Prior Authorization Guide for the Healthcare Team

✅ Prior Authorization Checklist

- Verify the patient's most current insurance card.
- Confirm whether the service is covered under medical or pharmacy benefits.
- If denied, call the pharmacy to confirm the drug name and quantity.
- Mark requests as **urgent** if needed; requires a response within **72 hours**
- Make sure the insurance company receives your submission—timelines start then.

Involve the Patient:

- Give them the *Patient's Guide to Prior Authorization* and *Flow Chart*.
- Suggest they request a Care Coordinator or Nurse Case Manager.
- Help them complete a form allowing you to appeal on their behalf.

🏡 Is Insurance State or Federally Regulated?

- **Marketplace Plans (ACA) = State Regulated**
  - Examples: BCBS (some), PacificSource, Mountain Health Co-Op
- **Employer Plans = Federally Regulated (ERISA)**
  - Not subject to Montana state law

Ask: Did you buy your plan through the marketplace or get it from your employer?

Still unsure? Call the Montana Insurance Consumer Services Office: **(406) 444-2524**

📄 Montana Law (Marketplace Plans)

Duration of Prior Auth:

- All conditions: minimum **6 months** (effective Jan 2026)
- Chronic conditions: **12 months** (effective Jan 2026)

Continuity of Care:

- When switching plans, new insurers must honor current prior auths from the previous insurer for **90 days** (effective Jan 2026)

Timelines for determinations:

- Pre-approval: **7 days**
- Initial determination: Urgent **24 hrs**, Standard **7 days**
- Appeals: Urgent **72 hrs**, Standard **30 days** (+ one 15-day extension)

Grievances (if appeal is denied):

- Patient has **180 days** to file a grievance
- Payer has **30 days** (prospective), **60 days** (retrospective) to respond
- **External Review:**
    - Payer must respond in **5 days**
    - Reviewer has **45 days** to decide
    - Patient has **120 days** to request
- **Final Appeal:** Montana Insurance Commissioner (406) 444-2524

Other Protections (Jan 2026):

- Peer-to-peer must involve a comparable specialist
- No retroactive denials (unless fraud or loss of coverage)
- Children's biologics must be approved with supporting research
- Prescriptions costing less than $5000 per day that are prescribed on hospital discharge must be filled for at least 3 days without requiring prior auth

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🏛️ Federal Law (ERISA/Self-Funded Plans)

Timelines:

- Pre-approval: **15 days**
- Initial determination: **7 days**
- Post-service claims: **30 days**
- Urgent extensions: **24–72 hours**
- First-level appeal: **30 days**
- Grievance response: **15 days**

Note: Peer-to-peer rules are not clearly defined and vary widely; check plan policies.

📆 2026 CMS Rule Change

Applies to: Medicare Advantage, Medicaid, CHIP, ACA Marketplace Plans

- Requires electronic submission and tracking of prior auths
- Integrated with EMR for real-time updates
- Traditional Medicare is likely to follow these changes

⚠️ What To Do When There's a Problem

Encourage complaint filing:

- **Patients**, **providers**, and **staff** are all eligible to file complaints

For ERISA Plans:

- Contact EBSA: **1-866-444-3272** or askebsa.dol.gov

For Commercial Plans:

- Call Montana Commissioner of Securities and Insurance: **(406) 444-2524**

💡 Tips to Remember

- Document ***everything.***
- When calling insurers or Pharmacy Benefit Managers (PBMs), always get the representative's name, title, and the case/reference number.
- For peer-to-peer reviews, request the reviewer's name, title, specialty, and license status. You can request to reschedule with someone of comparable specialty (this must be honored for Montana Marketplace plans and may be honored for ERISA plans)
- Save supporting studies for medical necessity.

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[1] Updated June 2025