



ADMINISTRATIVE RULES OF MONTANA



24.29.1621 PRIOR AUTHORIZATION

- (1) Prior authorization must be obtained in cases where treatment(s) or procedure(s) are requested that:
 - (a) are not specifically addressed or recommended by the Montana Guidelines for a body part that is covered by a guideline or for body parts not covered by the Montana Guidelines;
 - (b) are after maximum medical improvement;
 - (c) are beyond the duration and frequency limits set out in the guidelines; or
 - (d) the guidelines require prior authorization before proceeding with the treatment.
- (2) Prior authorization is not required for emergency procedures.
- (3) When the guidelines explicitly require prior authorization for a treatment or modality, documentation need only include the clinical indications outlined in the guidelines to support that the treatment or modality is appropriate for the injured worker.
- (4) When prior authorization is required because an interested party wishes to rebut the presumption of the guidelines, the interested party must submit to the insurer documentation to support the request and justification that the medical treatment(s) or procedure(s) are reasonable and necessary care for the injured worker. Documentation must consist of a preponderance of credible medical evidenced-based material and medical reasons to rebut the Montana Guidelines. Documentation submitted to rebut the guidelines may include any information from the following list. However, nothing in this list is intended to imply that any given information is sufficient to rebut the guidelines. Rather, whether the presumption of the guidelines is rebutted can only be determined on a case-by-case basis. Submitted information may include:
 - (a) an explanation or documentation of how the patient's medical condition is different from the medical indications used in the Montana Guidelines that may have resulted in a negative recommendation or exclusion;
 - (b) an explanation or documentation of objective findings and functional improvements that would be the expected result of the treatment(s) or procedure(s), either from past experience or from an explanation about the mechanism of injury and the effect of the treatment(s) or procedure(s), and where improvement can be measured;
 - (c) an explanation or documentation of objective signs of functional restoration for treatment conducted thus far;
 - (d) an explanation or documentation of measurable goals and progress points expected from additional treatment;

- (e) a statement of how the request will benefit both a short-term and long-term treatment plan; or
 - (f) any additional evidence-based utilization and treatment guidelines or studies that support the interested party's case.
- (5) All prior authorization requests must be made at least 14 days prior to the date the service is scheduled.
- (a) Authorization is presumed to be given if not denied within 14 days.
 - (b) An insurer may notify the interested party of authorization by written confirmation, e-mail, or facsimile (fax).
 - (c) A verbal request for authorization must be memorialized in writing to the insurer by the provider promptly. The memorialization must include all relevant details of the request and approval.
- (6) If the insurer denies the prior authorization request, the denial must be in writing and must contain an explanation of why the justification is not sufficient.
- (a) The denial must not be based solely on the fact that the medical treatment(s) or procedure(s) are not specifically addressed or recommended by the Montana Guidelines.
 - (b) If the written denial is five or fewer days before the expiration of the 14- day response period, the insurer must also notify the interested party of the denial by e-mail or facsimile (fax).
- (7) When an insurer denies liability for an injury or occupational disease, and the insurer then later assumes liability for a particular condition, the insurer may not deny payment for the medical services provided for that condition during the period of denial based solely on failure to obtain prior authorization.

Authorizing statute(s): 39-71-203, 39-71-704, MCA

Implementing statute(s): 39-71-704, MCA

History: NEW, 2011 MAR p. 1137, Eff. 6/24/11; TRANS from ARM 24.29.1593, 2018 MAR p. 2531, Eff. 1/1/19; AMD, 2024 MAR p. 1066, Eff. 5/11/24.