Medicaid Coverage Exception Requests

4.105 Medicaid Coverage of Exception Requests

4.105.1 General

(A) Beneficiaries who are 21 years old and older may request coverage of a service that Vermont Medicaid has not already determined to be a covered service. The request should be made using the Medicaid Coverage Exception Request process described by this rule.

1. For beneficiaries who are under 21 years old who request coverage of a service that has not already been determined to be covered, Vermont Medicaid will process the request pursuant to the requirements of HCAR 4.106, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

(B) Filing an Exception Request; Decision on Exception Request

1. A beneficiary may file an exception request by sending the request and supporting medical documentation to Vermont Medicaid.
2. Vermont Medicaid will make a good faith effort to timely obtain any additional information necessary to determine whether to approve or deny the exception request.
3. The Commissioner of the Department of Vermont Health Access (DVHA) or their designee will make a good faith effort to decide, within thirty days of receipt of the request, to approve or deny the request.

4.105.2 Criteria

(A) The request must be for a beneficiary who is 21 years old or older, and the service must:

1. Fit within a category or subcategory of services described at 42 U.S.C. 1396d(a),
2. Be medically necessary pursuant to HCAR 4.101.1(c),
3. Be necessary due to extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service was not provided, and
4. Have not been reviewed and denied approval by the Federal Drug Administration (FDA), if the service is subject to FDA approval.

(B) If the requirements of 4.105.2(A) are met, the Commissioner of DVHA or their designee will consider the following additional criteria, in combination, in determining whether to approve or deny coverage of the service:

1. The service has not been identified in administrative rule or statute as a non-covered service, or, if the service has been identified as non- covered and a reason for its non-coverage includes its lack of efficacy, then there has been credible and material new evidence about the efficacy of the service since it was identified as non-covered.
2. The service fits within a category or subcategory of services described at 42 U.S.C. 1396d(a) that is offered by Vermont Medicaid for adults,
3. The service is consistent with the objective of the Medicaid Act (Title XIX of the Social Security Act), to provide medical assistance to eligible individuals.
4. Denial of the service would be arbitrary. Vermont Medicaid may not deny coverage for a service solely based on its cost.
5. The service is not experimental or investigational.
6. The medical appropriateness and efficacy of the service has been demonstrated in credible scientific evidence published in peer-reviewed literature or by medical experts in the relevant clinical field.
7. Less expensive, medically appropriate alternatives are not available, or have been trialed and failed,

or are contraindicated for the beneficiary.

8. The service is primarily and customarily used to serve a medical purpose, and it is generally not useful to an individual in the absence of an illness, injury, or disability.
9. If the request is for a brand-name prescription drug that is not covered because the drug manufacturer does not participate in the Federal Drug Rebate Program, then coverage of this drug must be needed because the currently covered drug has not been effective in treating the beneficiary's medical condition or causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

4.105.3 Outcomes

(A) The Commissioner or their designee will approve or deny coverage of the service for the beneficiary.

(B) For approvals and denials in the exception request process, the Commissioner or their designee will determine whether to pursue administrative processes (e.g., state plan amendment, administrative rule) that are necessary to cover the service by Vermont Medicaid.

4.105.4 Approvals

(A) Annually, Vermont Medicaid will publish on the DVHA website a document updating the list of the approved coverage decisions made under the exception request process that do not result in the service being considered for pursuit of coverage by Vermont Medicaid, as described at 4.105.3(B).

(B) Vermont Medicaid will ensure that all Medicaid beneficiaries who are similarly situated to the individual who has obtained coverage pursuant to the exceptions request process are treated similarly with respect to coverage of the same service.

4.105.5 Adverse Decisions

(A) Vermont Medicaid will inform a beneficiary who receives an adverse decision of their right to appeal through the State fair hearing process.

(B) A request for a service for which there has been an adverse decision may not be renewed by the same beneficiary until twelve months have elapsed since the previous final decision or until one of the following has been demonstrated:

1. New documentation of the individual's condition that was not available at the time of the prior request,
2. A material change in the individual's condition,
3. New and material medical evidence, or
4. A material change in technology has been demonstrated.