Document ID: DOC-018416	Title: Amendment - Medicaid and CHIP Prior Authorization Process (New York)	
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Exhibit(s): N/A		
Document Type: Policy and Procedure		

PURPOSE

To define the steps necessary for processing Medicaid requests for review received by the Medicaid Department.

SCOPE

CVS Caremark® Prior Authorization Department.
* Applies only to New York.

POLICY

This Amendment is written to meet regulatory and legislative requirements pertaining to Medicaid prior authorization review specified in Article 49 of the New York State Public Health Law (PHL) and Insurance Law that impact the Prior Authorization Process for New York.

Under New York law, there are Medicaid Prior Authorization requirements that deviate from or exceed the timeliness and notification standards outlined in the Prior Authorization Process Policy, PAR-0011. This Amendment will be used in conjunction with PAR-0011 to comply with those New York requirements.

PROCEDURES

General

1. The PA Department's policies and procedures shall include, but not be limited to, the following:
    a. Urgent Review must be conducted when the PA Department determines or the provider indicates that a delay would seriously jeopardize the Plan Member's life or health or ability to attain, maintain, or regain maximum function. The Plan Member may request Urgent Review.
    b. The PA Department will not deny a Plan Member's request for an Urgent Review.
    c. Prior authorizations (Urgent and non-urgent) will be reviewed as follows:
        i. A Denial based on lack of a Medically Necessary service or a prior authorization that involves clinical issues:
            1. Will be reviewed by a licensed physician who:

i. Is in the same/similar specialty as a health care provider that typically manages the medical condition, procedure, or treatment;
ii. Holds an active, unrestricted license to practice medicine or a health profession; and
iii. Has the appropriate clinical expertise, as determined by the state, in treating the Plan Member's condition or disease;

ii. Non-clinical Denials are completed by prior authorization representatives who are appropriately trained and supervised.

d. The PA Department will accept the New York Standard Medicaid Prior Authorization Form for review and approval of prior authorization requests.
e. The PA Department will accept communication from providers and refer Reconsiderations to a Clinical Peer Reviewer if there has been no previous discussion with a provider.
    i. The PA Department will either open a new PA for a Reconsideration or attempt verbal contact with the provider.
    ii. The PA Department will maintain a record of the Reconsideration determination.
f. Prescriber Prevails – For PA requests involving a prescription drug that is included on the NY Department of Health's "Prescriber Prevails" list, the PA department will consult with the provider to determine whether such drugs are,
    i. In the prescriber's reasonable professional judgment, either by consistency with US Federal Drug Administration approved labeling or use supported in at least one of the Official Compendia as defined in federal law, medically necessary and warranted to treat the Plan Member.
    ii. The PA Department will require the provider's attestation that the drugs are medically necessary and warranted.
g. The PA Department will make a minimum of two attempts to reach the prescriber if the PA request does not contain all necessary information to make a determination. The attempts will be made in the following order;
    i. An initial outbound call to reach the prescribing provider will be made;
    ii. If the PA Department is not able to speak with someone to complete the request, a fax will be sent to the prescriber in an attempt to obtain the information.
    iii. If the prescribing provider's office is closed when the initial outbound call attempt is made a second outbound call attempt will be made to reach the prescribing provider.

Timeframes for Prior Authorization Determinations

1. The PA Department will make a determination and provide notice as fast as the Plan Member's condition requires and no more than twenty-four (24) hours after receipt of the PA request

Notices

1. The PA Department shall ensure that all notices are in writing and in easily understood language and are accessible to non-English speaking and visually impaired Plan Members.

Notices shall include that oral interpretation and alternate formats of written material for Plan Members with special needs are available and how to access the alternate formats.

2. Written and telephonic notification of decisions shall be communicated to the Plan Member by telephone, and provider by fax, within the time periods outlined for Urgent and non-Urgent requests.
    a. If the fax is unsuccessful, an outbound call will be made and the letter will be mailed to the provider.
3. Notice to the Plan Member and prescribing provider of a PA determination shall:
    a. Include taglines in the prevalent non-English languages in the State as well as print no smaller than 18 point that will provide the toll –free telephone and TTY/DYD telephone number of CVS Caremark's customer service department as well as explain the availability of written or oral translations if they are needed to understand the information provided;
    b. Include a tagline no smaller than 18 point and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats;
    c. Be in an easily understood language and format;
    d. Use a font no smaller than 12 point; and
    e. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.
4. Notice to the Plan Member and provider regarding a PA Department-initiated extension shall include:
    a. The reason for the extension;
    b. An explanation of how the delay is in the best interest of the Plan Member;
    c. Any additional information the PA Department requires from any source to make its determination;
    d. The right of the Plan Member to file a Complaint regarding the extension;
    e. The process for filing a Complaint with the PA Department and the timeframes within which a Complaint determination must be made;
    f. The right of a Plan Member to designate a representative to file a Complaint on behalf of the Plan Member; and
    g. The right of the Plan Member to contact the New York State Department of Health regarding his or her Complaint, including the SDOH's toll-free number for Complaints.
5. Notice to the Plan Member and provider regarding Prescriber Prevails must clearly state:
    a. The requested medication will be provided when the prescriber demonstrates that in their reasonable professional judgment, either by consistency with US Federal Drug Administration approved labeling or use supported in at least one of the Official Compendia as defined in federal law that the medication is medically necessary and warranted to treat the Plan Member; and
    b. Action is being taken by the plan because:
        i. The necessary information to complete the Service Authorization Request was not provided to the PA Department and the time for review has expired, or
        ii. The prescriber's reasonable professional judgment has not been adequately demonstrated and the time for review has expired, and

c. The information that must accompany the Reconsideration request or with an Appeal.

