

~~7102—4.103~~ Prior Authorization ~~(04/01/1999, 98-11F)~~

4.103.1 Definitions

~~(a) Prior authorization is a process used by the department to assure the appropriate use of health care services. The goal of prior authorization is to assure that the proposed health service is medically needed; that all appropriate, less expensive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. The department shall notify each patient and provider of its decision, which is arrived at by applying the criteria set forth in rule 7102.2.~~

For purposes of this rule, the following definitions apply:

(a) “**Prior authorization**” is a process through which a request for coverage of a service is submitted to Vermont Medicaid for review and approval before the service is provided in order for the service to be covered.

(b) “**Pharmacy benefit**” means the covered Vermont Medicaid services described in HCAR 4.207, titled “Prescribed Drugs.”

~~71024.103.4—2~~ Criteria for Utilizing Prior Authorization ~~(04/01/1999, 98-11F)~~ _____

(a) Vermont Medicaid requires prior authorization for any service that has an imminent harm code. The list of imminent harm codes can be found on the Department of Vermont Health Access (DHVA) website.

(b) ~~The department Vermont Medicaid~~ may require prior authorization ~~of payment for a service if it determines that when~~ one or more of the following criteria are met:

A. ~~_____~~ (1) The ~~health~~ service is of questionable medical necessity as determined by ~~the department Vermont Medicaid~~. ~~B. _____~~

(2) ~~The department Vermont Medicaid~~ determines that use of the ~~health~~ service ~~needs requires~~ monitoring to manage the expenditure of Medicaid program funds.

C. ~~_____~~ (3) Less expensive medically appropriate alternatives to the ~~health~~ service are generally available. ~~D. _____~~

(4) The ~~health~~ service is investigational or experimental.

(5) The service is not already determined to be covered for beneficiaries who are under the age of 21 pursuant to the requirement of HCAR 4.106, titled, “Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.”

(6) The request is for coverage of routine patient costs for services furnished in connection with participation in a qualifying clinical trial pursuant to 42 USC

1396(a)(30)(hereinafter referred to as “routine patient costs related to a qualifying clinical trial”).

~~E.(7) -The~~ ~~The health~~ service is newly developed or modified.

~~F.(8) -The department~~ Vermont Medicaid determines that monitoring a ~~health~~ service of a continuing nature is necessary to prevent the continuation of the service when it ceases to be beneficial.

~~The complete and current list of all services and items including procedure codes that require prior authorization is set out in the Provider Manual. The list is updated periodically. Additions and deletions to the list are also published in advance in the provider advisory newsletter and other communications to providers.~~

4.103.3 List of Services Requiring Prior Authorization

(a) Prior authorization is required for some services. A list of services that require prior authorization can be found on the DVHA website.

(1) Services, other than the pharmacy benefit, that require prior authorization are identified in the Fee Schedule in the Vermont Medicaid Portal, which is available on the DVHA website.

(2) Pharmacy benefits that require prior authorization are identified in the Preferred Drug List, which is available on the DVHA website. Some preferred and all non-preferred drugs are subject to prior authorization as described in the Preferred Drug List.

~~7102.24.103.4~~ Prior Authorization Determinations ~~(04/01/1999, 98-11F)~~

(a) Vermont Medicaid will approve a ~~A~~ request for prior authorization of a covered ~~health~~ service ~~will~~ if it determines that the service meets the following criteria:

~~be approved if the health service:~~ ~~A. is~~ (1) Medically necessary-necessity for covered services criteria as set forth in HCAR 4.101, titled “Medical Necessity for Covered Services,”(see rule 7103);

~~B.(2) -Is~~ appropriate and effective to the medical needs of the beneficiary;

~~C. (3) Is~~ timely, considering the nature and present state of the beneficiary's medical condition;

~~D. (4) is~~ Is the least expensive, appropriate ~~health~~ service available;

~~E.(5) -is~~ Is FDA-~~approved~~ or authorized, if ~~it~~ the service is FDA regulated;

~~F.(6) -Is~~ subject to a manufacturer's rebate agreement and meets applicable criteria in the Preferred Drug list, if the service is a prescribed drug;

(7)

~~G. -Is~~ not a preliminary procedure or treatment leading to a service that is not covered by Vermont Medicaid;

