**BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS**
**ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES**

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| In the Matter of: | ) | |
| | ) | |
| F H | ) | OAH No. 12-0184-MDS |
| | ) | Agency No. |

## DECISION

### I. Introduction

On July 3, 2012, F H obtained a prescription for medication from her physician. Ms. H's husband, C J, attempted to purchase the medication at his local pharmacy on July 5, 2012. The pharmacy declined to provide the requested medication, on the ground that it had not received prior authorization from the Medicaid program's pharmacy benefits claims administrator. Through her husband, Ms. H appeals, arguing that the administrator failed to approve a request for pre-authorization in a timely manner.

The assigned administrative law judge conducted a hearing on August 8, 2012. Mr. J participated, and Gerry Johnson represented the Division of Health Care Services. C.J. Kim, an employee of the claims administrator, provided testimony.

Because the claims administrator responded to the communications it received within 24 hours, and because prior authorization was provided within 24 hours of the receipt of the information required to process a request for prior authorization, the appeal is denied.

### II. Facts

F H and her husband, C J, live in No Name. Ms. H had for some time been authorized for treatment using a prescription drug, Protonix. She last filled her prescription on May 30, 2012.[1] Ms. H's authorization for use of the medication, which was on file at her pharmacist's office, expired on June 17.[2] Ms. H was not notified of the expiration of the authorization.[3]

On Tuesday, July 3, Ms. H visited her physician and obtained a new prescription for Protonix.[4] The prescription was valid for one year, to be filled in twelve one-month supplies.[5] Ms. H's physician provided the prescription to the pharmacist for processing.[6] The pharmacist

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1 C. J, statement at hearing.
2 G. Johnson, statement at hearing.
3 G. Johnson, statement at hearing.
4 C. J, statement at hearing.
5 C. J, statement at hearing.
6 C. J, statement at hearing. Mr. Kim testified that typically a physician will issue a prescription and then request authorization.

contacted the division's pharmacy benefits claims administrator, Magellan,[7] and at 3:14 p.m. on July 3, the claims administrator notified the pharmacist that in order to authorize payment, additional information was needed from the prescribing physician.[8] The additional information would be used by the claims administrator to confirm that the medication was medically necessary according to the claims administrator's criteria.[9]

Mr. J went to the pharmacist's office on July 5 to pick up the requested medication. He was informed that authorization for the purchase had not been forthcoming. Mr. J promptly filed a request for a hearing.[10] He walked home from the pharmacy without the medication, and Ms. H missed at least one dose of her prescribed medication.[11] The next day, July 6, a representative of the physician (N) contacted the claims administrator and provided the additional information that had been requested.[12] The claims administrator approved the request for prior authorization on July 6, backdated to July 3.[13] Mr. J returned to the pharmacy on July 6 and was provided the generic substitute for Protonix.

## III. Discussion

The division generally will not pay a provider for Protonix (or a generic substitute) absent prior authorization.[14] Similarly, a provider must obtain prior authorization before dispensing Protonix (or a generic substitute),[15] except in an emergency.[16] In this case, Ms. H obtained a prescription from her physician on July 3, which the physician transmitted to the pharmacist. The pharmacist, in turn, transmitted the prescription to the claims administrator for processing.

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[7] Mr. Kim identified the claims administrator as Magellan. The online Medication Prior Authorization Form identifies Magellan as the administrator. *See* http://hss.state.ak.us/dhcs/pharmacy/pdfs/General%20PA%20form.pdf (accessed September 4, 2012). However, a webpage of the Division of Health Care Services identifies Xerox State Healthcare, LLC, as the agency providing prior authorization for medications. http://hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm (accessed September 11, 2012). That entity in 2012 acquired ownership of Affiliated Computer Services, which is identified as providing prior authorization on a different division webpage, http://hss.state.ak.us/dhcs/medicaid_medicare/authorization_hcs.htm (Affiliated Computer Services) (accessed September 11, 2012). *See* http://medicaidalaska.com (accessed September 11, 2012).

