



## Disclaimer

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NOTICE: In order to assure that you have the most current version of this document, please refer to [www.vtmedicaid.com](http://www.vtmedicaid.com). This is the site for the most current edition of the [Provider Manual](#) and its Supplements. If you do not have access to the Internet contact EDS Provider Services at 800-925-1706 or 802-878-7871 to receive an electronic file.

## **SECTION 1      PRIOR AUTHORIZATION**

Prior authorization is a process used to assure the appropriate use of health care services. The goal of prior authorization is to assure that the proposed health service, item or procedure meets the medical necessity criteria; 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**. Authorization will not be granted after the service is rendered unless an exception applies. See section 1.5.

### **1.1      Services and Items Requiring Prior Authorization**

Some services and items require prior authorization. A complete listing of the codes and reviewers can be found in Section 2. In addition, prescription drugs are reviewed by First Health Services Corp. See the Pharmacy Provider Manual for complete details.

Most requests for items requiring prior authorization are sent to:

OVHA, Clinical Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05494  
Fax: 802-879-5963

See Section 2 for more details.

### **1.2      Review of Records**

Notwithstanding any other review, the State reserves the right to review medical records at any time and without advance notice.

### **1.3      Date of Service**

Unless otherwise indicated in a Manual, the date of service is the actual date that the service was provided, or the item was delivered to the beneficiary. If the date of service is a range of dates, e.g. an inpatient stay, prior authorization must be secured before the first day of service.

### **1.4      Prior Authorization Requirements**

The OVHA prior authorization criteria in regulations can be found in section M106 of the Welfare Assistance Manual (WAM). Copies of the OVHA regulations are available at the OVHA web site (<http://www.ovha.state.vt.us/>). These rules and procedures govern not only the prior authorizations done by the OVHA but also those performed by its agents.

The OVHA prior authorization requirements only apply when the OVHA is known to be the primary payer for the service or item. If our system indicates that there is no other insurance

coverage for this service or item, prior authorization is necessary. See the Provider Manual for details on how to use the verification systems.

## **1.5 Prior Authorization Exceptions**

WAM section M106 allows two general exceptions to securing authorization prior to the date of service. (see §1.5.1) Other specific exceptions for prior authorization (PA) have been added as needed. (see §1.5.2)

Under federal law PA is not required to dispense a 72-hour supply of a covered drug in an emergency situation.

### **1.5.1 GENERAL EXCEPTIONS**

Emergency Services - Services normally requiring PA do not require PA when treating an emergency condition.

Retroactive Eligibility - Covered services that normally require PA, which were provided to individuals on a date of service prior to when they were determined eligible for Medicaid, do not require prior authorization. A copy of the Notice of Decision (220MP), showing retroactive eligibility, which may be obtained from the beneficiary's District Office, must be attached to the claim.

### **1.5.2 IMMEDIATE NEED EXCEPTION**

1. Authorization in advance does not have to occur if the service or item is rendered for urgently needed care as defined below and if the urgent care is required outside of normal OVHA business hours. If a request for authorization is shown to be for urgently needed care, and if the request for authorization is made on the next business day, the request will be considered timely. Payment for such services or items will further depend on a determination that they are medically necessary. If any such item is not considered medically necessary, the OVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the OVHA will provide normal reimbursement for the rental of such items in thirty-day increments.
2. Authorization in advance does not have to occur if the service or item is rendered for immediately needed care as defined below. However, prior notice of the order, or prescription, for the service or item is required to be considered timely. This may be accomplished by Fax or e-mail to the OVHA on a 7-day per week basis. Following the notification, the provider should submit documentation of medical necessity and evidence that the care or item was immediately needed. This may take the form of an order or a discharge plan. Payment for such services or items will further depend on a determination that the service(s) are medical necessary. If any such item is not considered medically necessary, the OVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the OVHA will provide normal reimbursement for the rental of such items in thirty-day increments.

