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Best Practice Recommendation for

Emergency Fills and Notification Timeframes for Pre-Authorization Requests under a Member's Pharmacy Benefit

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Version	
Issue Date	**Explanation**
10-20-2014	First Release
11-24-2014	Standard Review Request timeframe to 14 days (pg 6)

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BEST PRACTICE RECOMMENDATION

Topic: Emergency Fills and Notification Timeframes for Pre-Authorization Requests

Note: For the purpose of this document, the term pre-authorization includes any authorizing related action that needs to be taken prior to dispensing of the medication in order for a claim to pay. Interchangeable terms for those Pre-Authorization actions include, but are not limited to pre-authorization, pre-auth, pre-cert, prior auth, prospective review etc.

Improvement Opportunity:

Clear and consistent expectations about pre-authorization decision timeframes will help to manage member, prescriber and pharmacist expectations about medication dispensing.

This document recommends best practice standard timeframes for processing pre-authorization requests and for notifications about the decision. It also recommends best practices for an Emergency Fill of a prescription.

Summary of Recommendation:

Pre-Authorization decisions will be made and prescribers will be notified within timeframes that meet or exceed standards established by the National Committee for Quality Assurance (NCQA) and/or Washington State WACs, based upon the acuity of the patient's need for care or treatment. (Note: NCQA timeframes are consistent with those of URAC and ERISA.) These timeframes are the longest that the decision making and notification process should take. In many situations, the process will be more timely.

In specified situations an Emergency Fill will be authorized and dispensed to allow time for processing the pre-authorization request for the medication.

Applicability:

The best practices that are recommended in this document apply to all services that are covered under a member's pharmacy benefit whether the health plan directly performs the practice or outsources the practice to another organization, e.g. PBM. References in this document to best practice recommendations for "health plan" means the inclusion of the health plans, payers as well as any other outsourced organization e.g. PBM, that are performing those services.

These Best Practice Recommendations only apply in those situations when a health plan ***requires*** that a prescriber obtain a prior authorization for medication**.** This BPR ***does not call for health plans to require*** authorization as a pre-condition of claims payment.

All health plans, prescriber and pharmacy organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical.

Emergency Fills for Medications Requiring a Pre-Authorization

The intent of Emergency Fills is for those circumstances where a patient presents at a pharmacy with an 'immediate therapeutic need' for a prescribed medication that requires a pre-authorization due to formulary or other utilization management restrictions.

A. Definitions

1. *Immediate therapeutic needs* - are those where passage of time (i.e. the timeframe required for an Urgent Review) 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

2. *Emergency Fill* - A short term dispensed amount of medication that allows time for the processing of a pre-authorization request. Though the medication dispensed will be approved and paid, Emergency Fill 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.

   The authorized amount of the Emergency Fill will either be the minimum packaging size that cannot be broken (e.g. injectable), or the lesser of a 7-day supply or the amount as prescribed. (Depending upon their policies, Health Plans may exceed this baseline dispensing amount). In the event the medication is to be continued for treatment beyond the emergency fill authorization, health plans may apply formulary or utilization management restrictions that will be reviewed following the health plans' standard procedure.

B. Policy and Operational Processes

1. Health plans will have an Emergency Fill Policy and will publish it on their website. (See BPR-Health Plan Web Capabilities)

2. When a currently eligible member presents at a contracted dispensing pharmacy with an immediate therapeutic need and a corresponding prescription from their

provider for a medication requiring a pre-authorization that is specified on the list in '3.' below,

a. If the health plan has 7 day x 24 hours availability to respond to phone calls from a dispensing pharmacy but the health plan cannot reach the prescriber for full consultation, an emergency fill will be authorized for dispensing.

   OR

b. If the dispensing pharmacy cannot reach the health plan's pre-authorization department by phone as it is outside of that department's business hours, an Emergency Fill can be dispensed by the pharmacy and will be approved and paid.

   The health plan's Emergency Fill policy will outline their process by which the dispensing pharmacy can secure payment for emergency fill. Two typical processes are:

   - The dispensing pharmacy will be given a code that can be submitted with the claim that designates the dispensed medication as an emergency fill and will authorize payment.
   - The dispensing pharmacy will contact the health plan's pre-authorization department within 2 business days to inform them of the Emergency Fill so that a claim for the dispensed medication can be retrospectively submitted and paid.

3. The Best Practice Recommended inclusion medication list for emergency fill to address immediate therapeutic needs is as follows: (Medications in addition to those listed below may be covered for Emergency Fill on a health plan by health plan basis).

   - Antibiotics & Antivirals for acute infections
   - Medications for mental health conditions
   - Anticoagulant / Antiplatelet medication
   - Antiemetics (for imminent Nausea and Vomiting)
   - Anti-Rejection/Immunosuppression medication for post-transplant patients
   - Antiretrovirals (continuing current therapy, not new starts except for emergency use)
   - Cardiovascular medications for acute treatment only (e.g. antiarrhythmics, anti-hypertensives)
   - Epinephrine injections
   - Generically available, immediate release pain medication (does not include transmucosal immediate release fentanyl)
   - Gout flare (acute) medications
   - Insulin (continuing current therapy, not new starts)

- Naloxone
- Non-OTC pediculocides ---lice and scabies treatments
- Rescue Inhalants and delivery support devices
- Seizure/epilepsy medications
- Triptans

High dollar medications for chronic conditions, e.g. oral oncology, hepatitis C, biologics, multiple sclerosis treatments, enzyme replacements, etc. are not consistent with the above definition of "immediate therapeutic needs" and thus would not be covered for emergency fill.