[8] Testimony of C. Kim. Mr. Kim characterized the action taken as "rejection" of the request, rather than as "denial"; he testified that "denial" of a request for pre-authorization would only occur if after receiving the requested additional information, the request did not meet the criteria for approval.

[9] Testimony of C. Kim.

[10] The hearing request in the record is unsigned and undated. *See* Ex. C1. The division has asserted that Mr. J's request was filed on July 5. Position Statement, p. 1.

[11] Ex. 1, p. 1.

[12] Testimony of C. Kim.

[13] Testimony of C. Kim.

[14] 7 AAC 105.130(a)(13), (b). Mr. Johnson represented, and Mr. J did not dispute, that Protonix (and its generic substitute) are on the list of medications requiring prior authorization, the *Alaska Medicaid Prior-authorization Medications* list.

[15] 7 AAC 120.130(a)(1).

[16] 7 AAC 120.130(b).

At 3:14 p.m. on July 3 the claims administrator notified the pharmacist that more information was needed.[17] July 4 was a holiday. On July 6, the necessary information was provided to the claims administrator, and the administrator authorized dispensation of the medication.

At the hearing, Mr. J raised three issues. First, Mr. J asserted that on July 3, the claims administrator denied a request for prior authorization that was submitted on that date, and that it failed to provide timely notice to Ms. H of the denial. Second, he objected to the practice of the Alaska Medicaid program, which is not to provide any written notice to the patient of the issuance or effective dates of a prior authorization.[18] Third, Mr. J asserted that the turnaround time to obtain prior authorization in this case was unreasonably long, asserting that prior authorization should have been issued no later than July 5.

A. Notice of Denial of Prior Authorization

Under federal and state law, the division must provide Medicaid recipients with timely and adequate notice of an action or proposed action to deny, terminate, suspend or reduce services.[19] One service that may be provided to Medicaid recipients is the provision, through participating pharmacists, of covered prescription medication. That service is provided, for certain medications, only after prior authorization.[20]

The claims administrator must have in place procedures that enable Medicaid recipients to obtain authorization for dispensation of prescription medications in a timely manner.[21] Whether the division is required under federal law to provide notice to a Medicaid recipient of the denial of a request prior authorization and the reason for the denial is a question that is at

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[17] Testimony of C. Kim.

[18] Mr. Kim confirmed that the program does not provide any written notice to a patient of the effective dates of an authorization. He was unable to state whether physicians or pharmacists are provided that information. Mr. J asserted that as a participant in the Medicare Part D program, he is provided written notice of the dates for which prior authorization will be effective.

[19] 42 U.S.C. §1396a(a)(3) (claim for assistance denied or not acted upon with reasonable promptness); 42 C.F.R. §435.919(a) (eligibility terminated, discontinued or suspended; services reduced or discontinued). *See* 7 AAC 49.060 (prior notice required before action taken to deny, suspend, reduce, or terminate "assistance").

[20] 7 AAC 120.410(a).

[21] *See* In Re F H, OAH No. 12-0610-MDS (Commissioner of Health and Social Services 2012). In that case, the administrative law judge concluded that federal and state law "cumulatively require that Alaska's Medicaid prescription drug program be administered in such a way as to prevent Medicaid-caused lapses in the availability of prescription medications to Medicaid recipients." *Id.*, at 4. The commissioner's designee modified the factual findings in the decision, observing that because the claims administrator had implemented a pre-authorization procedure to eliminate gaps in coverage for the specific drug at issue in that case, the public interest exception to mootness did not apply in that case. *Id.*, Non-Adoption Option C, September 10, 2012. The commissioner's designee did not reject, modify or amend the administrative law judge's conclusion that the program must be administered in a manner that prevents such gaps from occurring as to other medications as well.

