POLICY AND PROCEDURE	
TITLE: Submission of Prior Authorization & Claims	
DEPARTMENT: Medical Management - Pharmacy	**POLICY #:** PH23
EFFECTIVE DATE: 09/12/17	**REVIEW/REVISION DATE:** 09/17, 12/18, 05/19
COMMITTEE APPROVAL DATE: P&T 05/14/2019; PRC 06/19/2019 QMUM 07/10/2019	**RETIRE DATE:** None
PRODUCT TYPE: Medi-Cal	**REPLACES:** None

I. PURPOSE

To ensure timely, efficient, and complete submission of pharmacy prior authorization requests and claims.

II. POLICY

Prior authorizations shall be reviewed by Health Plan of San Joaquin (HPSJ) pursuant to pharmacy policy PH05.

Prior authorizations should always be submitted prior to dispensing when eligibility information is known. Pharmacy claims should be processed prior to dispensing to ensure payment for the medications. Pharmacy claims processed after dispensing are not guaranteed payment if prior authorization or step therapy criteria have not been met, or if benefit limits have been exceeded.

III. PROCEDURE

A. Prior Authorization Form

1. In accordance with Senate Bill (SB) 282, effective 7/1/2017 the Department of Managed Health Care (DMHC) requires all Managed Care plans (including HPSJ) to utilize the state-wide universal medication prior authorization form (Form 61-211) developed by the Department of Managed Health Care and the Department of Insurance. No other forms may be accepted. PA requests using an outdated form will be denied without review.

B. Prior Authorization Submission

1. Every effort is made to approve or deny each PA upon the initial submission. In order to expeditiously approve medically necessary medications for which prior authorization is required, pharmacies must:

a. Review the applicable drug/class coverage criteria in the Prior Authorization Coverage Criteria policies and/or the formulary lookup

b. Completely fill out the Pharmacy Prior Authorization Request Form 61-211

c. Attach clinically relevant clinic notes, consults, and lab values

d. Submit all gathered information to the HPSJ Utilization Management Department

C. Timeliness of Prior Authorization Submission

1. Prior authorizations should always be submitted prior to dispensing when eligibility information is known.

2. It is the responsibility of the pharmacy to obtain eligibility information and submit prior authorization as soon as possible if necessary for coverage. Providers and pharmacies are encouraged to use the State Automated Eligibility Verification System (AEVS) to verify eligibility. During the interim while the member's eligibility status is being researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications for emergency situations while pending eligibility verification.

3. All prior authorization requests must be received by HPSJ no more than 14 calendar days after the requested start date of service. Prior authorizations received by HPSJ that do not adhere to the timeframes defined for timely submissions will be denied.

a. Retroactive prior authorizations received after 14 days of requested date of service may be considered for review on a case-by-case basis for reasons such as:

i. Member's Other Health Coverage (primary insurance) denied payment of a claim for services. Prior authorization must be submitted within 90 calendar days from the requested date of service, and must include: (1) a primary insurer denial letter or Explanation Of Benefits (EOB) documenting that the primary insurer does not cover the service, and (2) documentation of amount paid by the other carrier & amount being billed to HPSJ.

ii. Member has obtained retroactive eligibility. Prior authorization must be received by HPSJ within 90 calendar days of the date retroactive eligibility was established.

b. If a pattern of misuse/abuse of retroactive prior authorizations exceeding 14 days is detected, the pharmacy will receive consultation by the Director of Pharmacy or designee. If a pharmacy is counseled three times about inappropriate retroactive prior authorizations as defined in the Policy section, all subsequent prior authorizations from that pharmacy will be denied.

4. Providers are contractually prohibited from holding any member financially liable for any service administratively denied by HPSJ for failure of the provider to obtain timely authorization for medications covered by HPSJ.

D. Claim Submission

1. All claims going through the HPSJ pharmacy benefit must be billed to the contracted Pharmacy Benefits Administrator (PBA).

2. HPSJ is the payer of last resort for coordination of benefit claims. HPSJ is responsible for co-insurance, copayments, and deductibles only after all prior authorization processes through the primary payer have been exhausted.

3. Pharmacies have up to 365 calendar days from the date of service to submit claims to the Pharmacy Benefit Manager. This claims deadline is in accordance with Title 28 CCR § 1300.71(13)(b) and Insurance Code 10133.66(a). Claims received after 365 days from the dispense date may be considered for review:

   a. If a member was not eligible with HPSJ at the time service was rendered and was subsequently granted retroactive eligibility—in which case the pharmacy has up to 90 calendar days from the date retroactive eligibility was established.

   b. If a member has other primary insurance and claims are processed by the primary insurance carrier. In this case, the pharmacy has up to 90 calendar days from the date of payment or date of contest, denial, or notice from the primary payer.

   c. Upon reversal of denial decision on appeal, Independent Medical Review, or State Fair Hearing.

4. HPSJ covers medically necessary medications prescribed for up to a 30-day supply in a 30-day period. The two exceptions to this limit are:

   a. Pharmacies dispensing to members who reside in Long-Term Care (LTC) facilities are limited to dispensing a maximum of 7 days' supply at a time. Medications that must be dispensed in their original container, as indicated in the

Food and Drug Administration Prescribing Information, and packages that cannot be split into smaller quantities are excluded from this limit.

b. For maintenance, non-controlled medications requiring a vacation supply or medication synchronization, pharmacies may dispense a one-time fill for up to a 90-day supply. More details can be found in PH22.

IV. ATTACHMENT(S)

None

V. REFERENCES

A. H&S §1379, §1385

B. Title 28, CCR, § 1300.67.8

C. Title 28, CCR, § 1300.71

D. Ins. Code 10133.66 (amended)

VI. REGULATORY AGENCY APPROVALS

DHCS Approved on (pending).

VII. REVISION HISTORY

STATUS	DATE REVISED	REVISION SUMMARY
Initial	09/12/17	Creation of policy to explain the process for retro authorization requests.
Reviewed	12/11/18	No content change, annual review.
Reviewed	05/14/19	No content change, updated policy template, annual review.

Health Plan of San Joaquin Approval: Signatures on File in C360