## **Definitions:**

1. “Emergency medical condition” means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in:
  - A. placing the member’s physical or mental health in serious jeopardy; or
  - B. serious impairment to bodily functions; or
  - C. serious dysfunction of any bodily organ or part.
2. “Urgently-needed care” or “urgent care” means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.
3. “Immediately needed” means that action is needed on the same day to avoid delay in discharge or to allow the beneficiary to remain in a community setting.

Note: these definitions are consistent with both Medicaid rules and those of the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

### **1.5.3 CONVERSION FROM OTHER INSURANCE FOR PHYSICAL THERAPY EXCEPTION**

Payment for physical therapy requires prior authorization for services extending beyond 4 months from the original date of service. If the OVHA is or becomes the primary insurer in the first three months, authorization must be approved prior to any service provided beyond four months. If the OVHA is not the primary insurer at any time in the first three months and becomes primary afterwards, authorization must be approved within thirty days of the OVHA becoming the primary insurer for continuing care beyond four months.

When other insurance does not cover a service, due to exhaustion of benefits or non-covered services, Medicaid becomes the primary insurer and PA rules apply, as necessary. Providers have a 30-day window to secure PA. PA is not required in that 30-day window, until the PA decision is rendered.

Primary benefits must be used before Medicaid, and any rules for obtaining services must be followed for the primary carrier. If the rules are not followed, Medicaid will deny the charges. It is the responsibility of the provider to provide proof that other insurance is not considered primary for the charges submitted, in order for those charges to be processed as primary with Vermont Medicaid.

In order for providers to determine whose rules will apply, it is imperative that you understand how to find and interpret the information available to you.

When using the VRS (Malcolm) you will receive the following information:

“The beneficiary has an insurance policy with (Other Insurance Company Name).”

If the insurance company name is on the list of the 50 most frequently used carrier names, the system speaks the recorded company name. If the insurance company name is not on the list, the system speaks the company code:

“The beneficiary has an insurance policy with coverage type (10).”

-or-

“Carrier number is: (Two-digit carrier code (i.e. DZ), which is assigned to each different carrier and/or benefit plan)

The system will speak five TPL segments and on the sixth segment the system will provide the user with the following options:

- Continue to receive carrier information
- Transfer to a PSU Help Desk representative

In order to determine whether there is primary insurer for the services you are rendering, you will need note the Insurance coverage type and refer to the Third Party Liability Coverage Code Matrix, found in the Provider Manual, Section 1.3. You will find that each coverage code listed will also show services that would be considered eligible under this insurers plan.

In the example above, insurance coverage type 10 covers outpatient and physician services. Because PT/OT/ST is normally covered as an outpatient or physician service, it would be logical to assume that this insurance is primary for these services.

In another example, if the insurance coverage type is 09, the matrix indicates this type of insurance covers only pharmacy, so it would be logical to assume VT Medicaid is the primary insurer and that any guidelines associated in receiving services would need to be followed.

Once you have determined that there is a primary insurer, you will need to gather the billing information in order to submit your charges. The Insurance Carrier codes (also found in the Provider Manual or on the EDS website at: [www.vtmedicaid.com](http://www.vtmedicaid.com)) will allow you to look up information necessary to billing.

In order for benefits to be payable under Vermont Medicaid, the primary insurers rules must be followed, including requesting an extension of benefits, if applicable.

#### **1.5.4 REHABILITATIVE THERAPY**

Provision of PT/OT/ST beyond four months requires prior authorization. Prior authorization will be granted when the need for continuing care is shown. The need must meet the requirements of WAM section 106.3 Authorizations may be approved for any period beyond four months and up to 12 months from the original start date. Extension of services can be approved up to four additional months per request.

Provision of PT/OT/ST beyond the 12-month limit requires prior authorization, and will be granted when the following criteria are met (reference WAM section M710.5):

- The service may not be reasonably provided by the patient's support person(s), AND
- The patient undergoes another acute care episode or injury, or
- The patient experiences increased loss of function, or
- Deterioration of the patient's condition is imminent and predictable.

### **1.5.5 PRIOR AUTHORIZATION FOR MEDICAID PEDIATRIC BENEFICIARIES**

Effective August 1, 2003, all medical review for therapies, including pediatric beneficiaries, will be conducted by OVHA. Requests for therapy services for pediatric beneficiaries beyond the first year of care must be forwarded to:

OVHA  
Clinical Review Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05494

Prior authorization requests may also be faxed to 879-5963.