presently the subject of litigation in the federal courts.[22] Moreover, it is an open question whether the division's action taken on July 3 is properly characterized as a denial of the request that had been submitted to it, or as the division would have it, as a request for additional information.[23]

For purposes of this decision, let us assume that Mr. J's characterization is correct, and that the action taken by the claims administrator on July 3 is properly characterized as a denial of a request for pre-authorization. So far as the record reveals, Ms. H was not provided any written notice of the July 3 action at all. However, if Ms. H had been provided written notice, through the mail, of the July 3 action, she would not have received the notice in time to rectify any error before she needed to obtain the medication. Although she was not given any written notice, Ms. H received actual notice (verbally, through the pharmacist and her husband), when Mr. J went to the pharmacist's office on July 5. Because providing written notice to Ms. H, through the mail, on July 3 would not have enabled her to resolve any problems in a timely manner, it is apparent that in this particular case, the real basis of Mr. J's objection is not that Ms. H was not sent written notice of the July 3 action, but rather that the actual notice provided to her on July 5 did not include the reason for the July 3 action. His point is that if he had been told on July 5 that the request had not been approved because it was not accompanied by sufficient information, then he could have contacted his wife's physician to obtain the necessary information and his wife would not have missed out on having her medication on July 5.[24]

But it is established that when Mr. J went to the pharmacist on July 5, the physician's office had already been informed that the request had been rejected and of the reason for the rejection, on July 3. There is nothing in the record to establish that if Mr. J had been told the same thing, he would have been able to get the necessary information from his physician any

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[22] *See* N.B. v. District of Columbia, 682 F.3d 77 at 80, 82 (D.C. Cir. 2012) (remanding lawsuit seeking declarative and injunctive relief based allegations that "the District systematically denies Medicaid coverage of prescription medications without providing the written notice required by federal and D.C. law"; complaint includes allegation that beneficiary "was never informed that the prior authorization previously obtained by Doe's physician had expired, triggering the coverage denial").

[23] *See* note 8, *supra*. That Mr. Kim characterized the division's action as not constituting a denial is not dispositive. In N.B. v. District of Columbia, for example, the plaintiffs asserted that "If coverage is denied, ACS [Affiliated Computer Services, the entity now owned by Xerox Healthcare, LLC] gives the pharmacy a 'rejection code' identifying the reason for the denial." 682 F.3d at 81. Mr. Kim characterized the action taken by the claims administrator on July 3 as a rejection, rather than as a denial, a characterization that appears at odds with the characterization of that type of action in the cited case. Mr. J, for his part, characterized the July 3 action as a denial.

[24] The fact that Ms. H was not provided the requested services distinguishes this case from Banks v. Secretary of the Indiana Family and Social Services Administration, 997 F.2d 231 (7th Cir. 1993), in which the court held that "Medicaid regulations "in no way provide for notice and a hearing to a recipient either before or after a *provider's* claim for reimbursement is denied." [italic in original].

sooner than it was actually provided, on July 6. Assuming that the division is required by law to provide notice to a Medicaid recipient of the denial of a request for prior authorization and the reason for it, assuming that the action taken by the claims provider on July 3 is properly characterized as a denial rather than as a request for additional information, and, finally, assuming that sending a written notice of the July 3 to Ms. H by mail would not have been sufficient to meet the division's legal obligation, it has not been shown if Mr. J on July 5 had been given verbal notice of the reasons for the July 3 denial, Ms. H would have been able to obtain the medication at the time she needed it.

In any event, what Mr. J requested as a remedy in this case was not a change in current status of his wife's claim, but rather a ruling as to whether the pharmacist's request for prior authorization was processed in a timely manner. That issue can be addressed without ruling on the division's legal obligation with respect to notice to a Medicaid recipient of the denial of a request for prior authorization submitted by a provider of prescription medication. Moreover, the division could provide notice of denials and the reasons for them even if it is not required by law to do so.[25] For these reasons, it is not necessary to determine the nature of the division's legal obligation with respect to notice in order to resolve this appeal.