6. Notice to the Plan Member and provider of a Denial shall include:
   a. The description and reasons for the determination, including the clinical rationale, if any;
   b. The statement of clinical rationale for an adverse determination will, at a minimum, identify:
      i. The Plan Member and the nature of his/her medical condition;
      ii. The medical service, treatment or procedure in question; and
      iii. The basis on which it was determined that the service, treatment or procedure is not medically necessary or experimental/investigational.
   c. The Plan Member's right to file an Appeal, including:
      i. The PA Department will not retaliate or take any discriminatory action against the Plan Member because he/she filed an Appeal.
      ii. The right of the Plan Member to designate a representative to file an Appeal on his/her behalf.
   d. The process and timeframe for filing an Appeal, including an explanation that an Urgent Review Appeal can be requested if a delay would significantly increase the risk to a Plan Member's health, a toll-free number for filing an oral Appeal and a form, if used by the PA Department, for filing a written Appeal;
   e. The right of the Plan Member, their representative, and provider to review the Plan Member's case file, including medical records and any other documents and records being used to make a decision on their case;
   f. A description of what additional information, if any, must be obtained by the PA Department from any source in order for the PA Department to make an Appeal determination;
   g. The timeframes within which the Appeal determination must be made;
   h. The right of the Plan Member to contact the SDOH with his or her Complaint, including the SDOH's toll-free number for Complaints;
   i. The "Fair Hearing" request form ("Managed Care Action Taken") containing the Plan Member's fair hearing and aid continuing rights;
   j. For Denials based on issues of Medically Necessary or an experimental or investigational treatment, the notice of Denial shall also include:
      i. A clear statement that the notice constitutes the initial adverse determination and specific use of the terms "Medically Necessary" or "experimental/ investigational";
      ii. A statement that the specific clinical review criteria relied upon in making the determination is available upon request;
      iii. A statement that the Plan Member may be eligible for an external Appeal;
      iv. A statement that if the Denial is upheld on Appeal, the Plan Member will have 4 months from receipt of the final adverse determination of the standard Appeal to request an External Appeal;
      v. A statement that if the Denial is upheld on an Urgent Review, the Plan Member may request an External Appeal or request a standard Appeal; and
      vi. A statement that the Plan Member and the Plan may agree to waive the internal Appeal process, and the Plan Member will have 4 months to

request an external Appeal from receipt of written notice of that agreement.

7. Written Notice will be provided to the Plan Member when the decision is to reduce, suspend, or terminate a previously authorized service at least ten (10) Days prior to the action, except:
    a. The period of advance notice is shortened to five (5) Days in cases of confirmed Plan Member fraud; or
    b. The PA Department must mail notice no later than the date of the Action for the following:
        i. The death of the Plan Member;
        ii. A signed written statement from the Plan Member requesting service termination or giving information requiring termination or reduction of services where the Plan Member understands that this must be the result of supplying the information);
        iii. The Plan Member's admission to an institution where the Plan Member is ineligible for further services;
        iv. The Plan Member's address is unknown and mail directed to the Plan Member is returned stating that there is no forwarding address;
        v. The Plan Member has been accepted for Medicaid services by another jurisdiction; or
        vi. The Plan Member's physician prescribes a change in the level of medical care.

DEFINITIONS

1. **Adverse Determination:** A determination by a reviewer not to certify, either before, during or after services are received, a service, because, based on the information provided, the request does not meet the requirements for medical necessity under the applicable benefits plan.
2. **Appeal**: A request to change an adverse determination for services.
3. **Clinical Peer Reviewer:** a physician who possesses a current and valid non-restricted license, certificate or registration or a health care professional other than a licensed physician who has a current and valid non-restricted license, certificate or registration, or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review.
4. **Complaint**: A Plan Member's expression of dissatisfaction with any aspect of his or her care other than an Appeal. A "Complaint" means the same as a "grievance" as defined by 42 CFR §438.400 (b).
5. **CVS Caremark®**: Caremark Rx, L.L.C. and each of its pharmacy benefit management subsidiaries and affiliates, including Caremark, L.L.C.
6. **CVS Health®:** CVS Health Corporation and each of its subsidiaries and affiliates.
7. **Day:** Per CMS guidance, a day, either calendar or business goes up until 11:59 pm.
8. **Denial (non-certification)**: A determination by an organization that a prescription, service or course of treatment had been reviewed and, based on the information provided does not

meet the clinical requirements for medical necessity, appropriateness, or effectiveness and/or not a covered benefit under the applicable benefits plan.

9. **Medically Necessary**: As defined under New York law means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.
10. **Plan Member**: A person whose prescription drug benefit is administered by CVS Caremark®.
11. **Reconsideration**: A request previously closed due to no response from the physician's office.
12. **SDOH**: New York State Department of Health.
13. **Urgent Review**: A request for services in which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Plan Member based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the Plan Members medical condition, would subject the Plan Member to sever pain that cannot be adequately managed without the treatment this is the subject of the request.