations/formulary.

Q: How is the ODG formulary structured?
A: The ODG formulary is a comprehensive list of drugs that are commonly prescribed for work-related injuries and each drug is given either a preferred ("Y") or non-preferred ("N") status. The ODG list is formatted in three ways—by drug class, by brand name, and by generic name—and is available to view on the Department's website at no charge.

Q: Who oversees updates to the ODG formulary?
A: The ODG formulary is updated monthly or on an as needed basis by MCG Health, LLC. However, at least one pharmacy representative will be added to the Montana Utilization & Treatment Guidelines medical provider group to annually review updates made to the ODG formulary to ensure reliability.

Q: Is the formulary part of the Montana Utilization and Treatment Guidelines?
A: Yes, the formulary along with the Montana Guidelines provide the basis for best practices among prescribers and providers. As such, the formulary rules have been integrated with the U&T rules and both can now be found in the 24.29.1600 series of the administrative rules.

Q: Does the formulary apply for inpatient care?
A: No, the formulary is only applicable for outpatient care. Medications prescribed during inpatient care are not subject to the formulary.

Q: How can the formulary be accessed?
A: The formulary list can be viewed at no charge on the Department's website http://erd.dli.mt.gov/work-comp-claims/medical-regulations/formulary. Those stakeholders interested in the underlying evidence and studies used to determine drug status may choose to purchase an ODG subscription at https://www.mcg.com/odg/.

Q: Where can I find the formulary rules?
A: The formulary rules can be found at ARM 24.29.1600 series and can be viewed in full at http://erd.dli.mt.gov/work-comp-claims/medical-regulations/formulary.

Q: What are the applicability dates of the formulary?
A: As of January 1, 2019, the formulary and formulary rules will apply to all new claims with dates of injury on or after April 1, 2019. For claims with dates of injury *before* April 1, 2019, the formulary and formulary rules will apply on April 1, 2020. For more information on claims with dates of injury before April 1, 2019, please refer to the Legacy Claims section below.

Q: Is the formulary designed to be two-tiered, incorporating both ODG and MT U&T Guidelines?
A: No. The only ODG material being adopted in Montana is the formulary list developed by ODG. Providers must consult the MT U&T Guidelines for best medical practices and the formulary for drug prescriptions.

Q: Does the Formulary apply to claims with an occurrence date prior to 7/1/17?
A: Yes. The drug formulary is part of the U&T Guidelines, which constitutes "reasonable primary medical services" for dates of service occurring on or after the effective dates of the rule. The "date of service" applicability of the various medical service rules has historically applied irrespective of the date of injury. An injured worker has the right to reasonable medical services – it is not frozen at the date of the injury.

Prior Authorization

Q: Which drugs require prior authorization?
A: Any drug that does not have a "Y" status on the ODG formulary will require prior authorization before the drug can be dispensed. This includes "N" drugs and drugs *not listed* on the formulary. In addition, all compounds (including those containing only "Y" drugs) and experimental or investigational drugs also require prior authorization.

Q: Are all "Y" drugs automatically approved?
A: Yes, if the drug is injury appropriate, then a "Y" drug should be filled without delay.

Q: Why do "N" drugs and drugs *not listed* on the formulary require prior authorization?
A: "N" drugs require prior authorization because they are non-preferred as the first line of treatment based on the current medical literature. The ODG formulary is specific to workers' compensation and only includes those drugs that are statistically significant to work-related injuries. Therefore, drugs not listed on the formulary require prior authorization because they are not commonly prescribed for work-related injuries.

Q: Are there any exceptions to prior authorization?
A: Yes. Injury appropriate "N" drugs prescribed within the first 7 days after an injury occurs will not be subject to prior authorization for prescriptions written within 7 days. This is to ensure in outpatient emergent and urgent care situations, an injured worker will promptly receive the appropriate and necessary medications in the acute stages of their injury without being delayed by the prior authorization process. This exception is still subject to the "generic first" statute per §39-71-727. Drugs *not exempt* from prior authorization during this timeframe include drugs not listed on the formulary, compounds, and experimental/investigational drugs. An injured worker may seek treatment on the 7th day following an injury and still receive a prescription for the full 7 days.

