PLAN POLICY AND PROCEDURE	
SHARP HEALTH PLAN make life better. **Title: SHP Pharmacy Management Procedure for Pharmacy Denial Process**	**Product Line** (check all that apply)**:** ☒ All ☐ Group HMO ☐ Individual HMO ☐ PPO ☐ POS ☐ N/A
Division(s): Health Services	
Department(s): Pharmacy	
Owner (Title): Pharmacy Manager	
Relevant Regulatory/Accrediting Agencies/Citations (specify): ☐ CMS: _____ ☒ DMHC: Title 28 CCR §1300.67.241; RX-001 A ☒ NCQA-HP: UM 13B; UM 13.G ☐ NCQA-WHP: _____ ☐ OTHER: _____	
Approved by: (Signature of VP, Compliance Officer, or CEO) 	**Approval date:** 3/9/2016

I. PURPOSE:

This Policy and Procedure establishes Sharp Health Plan's (Plan) policy and procedure for its denial process including appropriate notification, timelines for Utilization Management decision making and alternatives for Members and Providers in the event of a health care service denial.

II. POLICY:

It is the policy of Sharp Health Plan (Plan) to review all medication prior authorization requests timely and to provide appropriate notification of determinations including alternatives for Members and Providers in the event of a health care service denial.

III. DEFINITIONS:

A. CMO: Chief Medical Officer

B. Commercial Members: Members enrolled in Sharp Health Plan Commercial benefits including Exchange and Mirrored plans

C. DMHC: Department of Managed Health Care

D. Member: An individual who has enrolled in the Plan and for whom applicable Premiums have been paid. This may include past Members whose coverage by the Plan may have terminated.

G. Physician Designee: A physician assigned by and under the oversight of the Plan's Chief Medical Officer or Medical Director to perform review for medical necessity and benefit coverage.

H. Provider: Prescribing physicians or other licensed prescribers

I. IMR: Independent Medical Review

J. PA: Prior authorization request

IV. RESPONSIBILITIES:

A. The Plan's Pharmacy Department licensed staff reviews all PA requests.

B. The Plan's Medical Director or Physician Designee reviews all service requests when there is a question of medical necessity or benefit coverage for final determination.

C. The Pharmacy Department staff produce and send all denial and approval letters using the MedResponse System.

V. PROCEDURE:

A. A denial may occur at any time during the authorization process. PA denial reasons usually fall into one of the following categories:

1. Not a covered benefit;
2. Not medically necessary;
3. Medical necessity not apparent;
4. Does not meet criteria;
5. Denial for experimental/investigational;
6. Member not eligible; or
7. Not enough information provided to make a determination;

B. When Pharmacy Department licensed staff are unable to approve authorization requests based on approved Health Plan guidelines or criteria, these cases are referred for evaluation to the Plan's Medical Director or Physician Designee.

C. All denial determinations and questionable covered benefit determinations are made by the Plan's Medical Director or Physician Designee. Board certified physicians in the appropriate specialty area may review specific cases as determined by the Plan's CMO or Physician Designee.

1. When a service is denied or modified, notification is sent to all affected parties as follows:
   a. The Member,
   b. The requesting Provider
2. It is the Plan's policy to notify the prescribing provider within 24 hours of receipt for urgent requests and 72 hours of receipt for routine requeststhat either:
   a. The prescribing provider's request is approved; or
   b. The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or
   c. The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the

prescription drug prior authorization request;

d. The patient is no longer eligible for coverage; or
e. The prescription prior authorization request was not submitted on the required form. Please resubmit your request on the attached Form No. 61-211.

3. In the event the notice of disapproval, consistent with the requirements above, is not sent to the prescribing provider within 24 hours of receipt for urgent requests and 72 hours of receipt for routine requests the prescription drug prior authorization request shall be deemed approved.

D. The denial letter includes the following:

1. A clear, accurate and concise explanation of the specific reason(s) for disapproving the prescription drug prior authorization request.
2. A description of the criteria or guideline used as the basis of the determination.
3. Clinical reasons for a decision regarding medical necessity.
4. Proposed alternative(s) covered by the plan, if any.
5. Additional information, testing or the additional examinations or tests required to make a determination.
6. Information regarding Members' right to appeal and the grievance process.
7. The DMHC "800" number and IMR information.
8. Options regarding independent external review (as applicable for experimental or investigational services).
9. Information to the Provider to include the name and a business telephone number of the health plan professional responsible for the decision for denial.

E. Notification of denial of service will be given within the following timelines:

Type of Denial Determination	**Timeliness of UM Decision**	**Guidelines for Notification**
Commercial Pharmacy Prior Authorization Request	Decision is made within two 24 hours of receipt of an urgent prescription prior authorization request and within 72 hours of receipt of a routine prescription prior authorization request.	Notification to the Provider of the denial decision within 24 hours of receipt of an urgent prescription prior authorization request and within 72 hours of receipt of a routine prescription prior authorization request.

F. When experimental or investigational therapies are denied, the UM staff follows the steps outlined in the Plan's EOC description of the IMR process.

G. Pharmacy Policies are available to Providers upon on request.

H. Pharmacy Policies are available to the public upon written request. When requested, a copy of the guidelines that were applied in the medical review process is sent with a letter that includes the following notice:
"The materials provided to you are guidelines used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

VI. ATTACHMENTS: None Applicable

VII. SUPPORTING DOCUMENTS: None Applicable

VIII. REFERENCES: Industry Collaboration Effort (ICE) Utilization Management Timeliness Standards (Commercial HMO – California)

IX. California Health and Safety Code Section 1300.67.241 Prescription Drug Prior Authorization Form Process

X. REVISION HISTORY:

Date	**Modification (Reviewed and/or Revised)**
06/08/2011	Original Document
11/01/2011	Revised
03/14/2012	Approved by P&T Committee
03/13/2013	Approved by P&T Committee
03/19/2014	Approved by P&T Committee
03/18/2015	Approved by P&T Committee
03/09/2016	Approved by P&T Committee