# MONTANA WORKERS' COMPENSATION UTILIZATION & TREATMENT GUIDELINES

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## SUMMARY OF U & T ADMINISTRATIVE RULE EFFECTIVE 7/1/2011

http://erd.dli.mt.gov/utilization-a-treatment-guidelines-project.html

Questions may be referred to Maralyn Lytle, Medical Claims Specialist, mlytle@mt.gov or 406-444-6604. If you have questions for our Medical Director, John Schumpert, MD, please send those requests through Maralyn Lytle.

**Rule will apply to medical services provided on or after July 1, 2011**

**HB334 – 39-71-704, MCA: "There is a rebuttable presumption that the adopted utilization and treatment guidelines establish compensable medical treatment for an injured worker."**

**UTILIZATION & TREATMENT GUIDELINES (ARM 24.29.1591):**

The Guidelines include the following nine chapters and **General Guideline Principles** which are included at the beginning of each chapter:

- Low Back Pain;
- Shoulder Injury;
- Upper Extremity;
- Lower Extremity;
- Chronic Regional Pain Syndrome;
- Cervical Spine Injury;
- Chronic Pain Disorder;
- Traumatic Brain Injury; and
- Eye Injury

The General Guideline Principles indicate that the Guidelines are to be administered in a progressive manner and are designed so that certain requirements need to be met prior to initiating additional treatment.

Less invasive, simpler, and less costly treatments are to be followed before more complex and expensive alternatives.

A provider is not to proceed to more complex treatments unless the clinical indications are present.

If a treatment is recommended in the Guideline that treatment is considered preauthorized, regardless of the level of evidence, such as "generally well accepted", "generally accepted", "acceptable/accepted", or "well-established".

Treatments considered inappropriate, unreasonable, or unnecessary are designated in the guideline as being "not recommended".

In cases where treatments or procedures are recommended, prior authorization is unnecessary unless the Guidelines require prior authorization.

All health care providers, including Managed Care Organizations (MCOs) and Preferred Provider Organizations (PPOs), shall use the Guidelines for medical care. The Guidelines do not alter how MCOs or PPOs are paid. The Guidelines do not create a legal standard of care.

Disallowed procedures listed in the Rule simply supplement all treatments designated as "not recommended" in the Guidelines.

**PRIOR AUTHORIZATION FOR SERVICES ON OR AFTER JULY 1, 2011 (ARM 24.29.1593):**

Prior authorization by the insurer is required when treatment or procedures:

- Are not specifically addressed or recommended for a body part covered;
- Are after maximum medical improvement;
- Are beyond the duration and frequency limits set out in the guidelines; or
- The guidelines require prior authorization

When prior authorization is required, the interested party must submit evidence and/or additional documentation, as listed in the Rule, to the insurer for consideration.

The Insurer must respond to requests for prior authorization within 14 days of request and if denied, must provide explanation of reason for denial. The denial may not be solely on the fact the treatment is not recommended in the Guideline.

Prior authorization is not required for treatments or procedures provided in a medical emergency.

**For body parts not covered by a chapter, the rule for prior authorization (ARM 24.29.1517) in effect prior to July 1, 2011** applies, for example:

Consulting specialist;
No treatment within last six months;
After maximum medical improvement;
Specialized tests, such as MRI or CT;
Psych counseling;
Pain clinic program

**INDEPENDENT MEDICAL REVIEW (ARM 24.29.1595):**

An interested party who has requested and been denied authorization by the insurer, or the insurer, may request an independent medical review, prior to mediation, by the Department's Medical Director, Dr. Schumpert.

Requests for review must be submitted to the Department with a copy to the other party. The Insurer must submit a copy of the request for prior authorization and all accompanying information to the Department. Both parties may submit additional information to the Medical Director.

Medical Director will review information, may consult with other physicians, and will issue recommendation. Medical Director's recommendation must be issued within 14 days from the date of the request or the review is deemed denied.

Medical Director's review and recommendation is an informal dispute resolution process and is non-binding. Medical Director's files and records are closed to all but the parties.

Just as mediators cannot participate in later court proceedings, the Medical Director may not be called to testify in any proceeding and the recommendation and any information contained in it are not admissible in any court of law.

Requests not resolved by the Independent Medical Review process may proceed to mediation first and then to the Workers' Compensation Court.

**APPLICABILITY OF RULES (ARM 24.29.1596):**

**Guidelines and rules apply to all treatments and procedures on or after July 1, 2011.**

The presumption of compensability applies to injuries/ODs occurring on or after July 1, 2007. The Legislature authorized establishment of Guidelines effective July 1, 2007.

The presumption of compensability does not apply to injuries/ODs occurring on or before June 30, 2007:

Treatment for these injuries/ODs made in accordance with the guidelines constitutes reasonable primary or secondary medical treatment for any condition identified in the guidelines.

Prior authorization is not required for treatment within the guidelines for these injuries/ODs unless otherwise required under these rules.

**AMENDMENTS:**

Remaining rule changes amend existing rules to coordinate with new rules or provide effective dates of rules that still apply for treatments and procedures provided before July 1, 2011.