Health Plan of San Joaquin

Mountain Valley Health Plan

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 & Social Services (BH/SS) 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)	

POLICY AND PROCEDURE	
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) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)	
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** N/A

I. PURPOSE

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

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 and Mountain Valley Health Plan ("Health Plan") pursuant to Health Plan policy PH05 Prior Authorizations.

Prior authorizations should always be submitted prior to dispensing or physician administration in the office of any medications that require Prior Authorization. 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. Further details and examples related to medical vs. pharmacy benefit claims can be found in Health Plan policy PH30 Medical vs Pharmacy Benefit.
Any pharmacy authorization requests for retroactive billing purposes of claims processed prior to January 1, 2022, must be processed to Health Plan.

III. PROCEDURE

A. Prior Authorization Form/Submission

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 Health Plan) 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 Health Plan.

2. 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://medi-calrx.dhcs.ca.gov/home.
   a. CoverMyMeds® (CMM) PA
   b. Medi-Cal Rx Secured Provider Portal
   c. Fax Submission
   d. NCPDP Transaction using the Pharmacy Point-of-Sale System
   e. Mail

3. All authorization requests should be filled out entirely.
    a. Attach clinically relevant clinic notes, consults, and lab values.
    b. Submit all gathered information to the respective organizations the authorization request is intended for (e.g., prior to 1/1/2022 is directed to Health Plan, on or after 1/1/2022 is directed to Medi-Cal Rx).

B. 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. 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.
    a. 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:
        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 Health Plan.

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

iii. If a pattern of misuse/abuse of retroactive authorizations exceeding 14 days is detected, the pharmacy receives 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 are denied.

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

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

1. 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.
2. DHCS, in partnership with Magellan, has a secure Managed Care Plan (MCP) Pharmacy Portal that allows for Health Plan's Designated Users (DU) to view recently processed Medi-Cal Rx pharmacy claims as well as Medi-Cal Rx prior authorizations and their statuses.
3. Health Plan is responsible for updating the DU list to add and remove DU based on Health Plan's employment and termination of those DU with access to the secure MCP Pharmacy Portal.

D. Retroactive Claim Submission

1. All claims for a date of service prior to 1/1/2022 must go through Health Plan's pharmacy benefit and must be billed to the contracted Pharmacy Benefits Administrator (PBA).
2. Health Plan is the payer of last resort for coordination of benefit claims. Health Plan 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 claim's 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 Health Plan 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.

II. ATTACHMENT(S)

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

III. REFERENCES

A. DHCS APL 22-012 – Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
B. H&S §1379, §1385
C. Ins. Code 10133.66 (amended)
D. Title 28, CCR, § 1300.67.8
E. Title 28, CCR, § 1300.71

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
002	Referenced PH30 and updated any organizational references to "Health Plan" for dual branding purposes.	09/03/2024
Initial Effective Date: 09/12/2017		

V. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	002	02/20/2025
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	002	11/27/2024
Quality Improvement Health Equity Committee (QIHEC)	002	09/18/2024
• Quality Operations Committee		
• Grievance		

VI. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	MCOD Operational Readiness	001	8/15/2023
Department of Managed Care (DMHC)			

VII. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	

Signature	Name Title	Date
	Chief Executive Officer	

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