WAC 182-530-3200 The medicaid agency's authorization process. (1) The agency may establish automated ways for pharmacies to meet authorization requirements for specified drugs, devices, and drug-related supplies, or circumstances as listed in WAC 182-530-3000 including, but not limited to:

(a) Use of expedited authorization codes as published in the agency's prescription drug program billing instructions;

(b) Use of specified values in national council of prescription drug programs (NCPDP) claim fields;

(c) Use of diagnosis codes; and

(d) Evidence of previous therapy within the agency's claim history.

(2) When the automated requirements in subsection (1) of this section do not apply or cannot be satisfied, the pharmacy provider must request authorization from the agency before dispensing. The pharmacy provider must:

(a) Ensure the request states the medical diagnosis and includes medical justification for the drug, device, drug-related supply, or circumstance as listed in WAC 182-530-3000; and

(b) Keep documentation on file of the prescriber's medical justification that is communicated to the pharmacy by the prescriber at the time the prescription is filled. The records must be retained for the period specified in WAC 182-502-0020(5).

(3) When the agency receives the request for authorization:

(a) The agency acknowledges receipt:

(i) Within twenty-four hours if the request is received during normal state business hours; or

(ii) Within twenty-four hours of opening for business on the next business day if received outside of normal state business hours.

(b) The agency reviews all evidence submitted and takes one of the following actions within fifteen business days:

(i) Approves the request;

(ii) Denies the request if the requested service is not medically necessary; or

(iii) Requests the prescriber submit additional justifying information.

(A) The prescriber must submit the additional information within ten days of the agency's request.

(B) The agency approves or denies the request within five business days of the receipt of the additional information.

(C) If the prescriber fails to provide the additional information within ten days, the agency will deny the requested service. The agency sends a copy of the request to the client at the time of denial.

(4) The agency's authorization determination may be based on, but not limited to:

(a) Requirements under this chapter and WAC 182-501-0165;

(b) Client safety;

(c) Appropriateness of drug therapy;

(d) Quantity and duration of therapy;

(e) Client age, gender, pregnancy status, or other demographics; and

(f) The least costly therapeutically equivalent alternative.

(5) The agency evaluates request for authorization of covered drugs, devices, and drug-related supplies that exceed limitations in this chapter on a case-by-case basis in conjunction with subsection (4) of this section and WAC 182-501-0169.

(6) If a provider needs authorization to dispense a covered drug outside of normal state business hours, the provider may dispense the drug without authorization only in an emergency. The agency must receive justification from the provider within seven days of the fill date to be reimbursed for the emergency fill.

(7) The agency may remove authorization requirements under WAC 182-530-3000 for, but not limited to, the following:

(a) Prescriptions written by specific practitioners based on consistent high quality of care; or

(b) Prescriptions filled at specific pharmacies and billed to the agency at the pharmacies' lower acquisition cost.

(8) Authorization requirements in WAC 182-530-3000 are not a denial of service.

(9) Rejection of a claim due to the authorization requirements listed in WAC 182-530-3000 is not a denial of service.

(10) When a claim requires authorization, the pharmacy provider must request authorization from the agency. If the pharmacist fails to request authorization as required, the agency does not consider this a denial of service.

(11) Denials that result as part of the authorization process will be issued by the agency in writing.

(12) The agency's authorization:

(a) Is a decision of medical appropriateness; and

(b) Does not guarantee payment.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-07-001, § 182-530-3200, filed 3/1/17, effective 4/1/17; WSR 16-17-071, § 182-530-3200, filed 8/16/16, effective 9/16/16. WSR 11-14-075, recodified as § 182-530-3200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-014, § 388-530-3200, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. WSR 08-21-107, § 388-530-3200, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 07-20-049, § 388-530-3200, filed 9/26/07, effective 11/1/07.]