7751 S. Manthey Rd | French Camp, CA 95231
1-888-936-PLAN (7526) TTY 711
www.hpsj-mvhp.org

POLICY AND PROCEDURE	
Policy # and TITLE: Submission of Pharmacy Benefit Prior Authorization & Claims	
Primary Policy owner: Pharmacy	**POLICY #:** PH23
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☐Care Management (CM) 5) ☐Claims (CLMS) 6) ☐Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☐Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☐Human Resources (HR) 15) ☐Information Technology / Core Systems (IT) 16) ☒Pharmacy (PH) 17) ☐Provider Networks (PRO) 18) ☒QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** Policy # and Policy Title

I. PURPOSE

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

Location:
https://hpsjonline.sharepoint.com/:f:/r/sites/Compliance-Team/Policy/Templates

II. POLICY

Outpatient physician administered drug prior authorizations (pharmacy services billed as a medical and/or institutional claim) shall be reviewed by Health Plan of San Joaquin/Mountain Valley Health Plan (HPSJ/MVHP) pursuant to pharmacy policy PH05.

Prior authorizations should always be submitted prior to dispensing or physician administration in the office of any medications. Any pharmacy benefits prior authorization (PA) requests and claims submitted on or after January 1, 2022, must go to Medi-Cal Rx. Medi-Cal Rx is responsible for the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered outpatient drugs, including physician administered drugs (PADs), medical supplies, and enteral nutritional products. Any pharmacy authorization requests for retroactive billing purposes of claims processed prior to January 1, 2022, must be processed to HPSJ/MVHP.

III. PROCEDURE

1. Prior Authorization Form/Submission

   a. 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/MVHP) to utilize the state-wide universal medication authorization form (Form 61-211) developed by the Department of Managed Health Care and the Department of Insurance. No other forms may be accepted for retroactive authorization requests submitted to HPSJ/MVHP.

   b. For prior authorization requests submitted to Medi-Cal Rx, five methods are accepted for PA submissions. Further details related to the five methods and job aids can be found at https://medicalrx.dhcs.ca.gov/home.

i. CoverMyMeds® (CMM) PA

ii. Medi-Cal Rx Secured Provider Portaliii. Fax Submission iv.

NCPDP Transaction using the Pharmacy Point-of-Sale System

v. Mail

c. All authorization requests should be filled out in its entirety.

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

ii. Submit all gathered information to the respective organization the authorization request is intended for (e.g., prior to 1/1/2022 is directed to HPSJ/MVHP, on or after 1/1/2022 is directed to Medi-Cal Rx).

2. Timeliness of Prior Authorization Submission

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

b. 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.

c. For authorization requests for medications that were already dispensed prior to 1/1/2022 and prior to receiving prior authorization, the requests are considered retroactive authorization requests.

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

1. 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/MVHP.

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

ii. If a pattern of misuse/abuse of retroactive 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 retroactive authorization requests from that pharmacy will be denied.

d. Providers are contractually prohibited from holding any member financially liable for any service administratively denied by HPSJ/MVHP but already dispensed/administered for failure of the provider to obtain timely authorization for the medications.

3. Pharmacy Benefit Claim Submission on or after 1/1/2022

a. Medications intended for billing on a pharmacy claims system (e.g., through a pharmacy adjudication system) must be billed to Medi-Cal Rx through the Magellan pharmacy benefit system.

b. DHCS, in partnership with Magellan, has a secure Managed Care Plan (MCP) Pharmacy Portal that allows for the HPSJ/MVHP's Designated Users (DU) to view recently processed Medi-Cal Rx pharmacy claims as well as Medi-Cal Rx prior authorizations and their statuses.

c. HPSJ/MVHP is responsible for updating the DU list to add and remove DU based on HPSJ/MVHP's employment and termination of those DU with access to the secure MCP Pharmacy Portal.

4. Retroactive Claim Submission

a. All claims for a date of service prior to 1/1/2022 must go through the HPSJ/MVHP pharmacy benefit and must be billed to the contracted Pharmacy Benefits Administrator (PBA).

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

c. 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:

i. If a member was not eligible with HPSJ/MVHP 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.

ii. 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.

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

II. ATTACHMENT(S)

1. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
2. Glossary of Terms Link
3. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

III. REFERENCES

1. APL 22-012 – Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
2. H&S §1379, §1385
3. Ins. Code 10133.66 (amended)
4. Title 28, CCR, § 1300.67.8
5. Title 28, CCR, § 1300.71

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IV. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	09/17, 12/18, 05/19, 05/20, 12/21, 09/22	N/A
001	Moved PH23 to new template. Reviewed and no changes made.	09/08/2023

Initial Effective Date: 09/12/2017

V. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	05/18/2023
☐ Privacy & Security Oversight Committee (PSOC)		
☐ Risk Management		
☐ Delegation Oversight		
☐ Policy Review	001	04/19/2023
Quality and Utilization Management		
☐ Quality Operations Committee		
☐ Grievance		

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Pharmacy & Therapeutics Committee	001	11/18/2022

VI. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	MCOD Operational Readiness	001	08/15/2023
Department of Managed Care (DMHC)			

VII. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy

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