Understanding Reimbursement Issues in Montana

A Guide for Health Care Providers and Practice Administration

Montana

Example EYLEA HD® (aflibercept) Injection Claim Issues and Applicable State Provisions

Prior Authorization

Issue: Plan delays prior authorization.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a request for prior authorization. Plan has not made a decision.

Montana Code Annotated Section 33-32-211 states...

For prospective review, the organization issues a determination **within 7 business days** of the receipt of request for a utilization management determination, if it is a nonurgent case; and for nonurgent cases, this period **may be extended 1 time** by the organization for up to 7 business days: 1) Provided that the organization determines that an extension is necessary because of matters beyond the control of the organization; and 2) Notifies the patient, prior to the expiration of the initial 15-calendar-day period, of the circumstances requiring the extension and the date when the Plan expects to make a decision; and 3) If a patient fails to submit the necessary information to decide the case, the notice of extension must specifically describe the required information, and the patient must be given at least 45 calendar days from receipt of notice to respond to the Plan request for more information.

Montana Code Annotated Section 33-32-102 states...

Adverse determination also includes any prospective or retrospective review that denies, reduces, terminates, or fails to provide or to make payment in whole or in part for a benefit.

Montana Code Annotated Section 33-32-221 states...

Section 1. Prior authorization requirements. (1) A Plan may not perform prior authorization on benefits for:
(a) any generic prescription drug that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the covered drug at the same quantity without interruption for 6 months;
(b) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication for the same drug if the covered person has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the prescription drug or drugs was approved;
(c) any prescription drug, generic or brand name, solely because the dosage of the medication for the covered person has been adjusted by the prescriber of the prescription drug, as long as the dosage is within the dosage approved by the Food and Drug Administration or is consistent with clinical dosing for the medication; or
(d) any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.
(2) Any adverse determination for a prescription drug made during prior authorization by a Plan must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination does not require the involvement of a physician on the part of a Plan.

Prompt Payment

Issue: Plan delays timely payment pending medical necessity determination.

Example scenario: Patient is diagnosed and meets medical necessity criteria for EYLEA HD injections. Provider submits a claim for EYLEA HD reimbursement, but 31 days later, claim is still pending medical necessity determination.

Montana Code Annotated Section 33-18-232 states...

Plan will pay or deny a claim **within 30 days** of receiving proof of loss unless Plan makes a reasonable request for additional information or documents to evaluate the claim.

If Plan fails to comply with these requirements and is liable for payment of the claim, Plan will pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due.

Request for Additional Information

Issue: Subsequent request for additional information.

Example scenario: Provider submits a claim for EYLEA HD reimbursement, but 31 days later, Plan indicates payment of claim is pending receipt of additional information.

Montana Code Annotated Section 33-18-232 states...

Plan will make a reasonable request for additional information or documents to evaluate the claim **within 30 days** of receiving proof of loss.

If Plan has made a reasonable request for additional information or documents, Plan will pay or deny the claim **within 60 days** of receiving the proof of loss unless Plan has notified the insured person, the insured person's assignee, or the claimant of the reasons for failure to pay the claim in full.

Filing Deadlines

Issue: Claim is past the filing deadline.

Example scenario: Provider timely submits an EYLEA HD claim. Plan denies the claim for being past the filing deadline.

Group Health Insurance Standards Act Section 8 states...

Written proof of loss must be furnished to the insurer **within 90 days** after the date of loss. Failure to furnish the proof within that time will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, **later than 1 year** from the time proof is otherwise required.

NOTE: This provision sets forth minimum standards. Provider should check contract for specific requirements.

Montana Code Annotated Section 33-22-150 states...

If Plan limits the time in which a provider or other person is required to submit a claim for payment, Plan will have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.

Provider Appeals

Issue: Provider appeals.

Example scenario: Provider wants to challenge Plan's denial or reduction of an EYLEA HD claim.

Montana Code Annotated Section 33-32-308 states...

Internal appeal: After receiving a grievance request, Plan will issue a decision and send notification within a reasonable period of time that is appropriate, considering the covered person's medical condition, but **no later than 30 days** for a prospective review and **no later than 60 days** for a retrospective review.

Montana Code Annotated Section 33-32-405 states...

Failure of Plan to respond within the appropriate time frame may allow the claimant to proceed to an **external review**.

Montana Code Annotated Section 33-32-410 states...

An external review must be requested **within 120 days** and will be decided **within 45 days**.

Montana Code Annotated Section 33-32-422 states...

Plan will pay for the costs of the external review.

Complaints regarding these and other payer issues can be made to the Office of the Montana State Auditor, Commissioner of Securities and Insurance website.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

REGENERON®

777 Old Saw Mill River Road, Tarrytown, NY 10591
05/2025 US.EHD.25.04.0018

This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.

Reference: Data on file. Regeneron Pharmaceuticals, Inc.

This information is provided to you by Regeneron, the maker of

EYLEA HD® (aflibercept) Injection 8 mg