B. Notice of Expiration of Authorization

Prior authorization means "approval by the department…of a certain type and number of units of Medicaid-covered services before those services are provided."[26] Because prior authorization is by definition limited to a "certain type and number of units", prior authorization for a prescription drug is limited to the number of units specified in the authorization. If the division does not provide pre-authorization for the full amount of the prescription presented, then it has partially denied the services requested and it can be argued that the division would have to notify the beneficiary of the limited nature of the pre-authorization.[27] But if the claims administrator provides prior authorization as requested, and the request includes the entire period covered by the prescription, then it has not denied anything at all, and that the prescription will at some point expire does not mean that the division terminated services.

In this case, that is precisely what occurred. In both 2011 and 2012, the pharmacist requested authorization to dispense all of the medication covered by the prescription, and the

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[25] *Cf.* In Re F H, OAH No. 12-0610-MDS (Commissioner of Health and Social Services 2012) (administrative action taken to eliminate gap in coverage).

[26] 7 AAC 160.990(b)(58).

[27] *See* note 21, *supra*.

claims administrator granted the requests in their entirety. It may be, as Mr. J asserted, that providing written notice of the expiration of the authorization would make it easier for Medicaid recipients to manage their own health care services, but when the claims administrator grants in its entirety a request for prior authorization of prescription medication, the division is not required by law to provide notice of the termination of service: the authorization, like the prescription, will expire rather than terminate.

However, to say that the division was not required to provide notice of the termination of services is not necessarily to say that the division need not give notice of the date on which the authorization will expire. 7 AAC 49.060 provides that the division must "give written notice to the client at least 10 days before the date the division intends to take action denying…assistance." Obviously, the division cannot give prior notice of the initial denial of an application for assistance, and 7 AAC 49.060 cannot reasonably be read to require advance notice of such an action. But when the claims administrator finds that administration of a particular prescription medication is medically necessary, with no limit on the period of time for which the medication will be medically necessary, and authorizes dispensation of that medication for a limited period of time unrelated to medical necessity, it knows that a future request for dispensation of that medication will be denied as of a date certain even if the services are medically necessary, absent prior authorization. It can be argued, in that context, 7 AAC 49.060 requires the division, through the claims administrator, to provide written notice to the client at least ten days notice in advance of the anticipated date of denial of assistance, that, is, the date on which the authorization will expire.

As a practical matter, even if notice of the termination date is provided, in a non-emergency situation a Medicaid recipient of prescription medication must submit a request for a renewed authorization sufficiently in advance of the termination date to allow for notice and a hearing, or an unwarranted gap in coverage may occur. Be that as it may, for purposes of this case, assuming (without deciding) that the division is required under 7 AAC 49.060 to provide ten days' prior notice to Ms. H of the date on which the authorization issued on July 6 will expire, the division has ample time to do so.

C. Timely Action

By federal law, a state may require prior authorization as a condition of payment for a covered outpatient prescription drug.[28] However, the state's system must provide a response by telephone or other telecommunication device within 24 hours of the request for prior

[28] 42 U.S.C. §1396r-8(d)(1)(A).

authorization.[29] States are encouraged to establish, as their principal means of processing claims for outpatient drugs, an online point-of-sale electronic claims management system to provide real time eligibility verifications and to assist pharmacists in applying for and receiving payment.[30] The division utilizes such a system.[31]

A request for authorization may be submitted in writing on a form available online from the division.[32] However, the primary manner for submitting requests for prior authorization is through the online system.[33]

In this particular case, the record does not include copies of any of the relevant online entries. Thus, the record does not definitively establish what sort of form, or what information, was transmitted by the pharmacist to the claims administrator on July 3. Nonetheless, the evidence suggests that the pharmacist submitted a request for prior authorization to the claims administrator on July 3, since the pharmacist could not have submitted a claim for payment before dispensing the medication and the only other reason to contact the claims administrator was to obtain authorization to dispense it.[34]

