Frequently Asked Questions for Handling Prior Authorization and Step Therapy in California

New California laws have changed the prior authorization and step therapy processes due to the passage of Senate Bill 866 (2011), Senate Bill 282 (2015) & Assembly Bill 374 (2015).

Standardized Prior Authorizations & Step Therapy Exception Request Form

As a result of these new laws, the Department of Managed Health Care and Department of Insurance jointly developed a 2-page form that is to be used when submitting a prior authorization, and now a step therapy exception request. You can access the form here: **http://bit.ly/21flnf0**.

What is a Step Therapy Exception Request?

A step therapy exception request is when the prescriber requests an override to the step therapy protocol in favor of immediate coverage of their originally selected prescription drug.

How Long Does the Insurer Have to Respond to a Prior Authorization or Step Therapy Exception Request?

If a health insurer fails to respond to a request within 72 hours (24 hours for urgent requests) the request shall be deemed granted.[i] (Does not apply to Medi-Cal)

Can I Submit the Request Electronically?

Yes. A prescribing provider may use an electronic process developed specifically for transmitting prior authorization information that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic transactions.[ii] (Form: **https://bit.ly/21flnf0**)

What Can Be Done If the Request Is Declined?

- If either request is denied, the plan may have an internal appeals/grievance process.
- The enrollee must initiate the appeal/grievance request. Once the grievance is received, the plan must provide written acknowledgment within five calendar days of the receipt. The plan must respond a clear and concise explanation of the reasons for the plan's response.[iii] This should last no more than 30 days for requests for non-formulary drugs.[iv]
- If grievance is denied, health plans and insurers must provide the patient with information on what recourse is available to them.[v]
- Next step if plan's appeal/grievance is denied: After exhausting the plans/insurer's internal process[vi], you can file an appeal with the Department of Managed Health Care or Department of Insurance. this appeal will start an Independent Medical Review (IMR). **https://bit.ly/2w4B7fN**
- An IMR will last no more than 30 days (3-7 days for an urgent/expedited IMR).
- In 2016, approximately 69% of DMHC's IMR's resulted in the consumer receiving the requested service.[vii]

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What Is the Next Step After the Grievance Process?

After either completing the grievance process and receiving a negative outcome or participating in the process for at least 30 days (or three days for requests involving nonformulary prescription drugs[viii]), a patient may submit a complaint/grievance to the Department of Managed Health Care or the Department of Insurance for an independent medical review (IMR.[ix])

If the department determines the case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a plan contract, or in any other case where the appropriate department determines that an earlier review is warranted, the patient is not be required to complete the plan's internal grievance process or wait 30 days prior to submitting to the appropriate department.[x]

How Can I File A Complaint?

Patients can file a complaint to the Department of Managed Health Care by visiting: **www.dmhc.ca.gov/FileaComplaint.aspx**.

Providers can file a complaint to the Department of Managed Health Care by visiting: **www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan.aspx**.

Questions?

If you have any questions about anything in this document, please don't hesitate to reach out to the Arthritis Foundation at **advocacy@arthritis.org** or the California Rheumatology Alliance at **info@calrheum.org**.

[i]Health & Safety Code § 1367.241 (b) and § 1367.244. Insurance Code § 10123.191 (b) and § 10123.197
[ii]Health & Safety Code § 1367.241 (e) and § 1367.244. Insurance Code § 10123.191 and § 10123.197
[iii]Health & Safety Code § 1368(a)(4)-(5)
[iv]Health & Safety Code § 1368.01 (a)
[v]Health & Safety Code § 1368.02, 1368(b)(4), 1367.24(b)
[vi]Health & Safety Code § 1368(b)(1)(A), and HSC section 1374.30(j)(3).
[vii]http://www.dmhc.ca.gov/File-a-Complaint/Apply-for-an-Independent-Medical-Review-IMR/IMR-Application-Form.aspx
[viii]Health & Safety Code § 1374.30(j)(3), 1368.01(c).
[ix]Health & Safety Code § 1368(b)(1)(A)
[x]Health & Safety Code § 1368(b)(1)(A)