(8) Is not the repair of an item that is not covered by Vermont

Medicaid, ~~INTERPRETIVE MEMO~~

~~[X] Medicaid Covered Services Rule~~

~~Interpretation~~

~~[] Medicaid Covered Services Procedure Interpretation~~

~~This interpretive memo remains effective statewide until it is specifically superseded either by a subsequent interpretive memo or by a contradictory rule with a later date.~~

~~Reference 7102.4 Date of this Memo 05/01/2008 Page 1 of 1~~

~~This Memo: [X] is New [] Replaces one dated~~

QUESTION: ~~Is there a change in the timeframe for processing prior authorization requests?~~

ANSWER: ~~Yes. The timeframes now correspond to 42 CFR §438.210. OVHA will continue to issue a notice of decision within three days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 days of receipt of the request, but that time frame may be extended up to another 14 days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest. Also, when a provider indicates, or OVHA determines, that following this timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, OVHA must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than three working days after receipt of the request. This may be extended up to 14 days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.~~

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~~H. is not the repair of an item uncovered by Medicaid; I. (9) Is not experimental or investigational; J. (10) — Is furnished by a provider working within their scope of practice, and (11) Is not solely for the convenience of the beneficiary or the beneficiary's caretaker or provider, with appropriate credentials.~~

~~(a)(b) Prior authorization is determined on a case-by-case basis.~~

~~(b)(c) The department Vermont Medicaid is responsible for determining questions of coverage and medical necessity under the Vermont Medicaid program. The department Vermont Medicaid may contract with external organizations to help assist with prior authorization make these determinations; but Vermont Medicaid however, is the final authority for these decisions. rests with the department.~~

~~(e)(d) A prior authorization request must include a Supporting information for a prior authorization request must include a completed claim-prior authorization form that has been submitted by a Vermont Medicaid-enrolled provider, and a completed medical necessity form. Additional information necessary to show that the service meets the relevant criteria that may be required, includes the following items:~~

- ~~• (1) the The patients-beneficiary's relevant complete-medical records;~~
- ~~• (2) Tthe patients-beneficiary's plan of care;~~
- ~~• (3) Aa statement of long-term and short-term treatment goals;~~
- ~~• (4) a-A response to clinical questions posed by the department Vermont Medicaid;~~
- ~~• (5) a-A second opinion or an evaluation by another practitioner-provider, at Medicaid-Vermont Medicaid's expense;~~
- ~~• (6) Tthe practitioners-provider's detailed and reasoned opinion in support of medical necessity;~~
- ~~• (7) a-A statement of the alternatives considered and the provider's reasons for rejecting them; and,~~
- ~~• (8) a-A statement of the practitioner's-provider's evaluation of alternatives suggested by the department Vermont Medicaid and the provider's reasons for rejecting them.~~

~~If any of this additional information is required, the department will notify the provider promptly. Once the necessary information has been received, the beneficiary will be sent a notice of decision that may be appealed. See rule 4151.~~

~~71024103.3—5 Waiver-Prior Authorization Requirements and Waiver of Prior Authorization (04/01/1999, 98-11F)~~

~~(a) When a service is subject to prior authorization, Vermont Medicaid will not pay for the service unless approval is given in advance of receipt of the service except if Vermont Medicaid determines the service meets the standards for waiver set forth at HCAR 4.103.5(b).~~

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~~(a) For covered services designated as needing prior authorization, The department Vermont Medicaid shall will waive the requirement that a covered service receive prior authorization if, in the department's judgement, it determines that the service that was provided without prior authorization is a covered service and meets one or both of the following circumstances.criteria:~~

~~(b)~~

~~• (1) The service was required to treat an emergency medical condition, or~~

~~• (2) The service was provided:~~

~~(A) prior to the determination of before the individual's Vermont Medicaid eligibility was determined, and~~

~~(B) within the retroactive coverage period.~~

7102.44.103.6- Prior Authorization Process (04/01/1999, 98-11F)

~~(a) Specific and general prior authorization forms can be found on the DVHA website.~~

~~(a)(b) The Pprior authorization process commences-begins when Vermont Medicaid with the receipt of areceives a written prior authorization request from a Vermont Medicaid-enrolled provider.-The department will issue a notice of decision within three working days of receiving all necessary information.~~