A proper request for prior authorization would have included information showing the medical justification for the request, that is, that the medication had a "medically accepted indication."[35] A medically accepted indication includes "any use for a covered outpatient drug which is approved by the Federal Food, Drug and Cosmetic Act."[36] In this particular case the claims administrator promptly responded to the pharmacist on July 3, stating that additional information was needed in order to process the request. The nature of the requested information is unknown. That authorization was not forthcoming in response to the pharmacist's initial submission suggests that either the pharmacist submitted a request for prior authorization that

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[29] 42 U.S.C. §1396r-8(d)(5)(A). Notwithstanding this federal statutory requirement, Mr. Kim testified that there is no written policy governing turnaround time. He added that typically requests are granted or denied within 24 hours.

[30] 42 U.S.C. §1396r-8(h)(1); 42 C.F.R. §456.722.

[31] Testimony of C. Kirk. The manner in which the District of Columbia's system operates was described in N.B. v. District of Columbia, *supra*, 682 F.3d at 80-81.

[32] http://hss.state.ak.us/dhcs/pharmacy/pdfs/General%20PA%20form.pdf (accessed September 4, 2012).

[33] Testimony of C. Kirk.

[34] Mr. Kirk's testimony on this issue was inconsistent. Initially, he testified the electronic records suggested that a request for prior authorization was submitted on July 3. He later testified that no request was submitted until July 6. In any event, Mr. Kirk did not provide an alternative explanation for the July 3 submission.

[35] *See* 7 AAC 130(e). The written form includes a space for that information. *See* http://hss.state.ak.us/dhcs/pharmacy/pdfs/General%20PA%20form.pdf (accessed September 4, 2012). It is reasonable to infer that a request for prior authorization submitted through the online system includes the same information.

[36] 42 U.S.C §1396r-8(k)(6).

was not properly completed, or the claims administrator erred in failing to provide authorization in response to the request.

We do not know whether the claims administrator erred in rejecting the initial request as incomplete. But we do know that the claims administrator promptly responded to the pharmacist's July 3 submission, and that no additional information was submitted to the claims administrator until July 6. Again, the claims administrator promptly responded, and the request for prior authorization was granted.

Mr. J has not shown that the claims administrator failed to comply with the federally-required 24-hour response time. Indeed, to the extent that the claims administrator's July 3 response is properly characterized as a denial, rather than as a request for more information, then the denial was more or less instantaneous. It is only if the July 3 response is characterized as something other than a denial that there is any possible issue as to timeliness. Assuming that on July 3 the pharmacist submitted a request for prior authorization, and that the claims administrator's response on that date was something other than a denial, the delay in approving that request was due to the failure of the pharmacist to transmit a request for information to the physician, or of the failure of the physician to supply the information, not the failure of the claims administrator to respond to the request for authorization. The requirement is for a "response" within 24 hours, not necessarily for a decision. The requirement for a response within 24 hours, to the extent it requires a decision, is necessarily predicated on a request that contains sufficient information for the claims administrator to make the decision. Mr. J has not shown that the claims administrator failed to timely respond to the request submitted to it on July 3, or that it should have approved the request as submitted.

## IV. Conclusion

The claims administrator immediately responded to the initial request for prior authorization submitted on July 3, and it immediately responded to the revised request submitted on July 6. Absent a showing that the initial request should have been approved as submitted on July 3, the appeal is denied.

DATED September 17, 2012.

By: *Signed*
Andrew M. Hemenway
Administrative Law Judge

## Adoption

The undersigned by delegation from the Commissioner of Health and Social Services, adopts this decision as final under the authority of AS 44.64.060(e)(1).

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 3rd day of October, 2012.

By: *Signed*
Signature
Kimberli Poppe-Smart
Name
Deputy Commissioner
Title

[This document has been modified to conform to the technical standards for publication.]