An emergency fill will not be paid in the following situations:
- Non-contracted pharmacy
- Refill too soon
- Quantity limitation exceeded
- Yearly maximum met

C. Continuous Quality Improvement (CQI)

The above Best Practice Recommended inclusion list will be periodically reviewed/refined on an ongoing basis by a multi-disciplinary group representing pharmacists, prescribers and health plans to ensure that the list is appropriate to clinical needs and reflects up-to-date pharmaceutical treatment options. Additions and deletions should be evidence-based considering frequency of actual occurrence.

Pre-Authorization Request Definitions:

A pre-authorization request is a request by a prescriber of a health plan to make a Utilization Management decision as to whether the patient's insurance benefits will cover a medication. Nationally recognized standards relating to pre-authorization requests are commonly defined and adopted by the following:
- The National Committee for Quality Assurance (NCQA) is a nationally recognized, non-profit organization that accredits and certifies health plans
- URAC is an independent, nonprofit organization that promotes health care quality through its accreditation and certification program.
- ERISA is the Employee Retirement Income Security Act of 1974 and sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries.

There are different types of requests depending upon the patient condition and when the request is made. These request types are based upon the following definitions.

1. *Urgent Care Review Request* - any request for approval of care or treatment where the passage of time could:
   - Seriously jeopardize the life or health of the patient
   - Seriously jeopardize the patient's ability to regain maximum function,
   - Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

2. *Standard Review Request* – any request for approval of care or treatment where the request is a) made in advance of the patient obtaining medical care or services, or b) a renewal of a previously approved request

   For the purposes of WAC 284-43-410, this type of request is also known as 'Nonurgent preservice review request' which is defined in the WAC as 'any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services and is not an urgent care request.'

Timeframes for Responding to Pre-Auth Requests:

For those types of requests where timeframes have been established by NCQA, URAC, ERISA and a Washington State WAC, the timeframe indicated below are consistent.

Considerations:

- The timeframes are calendar hours/days and not business hours/days
- For Standard Requests, a day is counted regardless of the time when the request is received by the health plan or when the prescriber is notified of a decision. For example, day 0 concludes at midnight whether the request is received at 7:00 AM or 11:00 PM. (The first day is considered Day 0.)
- Decision Notification timeframes include making information about the decision available, as appropriate, to the member, prescriber and pharmacy (only in those cases where the pharmacy initiated the pre-auth request).
  - Information about whether a request was approved or denied should be available either on the health plan's web site and/or from their call center, depending upon health plan's policies and procedures.
  - The member must be included in the notification if there is an adverse determination, e.g. when a request is denied or when requested services are not approved in full. Notification will be in a manner determined by the health plan, i.e. by phone, mail, fax, etc.
- These timeframes represent the longest period that a decision should take.
- If requested information is not received from the prescriber within the timeframe specified, the request may be denied or pended.

1. *Urgent Care Review Requests*

   (References: *NCQA* - UM 5,A,2 *URAC* - UM 17a ERISA 2560.503-1 f.2.i, WAC 284-43-410)

   If no information is needed from the patient or prescriber, decision notification will be within 48 hours of receiving the request.

   If information is needed from the patient or the prescriber, the health plan will ask for that information within 24 hours of getting the request from the prescriber. The patient or prescriber is given 48 hours to provide the information; then the health plan has 48 hours from due date or receipt of information, which ever is earlier, to make the decision.

   Requests that are indicated, by the prescriber, to be 'Urgent' must fit the criteria outlined above in section 'Types of Pre-Authorization Requests'. If the request does not fit the urgent criteria, the health plan will process it as a Standard Request and will notify the prescriber as such within the decision notification timeframe.

2. *Standard Review Requests -- Initial & Renewals*

   (Reference: WAC 284-43-410)

   Upon receipt of a request, a health plan will have 5 calendar days to either:
   a. Make a decision, or
   b. Request additional documentation from the provider or member, as appropriate, by phone, fax or secure electronic communication.

   The provider will respond to that request with the appropriate information within 5 calendar days. Upon receipt of all needed information, the health plan will make a final determination in no later than 4 calendar days.

Recommended Best Practices:

These Best Practice Recommendations apply to pre-authorization requests for medication under a member's pharmacy benefit.

Prescriber

1. Request pre-authorization decisions using the communication methods appropriate to the health plan. Send any supporting documentation required by the health plan along with the request. Note, health plans may have different guideline/documentation requirements and methods depending upon the type of service being pre-authorized.

2. Indicate the type of pre-authorization requested based upon the above definitions, i.e. Urgent or Standard
3. Respond in a timely manner to health plan requests for additional information. Be sure to fill in any form and/or answer any specific questions sent to you by the health plan.
4. Encourage your patient to respond to information requests from health plans in a timely manner.

Health Plan

1. Identify, on the web site, the guidelines/documentation requirements that need to be met in order for a pre-authorization request for a specific service to be reviewed.
2. Process the pre-authorization request and provide notification of decision within the timeframes outlined above. Decisions could be made sooner.
3. Notify prescribers, patients and the dispensing pharmacy (if known) of any adverse determination decision using established communication methods.
4. Notify prescribers of all approval decisions using established communication methods.