Section 28. Section 39-71-704, MCA, is amended to read:
"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates – fee limitation.

. . .

(2) (a) The department shall annually establish a schedule of fees for medical services that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.
~~(b) (i)~~ **Beginning January 1, 2011 the ~~department may not set the~~ rate for:**
(i) non-facility medical services shall be $66.00 per unit for non-anesthesia services and $61.00 per unit for anesthesia services.
(ii)The rate for inpatient hospital facility services shall be $8376 per admission. The Department shall provide additional payments for outliers and implantable devices.
(iii) The conversion rate for outpatient hospital facility services shall be $108.00. The Department shall provide additional payments for outliers and implantable devices.
(b) The rates specified in 2(a) shall be increased each subsequent year by 3% per unit. ~~at a rate greater than 10% above the average of the conversion factors used by up to the top five insurers or third-party administrators providing group health insurance coverage within this state who use the resource-based relative value scale to determine fees for covered services. To be included in the rate determination, the insurer or third-party administrator must occupy at least 1% of the market share for group health insurance policies as reported annually to the state auditor.~~
~~(ii) The insurers or third-party administrators included under subsection (2)(b)(i) shall provide their standard conversion rates to the department.~~
~~(iii) The department may use the conversion rates only for the purpose of determining average conversion rates under this subsection (2).~~
~~(iv) The department shall maintain the confidentiality of the conversion rates **65% above medicare's reimbursement rates for the same services.**~~
(c)(b) The fee schedule rates established in subsection (2)(b) (2)(a) must be based on the following standards as adopted by the centers for medicare and medicaid services in

effect at the time the services are provided, regardless of where services are provided:
(i) the American medical association current procedural terminology codes;
(ii) the healthcare common procedure coding system;
(iii) the medicare severity diagnosis-related groups;
(iv) the ambulatory payment classifications;
(v) the ratio of costs to charges for each hospital;
(vi) the national correct coding initiative edits; and
(vii) the relative value units as adjusted annually using the most recently published resource-based relative value scale.
(d)(c) The department may establish additional coding standards for use by providers when billing for medical services under this section.
(3) (a) The department ~~may~~ shall establish by rule evidence-based utilization and treatment guidelines for primary and secondary medical services. **The department shall convene a group of treating physicians and hospitals to provide an annual review of the guidelines.** There is a rebuttable presumption that the utilization and treatment guidelines established by the department are correct medical treatment for the injured worker.
(b) An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines adopted by the department unless the provider obtains prior authorization from the insurer. If prior authorization is not requested or obtained from the insurer, an injured worker is not responsible for payment of the medical treatment or services.
(c) The department may establish by rule an independent medical review process for treatment or services denied by an insurer pursuant to this subsection (3) prior to mediation under 39-71-2401.