~~(c) The department Vermont Medicaid will act in good faith to obtain the-any additional necessary information promptly so that it can determine, within 30 days-the relevant timeframes described at HCAR 4.103.6(e), (f), and (g), whether the request may-will be approved or denied. The department will issue a notice of decision within 30 days of receiving the initial prior authorization request, even if all necessary information has not been received.~~

~~(d) Any decision to deny a prior authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.~~

~~(e) Time requirements for prior authorization determinations on services other than covered outpatient drugs that are part of the pharmacy benefit and described at Section 1927 of the Social Security Act (hereinafter referred to as "covered outpatient drugs") and routine patient costs related to a qualifying clinical trial, as described at HCAR 4.103.2(b)(5):-:~~

~~(1) Standard Time. Vermont Medicaid will make a prior authorization determination and provide notice, compliant with HCAR 8.100.3(a)-(b), titled "Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services," as expeditiously as the beneficiary's condition requires, but not more than seven days from Vermont Medicaid's receipt of the request for prior authorization.~~

~~(1) Expedited Time. When a provider indicates, or Vermont Medicaid determines, that the standard time for a prior authorization determination could seriously jeopardize the beneficiary's life or~~

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health or ability to attain, maintain, or regain maximum function, Vermont Medicaid will make an expedited decision and provide notice, compliant with HCAR 8.100.3(a)-(b), titled “Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services,” as expeditiously as the beneficiary’s health condition requires and no later than 72 hours after receipt of the request for the service.

(2)

(3) Extensions of Time.

(A) The standard and expedited timeframes for a prior authorization determination on services other than covered outpatient drugs, as described at HCAR 4.103.6(e), may be extended up to 14 days if:

- (i) The beneficiary or provider requests the extension, or
- (ii) Vermont Medicaid justifies a need for additional information and shows that the extension is in the beneficiary’s best interest (e.g., more medical documentation is required and without it, the request would be denied).

(B) If Vermont Medicaid meets the criteria for extending the time for standard and expedited prior authorization determinations, it will:

- (i) Give notice to the beneficiary of the reason to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with the decision to extend the timeframe, and
- (ii) Issue and carry out its decision as expeditiously as the beneficiary’s health condition requires and not later than the date the extension expires.

(4) Maximum Time for Prior Authorization Determinations on services other than covered outpatient drugs, as described at 4.103.6(e), and routine patient costs related to a clinical trial, as described at HCAR 4.103.2(b)(5). The maximum time, including any extensions, for Vermont Medicaid to decide to approve or deny a prior authorization request is:

(A) 21 days from receipt of a request for a standard prior authorization determination (seven days plus 14 day extension), or

(B) 17 days from receipt of a request for an expedited prior authorization determination (72 hours plus 14 day extension).

(f) Prior authorization requirements, including time requirements, for covered outpatient drugs, as described at HCAR 4.103.6(e).

(1) Vermont Medicaid will:

(A) Provide a response by telephone or telecommunication device within 24 hours of a request for prior authorization, and

(B) Except with respect to excluded drugs listed in Section 1927(d)(2) of the Social Security Act, provide for the dispensing of at least a 72-hour supply of a covered outpatient drug, as described at 4.103.6(e), when prior authorization has not been secured and the need to fill the prescription is determined to be a medical emergency. Prior authorization will still be needed for further dispensing.

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(g) Prior authorization requirements, including time requirements, for routine patient costs of a beneficiary when related to a clinical trial, as described at HCAR 4.103.2(b)(5). Vermont Medicaid will provide a response within 72 hours of a request for prior authorization without regard to the geographic location or network affiliation of the health care provider treating the beneficiary or the principal investigator of the qualifying clinical trial. Extensions of time are permitted pursuant to HCAR 4.103.6(e)(3).

(h) Notice requirements. Vermont Medicaid will notify the requesting provider and give the beneficiary written notice of any decision to deny a prior authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice will be consistent with HCAR 8.100.3, titled “Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services,” or, if the service is a covered outpatient drug, as described at HCAR 4.103.6(e), then consistent with Section 1927(d)(5)(A) of the Social Security Act. 1927(d)(5)(A).