Q: Who makes prior authorization decisions?
A: Prior authorization is decided by the insurer. An insurer may delegate prior authorization decisions to a PBM or other third party with which it contracts, but any decision made by the PBM or third party is binding on the insurer. Ultimately, claims decisions are the responsibility of an in-state examiner per §39-71-107(2).

Q: Is utilization review or some other sort of medical review required to make a prior authorization determination?
A: An insurer must have a reasoned basis for granting or denying prior authorization. The rules do not specify whether a medical provider must be consulted for decision making. The Department concludes each insurer must use appropriate judgement in responding to a prior authorization request or they run the risk of handling the claim in an unreasonable manner.

Q: Can an insurer deny a drug *just because* it is an "N" drug on the formulary?
A: An insurer should not arbitrarily deny medication solely because it is an "N" on the formulary. The adjustor should consider whether the provider/prescriber has provided sufficient support for the prescribing of a drug that is not listed as "Y" on the formulary. See ARM 24.29.1624.

Q: What type of documentation should a provider/prescriber submit to sufficiently support the prescribing of a non-"Y" drug?
A: Providers/prescribers should first consult the Montana Guidelines. However, the Montana Guidelines may not address all drugs or diagnosis. The standard of documentation for prescriptions is the same as the standard of documentation for other treatment and services and is fully outlined in ARM 24.29.1624.

Q: How long does the insurer have to respond to a request for a prior authorization?
A: An insurer has three business days from receipt of the request to respond for prior authorization on a prescription drug.

Q: What happens if the insurer does not respond within three business days?
A: If an insurer does not respond within three business days from receipt of the request for prior authorization, the drug will be deemed automatically approved. Any refills for prescriptions dispensed due to untimely response may still require prior authorization.

Q: What about retrospective review?
A: Retrospective review is at the discretion of the insurer. Formulary rules do not cover retrospective review, as the Department feels this a matter of the insurer's claims handling practice. What this means for the injured worker is that refills of a drug that has previously been approved and dispensed, may later come under review if, for example, there is a question of medical necessity or injury appropriateness.

Dispute Resolution: Independent Medical Review (IMR)

Q: What can an injured worker/provider/prescriber do if they disagree with an insurer's denial of a *new* medication?
A: Any party may petition the Department for an Independent Medical Review at http://erd.dli.mt.gov/work-comp-claims/medical-regulations/utilization-and-treatment-guidelines/independent-medical-review-process. The IMR process will apply the same for drugs as it does for other medical treatment and services. See ARM 24.29.1641.

Q: How long does an IMR take to be completed?
A: The Medical Director will issue a recommendation within 14 days from the date of receipt of the request.

Q: Is an IMR binding?
A: No, an IMR is not binding. Therefore, if any party disagrees with the recommendation made by the Medical Director, the dispute may move to mediation or to the Work Comp Court. Recommendations made by the Medical Director for an IMR are not admissible as evidence into the Work Comp Court.

Q: What can an injured worker/provider/prescriber do if they disagree with an insurer's denial of a *previously prescribed and dispensed* medication?
A: If the discontinuing of a medication that has been previously prescribed and dispensed *poses a risk of a medical emergency*, an injured worker/provider/prescriber may petition the Department for an Expedited Case Review. For more information, please refer to the Dispute Resolution: Expedited Case Review section below.

Dispute Resolution: Expedited Case Review

Q: When is an Expedited Case Review available to an injured worker?
A: An Expedited Case Review is available when an insurer denies a *previously prescribed and dispensed medication*, in which the discontinuation *poses the risk of a medical emergency* for the injured worker. A "medical emergency" is defined as the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in placing the injured worker's health or bodily functions in serious jeopardy or a serious dysfunction of any body organ or part of the injured worker.

Q: How can I submit a request for an Expedited Case Review?
A: The form to request an Expedited Case Review can be found at the Department's website http://erd.dli.mt.gov/work- comp-claims/medical-regulations/formulary.

Q: How long does an Expedited Case Review take to be completed?
A: The Medical Director will issue a recommendation within 3 business days from the date of receipt of the request. Since the timeframe for an Expedited Case Review to be completed is short, all meaningful documentation should be submitted with the request.

Q: What is the timeframe to request an Expedited Case Review?
A: An expedited case review may only be requested within 14 days of an insurer's denial. Requests for an expedited case review that occur after 14 days of a denial will be rerouted to the standard IMR process.

