

NEBRASKA MEDICAID PRIOR AUTHORIZATION PROCESS

1. Drug Coverage information is listed on the Department of Health and Human Services (DHHS) Division of Medicaid and Long-Term Care Pharmacy Program website at <https://nebraska.fhsc.com>. There is a drug search function if a provider wants to look up a specific drug. Information available includes coverage status as well as limitations related to such things as age, quantity or payment. In addition, the Preferred Drug List is available online which indicates the medications in each therapeutic class that are preferred and available without prior authorization. Clinical criteria for many drug classes and prior authorization forms are also available.

Criteria and claim limits are developed from recommendations made by the Drug Utilization Review Board and the Pharmaceutical and Therapeutics Committee. Both of these professional advisory boards are made up of pharmacists and physicians. DHHS makes the final decision when setting criteria or limits.

2. If a prescription claim is denied during the prescription filling process, the pharmacy receives a message regarding the reason(s) for denial. Typically the pharmacy will resolve issues they can (for example a quantity limit) or notify the prescriber that prior authorization is required.
3. The majority of initial prior authorization requests are submitted to the contracted claims processor, Nebraska Total Care (Fax: 866-759-4115 or Phone: 800-241-8335). Nebraska Total Care evaluates the request based on criteria set by the Department of Health and Human Services Division of Medicaid and Long-Term Care. Many of the criteria used come from recommendations of professional advisory boards made up of pharmacists and physicians. When a prior authorization form is submitted, a response is sent back to the pharmacy and provider within one business day. There are times when Nebraska Total Care requests additional information from the provider to determine if the patient meets the criteria. Once all necessary information is received, the prescriber and pharmacy typically receive the approval or denial within one business day.
4. If the request is denied after review by Nebraska Total Care, the prescriber is advised that they have the option of requesting special consideration from the Department of Health and Human Services Division of Medicaid and Long-Term Care. The prior authorization request form states, "If criteria are determined not to be met, REQUESTS FOR SPECIAL CONSIDERATION should be submitted with supportive documentation to DHHS". The prescriber may then submit additional documentation of medical necessity directly to Nebraska Medicaid at Fax: 402-742-2348. A Pharmacy Consultant, who is a Registered Pharmacist, will then review material submitted and either request additional information or send an approval or denial to the prescriber and the pharmacy within one business day.
5. If the request is again denied, the prescriber may then request a peer to peer review. The peer to peer review is done by the Medicaid Medical Director or designee, who is a physician. In order to provide background for the Medicaid Medical Director or

designee, we recommend providers send a minimum six months chart notes and other information they feel significant to establish how the prescriber arrived at the treatment requested. The Medicaid Medical Director or designee reviews the material and at that point will make a decision to deny, approve, or contact the requesting prescriber for further information or discussion.

6. If the request is denied by the Medicaid Medical Director or designee, the client or the provider has the right to request a State Fair Hearing. Requests for State Fair Hearing should be submitted in writing to:

DHHS, Legal Services Hearing Officer Section
P.O. Box 98914
Lincoln, NE 68509-8914