Workgroup Recommendations
Refinements to WACs related to Pre-Authorization under the Pharmacy Benefit

The recommendations highlighted in green below are intended to align the WACs with the Best Practice Recommendation related to pre-authorization of pharmacy benefits.

WAC 284-43-410
Utilization Review- Generally
re: BPR – Emergency Fill

(1) These definitions apply to this section:
(f) "immediate therapeutic needs" are those where passage of time without treatment would result in imminent emergency care, hospital admission OR might seriously jeopardize the life or health of the patient or others in contact with the patient
(g) "emergency fill" is a short term dispensed amount of medication that allows time for the processing of a pre-authorization request. An Emergency Fill medication does not necessarily constitute a covered health service for that patient. Determination as to whether this is a covered health service under the patient benefit will be made as part of the pre-authorization processing

(8) Each carrier must have an emergency fill policy that recognizes the need for emergency fills during non-business hours. When medications prescribed for "immediate therapeutic needs" require a pre-authorization due to formulary or other utilization management restrictions and the prescriber is not available for full consultation, the health plan will authorize an "emergency fill" by the dispensing pharmacist and will approve claim payment. The inclusionary and exclusionary list of medications authorized by health plans for emergency fill are located on <<a website to-be-designated by the OIC.>> The authorized amount of the emergency fill will either be the minimum packaging size, or the lesser of a 7-day supply or the amount as prescribed.

WAC 284-43-818
Formulary changes.
re: BPR – Exchanging Pharmacy Info & BPR – Health Plan Web Capability

A carrier is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, a carrier must, at a minimum, comply with these requirements when a formulary change occurs.
(1) In addition to the requirements set forth in WAC 284-30-450, a carrier must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health benefit plan, policy or agreement otherwise provides coverage, unless the medication or drug is removed because the drug or medication becomes available over-

the-counter, is proven to be medically inefficacious, or for documented medical risk to patient health.
(2) If a drug is removed from a carrier's formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of black box warnings by the Federal Drug Administration, a carrier must continue to cover a drug that is removed from the carrier's formulary for the time period required for an enrollee who is taking the medication at the time of the formulary change to use a carrier's substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement.
(3) Formularies and related pre-authorization information must be posted on a carrier or a carrier's contracted pharmacy benefit manager web site and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted thirty days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay.
(4) Current formulary information must be made electronically available for loading into e-prescribing applications/Electronic Health Record utilizing the NCPDP Formulary and Benefit standard transaction, to include all required data elements as well as the following information
(i) Tier level
(ii) Contract exclusions
(iii) Quantity limits
(iv) Pre-Auth required
(v) Preferred/Step Therapy

WAC 284-43-321
Provider contracts – Terms and conditions of payment
re: BPR – Exchanging Pharmacy Info

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

Rejection of a claim (i.e. the processing of a claim has been stopped, pending a defined action required of the pharmacist, prescriber or member) must be made electronically available to the pharmacy utilizing the NCPDP Telecommunications standard transaction to include all required data elements as well as the following information, to the extent supported by the transaction

i. Rejection Reason (Pre-Authorization (PA), Quantity Level Limitations (QLL), Exclusion, etc.)
ii. Other medications to consider that would require a Pre-Authorization (if

applicable)
iii. Other medications to consider that would not require a Pre-Authorization (if applicable)
iv. Instructions for further processing of claim or for more specific contact information, may include a reference to a specific location on a web site
v. Phone number of person/department to contact

WAC 284-43-410
Utilization Review- Generally
re: BPR – Notification Timeframes

The workgroup suggests that the OIC consider the following before writing these recommendations into rule:

1) *Incorporate forthcoming timeframe-related recommendations of the Pre-Auth Workgroup – Medical Caucus that is scheduled to meet in November & December. The Medical Caucus will assess the current medical benefit related timeframes in light of the work of the Pharmacy Caucus as follows:*
    a. *Consider if/how 'Immediate Review Request' is renamed and/or redefined so that is not confused with 'Immediate Therapeutic Needs.*
    b. *Consider whether the proposed timeframe refinements to 'nonurgent preservice review requests' are appropriate for notification timeframes for medical benefit pre-authorizations. If not, the Medical Caucus will recommend WAC language specific to medical benefit pre-authorization timeframes.*
2) *If/as timeframe-related definitions and regulations differ between pharmacy pre-auth and medical pre-auth, these distinctions should be clearly stated in the WAC, through grouping or other such method that enhances the understandability of the WAC.*

(6) Each carrier must have written procedures to assure that reviews and second opinions are conducted in a timely manner.
(a) Review time frames must be appropriate to the severity of the patient condition and the urgency of the need for treatment, as documented in the review request.
(b) If the review request from the provider is not accompanied by all necessary information, the carrier must tell the provider what additional information is needed and the deadline for its submission. *Upon the sooner of the receipt of all necessary information or the expiration of the deadline for providing information, the time frames for carrier review determination and notification must be no less favorable than federal Department of Labor standards*, as follows:
(i) For immediate request situations, within one business day when the lack of treatment may result in an emergency visit or emergency admission;
(ii) For concurrent review requests that are also urgent care review requests, as soon as

possible, taking into account the medical exigencies, and no later than twenty-four hours, provided that the request is made at least twenty-four hours prior to the expiration of previously approved period of time or number of treatments;
(iii) For urgent care review requests, ~~within forty-eight hours~~ reviews all evidence submitted and takes one of the following actions:
(a) Within 24 hours requests the provider submit additional justifying information;
(i) The provider must submit the additional information within 48 hours of the request.
(ii) Approve or deny the request within 48 hours of the receipt of the additional information.
or
(b) Within 48 hours approves the request; or
(c) Within 48 hours denies the request if the requested service is not medically necessary;
(iv) For nonurgent preservice review requests, including nonurgent concurrent review requests, ~~within five calendar days~~ reviews all evidence submitted and takes one of the following actions within 5 calendar days:
(a) Approves the request; or
(b) Denies the request if the requested service is not medically necessary; or
(c) Requests the provider submit additional justifying information.
(i) The provider must submit the additional information within 5 calendar days of the request.
(ii) Approve or deny the request within 4 calendar days of the receipt of the additional information.
or
(v) For postservice review requests, within thirty calendar days.
(c) Notification of the determination must be provided as follows:
(i) Information about whether a request was approved or denied must be made available to the attending physician, ordering provider, facility, and covered person. Carriers must at a minimum make the information available on their web site or from their call center.
(ii) Whenever there is an adverse determination the carrier must notify the ordering provider or facility and the covered person. The carrier must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means. For an adverse determination involving an urgent care review request, the carrier may initially provide notice by phone, provided that a written or electronic notification meeting United States Department of Labor standards is furnished within seventy-two hours of the oral notification.
(d) As appropriate to the type of request, notification must include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.
(e) The frequency of reviews for the extension of initial determinations must be based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.