Therapists should use the Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the "from" and "to" dates that constitute the beginning and end of the 4-month authorization period, in the space available in column 1 of the form. Medical necessity determination for children will continue to use the information on EPSDT provided in regulations M107 and M770.

## **1.6 Required Documentation for Prior Authorization Requests**

At a minimum, the documentation required to support a prior authorization request includes a completed and legible copy of a medical necessity form, or other appropriate documentation, with the prescribing provider's signature, and all documents necessary for identification and pricing of the service requested. Providers need to keep the original or a legible copy of the medical necessity form on file in the patient's record. It is not necessary to submit a completed claim form with a PA request.

The outside envelope or FAX cover sheet should be clearly marked as a PA Request. If a notice of approval is received, providers may then submit a completed claim for payment, where the system matches PA information with claim information. If there are no additional attachments required, the claim may be submitted electronically. If a request for prior authorization is denied and a provider has questions or needs additional information, contact the person whose name appears on the PA Notice of Decision (the form received in the mail informing you of the decision).

## **1.7 Prior Authorization Responses**

Under WAM 103.3(J)(2) the OVHA is obligated to make its review determinations within three working days of obtaining all necessary information and to notify “the treating provider” by telephone. Written confirmation will be sent within 24 hours of the telephone notification. Under federal law, the department is obligated to provide a response within 24 hours of a request for prior authorization of a drug.

## **1.8 Medicaid Payment Decision Reconsideration Process**

The OVHA will conduct an internal review of the following types of OVHA decisions directly affecting providers in response to requests for reconsideration:

1. Prior authorization disapproval by OVHA or its agents (other than medical necessity determinations);
2. Prior authorization decisions about the “immediate need” for durable medical equipment;
3. Prior authorization disapproval because documentation was inadequate;
4. Error in manual pricing; and,
5. Purchase versus rental decisions for durable medical equipment.

The OVHA will not reconsider its regulations or review any decision other than those listed above.

Although this process is not an appeals process, the OVHA believes that providing a “second look” for certain decisions may help improve accuracy. Any affected provider may ask that the OVHA reconsider its decision. Such a request for reconsideration must be made no later than 21 days after the OVHA gives written notice to the provider of its decision. The reconsideration request should provide a brief background of the case, and the reasons why the provider believes the OVHA should have found differently. The OVHA will base its reconsideration on the materials presented by the provider in support of its reconsideration request and any additional information provided by the OVHA. It is expected that the request will contain all supporting documents. Supplemental information sent in after the reconsideration request is made, even if before decision, will not be considered by the OVHA except when the OVHA determines that extraordinary circumstances exist.

Upon receipt of the request with supporting information, the OVHA will undertake a good-faith review of the request, and the reasons supporting the provider’s request. The OVHA may take into consideration additional information, either verbal or written, from the provider or others, in order to further clarify the case. The Director of the OVHA, or a designee, will issue a written decision. The OVHA will make its best efforts to notify the provider of its reconsideration decision within 30 days of receipt of notice of the request for reconsideration by the provider. There is no additional review or reconsideration after the OVHA Director or the designee has made a decision on reconsideration.

All requests for reconsideration must be addressed to:

Director, Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05494

## **SECTION 2      PRIOR AUTHORIZATION LISTING**

The services and items that require prior authorization as of July 15, 2004 are listed in the Fee Schedule posted at: [www.vtmedicaid.com](http://www.vtmedicaid.com) Some DME items are subject to quantity limits that can be extended with prior authorization. A listing of the codes that have quantity limits and their limits can be found in the DME Fee Schedule available from EDS, Provider Services.

The contact numbers for the reviewers are noted below.

OVHA	(802) 879-5903 – Clinical Reviewer
Fax	(802) 879-5963
Dental	Mail to Dental Health, Department of Health, Burlington
VDH-MH	Phone (802) 241-2604
Pharmacy, Point of Sale	MedMetrics Clinical Call Center at 1-800-918-7549