Q: What happens if the Medical Director *disagrees* with the provider/prescriber/injured worker that discontinuing a drug poses a risk of a medical emergency, but the provider/prescriber/injured worker maintains that the drug is medically necessary?
A: In the situation where the Medical Director determines discontinuing of a previously prescribed and dispensed medication *does not* pose a risk of a medical emergency, but the provider/prescriber/injured worker maintains that the drug is medically necessary, the dispute will be rerouted to the standard IMR process. Additional documentation may be submitted if needed, and the time to complete the IMR will be 14 days after the appropriate documentation is submitted minus the time it took to complete the Expedited Case Review. However, if the dispute were to move to the Work Comp Court, the Medical Director's recommendation "may be offered in evidence in mediation or the Workers' Compensation Court" ARM 24.29.1645.

Q: What happens if the Medical Director *agrees* with the provider/prescriber/injured worker the discontinuing of the drug poses a risk of a medical emergency, but the insurer maintains the denial of the drug?
A: In the situation where the Medical Director determines the discontinuing of a previously prescribed and dispensed medication *does* pose a risk of a medical emergency, but the insurer maintains the denial of the drug, the dispute may move to either mediation or the Work Comp Court. The Department does not have the statutory authority to issue an order stating an insurer must cover the drug. However, if the dispute were to move to the Work Comp Court, the Medical Director's recommendation "may be offered in evidence in mediation or the Workers' Compensation Court" ARM 24.29.1645.

Legacy Claims

Q: How are legacy claims defined?
A: Legacy claims include any injured worker's claim that has a date of injury before April 1, 2019. Legacy claims that are prescribed drugs with a "Y" status drugs will likely not be impacted by the formulary. However, legacy claims that are prescribed drugs other than "Y" on the formulary will be subject to the formulary rules on the latter of April 1, 2020 or 90 days after an insurer sends notification.

Q: How will an injured worker know they are a legacy claim, and how will the provider/prescriber know their patient will be impacted by the formulary?
A: For claims that may be impacted by the formulary, the insurer should identify and notify the injured worker, the treating physician, and the prescriber. Notification letters must include at a minimum 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 inured worker's claim, and e) the date upon which the insurer will enforce the applicability of the formulary rules. Sample notification letters with example language can be found on the Department's website at http://erd.dli.mt.gov/work-comp-claims/medical-regulations/formulary.

Q: What happens to the injured worker if the insurer does not send the notification?
A: If the insurer does not notify the provider/prescriber and injured worker of the upcoming date of applicability, the formulary will not apply to those claimants.

Q: What happens if the provider/prescriber does not respond to the notification?
A: The Department believes it is unlikely a treating physician would ignore their responsibility to their patient and fail to respond. However, If a provider/prescriber does not respond to the notification the formulary rules will apply to prescriptions written on the latter of April 1, 2020 or 90 days after the insurer sends notification. An injured worker may also seek an Expedited Case Review in an emergency situation.

Q: Are legacy claims required to transition to a "Y" drug by April 1, 2020?
A: Not necessarily. If current treatment with a non-"Y" drug is appropriate, a provider/prescriber only needs to substantiate why continuing current treatment is medically necessary or appropriate. See 24.29.1631 for the standard of documentation.

Q: How will providers/prescribers be reimbursed for the time spent either developing alternative treatment plans or documenting that current treatment is appropriate?
A: To incentivize providers/prescribers to review current treatment and then document medical necessity or develop an alternative treatment plan, time spent doing so constitutes a "by report" service (CPT code 99080). In addition, this same CPT code can be used if a provider decides to transition patients sooner than required by rule.

Q: What supportive services are insurers required to pay for?
A: If the provider/prescriber determines that an alternative treatment plan is appropriate for their patient, the insurer is liable for supportive services reasonable and medically necessary for transitioning or weaning a patient from an "N" drug. This may include, but is not limited to, psychosocial support, physical therapy, alternative therapies, or inpatient services. Opioid use disorder should be treated as a chronic disease which may require long-term, on-going management.

If you have additional questions about the Montana Workers' Compensation Drug Formulary, you may submit them to the Montana Department of Labor & Industry, Employment Relations Division at:

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