Bureau of Managed Care

Managed Care Organizations

Policy / Procedures

General Contract Monitoring

Dispute Process: Prior Authorization

Prior Authorization Dispute Requirements

Plans must establish a service authorization dispute process that allows Providers to contest an authorization denial or a reduction, suspension or termination of a previously authorized service. Plans must provide a substantive response, in writing, intended to resolve the dispute within thirty (30) business days after receipt of the dispute request. See Section 5.29.7.2 of the Contract.

Anticonvulsant Medications

- Per Public Act 098-0104, the December 10, 2013 HFS provider notice, and the November 6, 2017 memo from Robert Mendonsa to all MCOs, clients, including those enrolled in managed care, are allowed access to any anticonvulsant medication (anti-seizure/epilepsy), be it brand or generic, under this law.
- Per the Contract, Medicaid health plans cannot be more restrictive than the Department.
- As long as there is a diagnosis of anti-seizure disorder in the claim record, there can be no prior authorization or exception review process applied to the dispensing of these medications.
- All drugs—brand and generic—are allowed per the law, regardless of whether or not that medication is on that Medicaid health plan's formulary.
- Failure to follow guidance of this policy will result in a Corrective Action Plan and/or possible sanction.

Contract References – Prior Authorization

4.6.1 – Newborns

Contractor shall not require prior authorization for inpatient newborn claims for newborns retroactively enrolled.

5.3.2.3 – Drugs

Contractor must cover without a prior authorization requirement at least one (1) drug in each drug class not contained on the Department's PDL for which the Department has a drug available without prior authorization.

5.3.2.8 – Family-Planning Drugs

Contractor shall utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and Attachment XXI.

5.10.10 – Prior Authorization Policy Changes
Contractor must notify Providers of any changes to prior authorization policies no less than thirty (30) days before the date of implementation.

5.19.8 – Services Requiring Prior Authorization
Contractor shall authorize or deny Covered Services that require prior authorization, including pharmacy services, as expeditiously as the Enrollee's health condition requires. Ordinarily, requests for authorizations shall be reviewed and decided on within four (4) days after receiving the request for authorization from a Provider, with a possible extension of up to four (4) additional days, if the Enrollee requests the extension or Contractor informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. If the Provider indicates, or Contractor determines, that following the ordinary review and decision time frame could seriously jeopardize the Enrollee's life or health, Contractor shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization. Contractor shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

5.19.8.1 – Chronic Conditions/LTSS
Contractor shall authorize services supporting individuals with ongoing or chronic conditions, or who require LTSS, in a manner that reflects the Enrollee's ongoing need for such services.

5.19.8.3 – Nursing Facilities
For authorizations for MLTSS Enrollees residing in a NF, if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, Contractor must pay for the service if it is a Covered Service, provided that the request is consistent with the policies and procedures of the Contractor.

5.20.2.1.1 – School-Based Health Centers
Contractor shall offer contracts to all the school health centers recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for school-based health center services provided by those school-based health centers with which Contractor has contracts.

5.20.2.3.1 – Local Health Departments
Contractor shall offer contracts to all the local health departments recognized by the Department of Public Health that are in Contractor's Contracting Area. Contractor shall not require prior authorization or a Referral as a condition of payment for local health department services provided by those local health departments with which Contractor has contracts.

5.21.1.4.2 – Emergency Services
Prior authorization is not required for Emergency Services.

Attachment XXI, 3.1.3 – Family Planning and Reproductive Healthcare
Regarding family planning and reproductive healthcare, Contractor policies shall not present barriers or restrictions to access to care, such as prior authorizations or step-failure therapy requirements.

Attachment XXII, 1.5.1.2 – Mobile Crisis Response Services
Contractor's Mobile Crisis Response Services shall include policies defining the delivery of Crisis and stabilization services, which shall not require Contractor's prior authorization, for an established period of time post-Crisis that shall not be less than thirty (30) days.

Policy History

General Contract Monitoring

Dispute Process: Prior Authorization

Date	Action	Policy Originator
April 2018	Contract Clarification	Laura Ray

Policy Revisions	Revision Approved
[revision date]	[name of person who approved revision]