Vermont Medicaid
Eating Disorder Treatment Services
Supplement

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

This supplement is designed as an additive and does not replace the Vermont Medicaid General Provider Manual which can be found at https://vtmedicaid.com/#/manuals. This supplement describes processes to be followed by admitting facilities and the Department of Vermont Health Access (DVHA) when Vermont Medicaid primary members are receiving Eating Disorder Treatment services. This supplement is specific to the authorization and reimbursement for 4 levels of care specific to eating disorder treatment and includes inpatient, residential, partial hospital program (PHP) and intensive outpatient (IOP).

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule, 7103, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition and must conform 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.

Section 2 Enrollment & Reimbursement

A provider/facility must be enrolled with Vermont Medicaid to be reimbursed for providing eating disorder treatment to Vermont Medicaid members. Both facilities and individual and/or attending providers must enroll with Vermont Medicaid. To enroll with Vermont Medicaid, please see the instructions within this link: https://vtmedicaid.com/#/provEnrollInstructions.

The chart below is intended to guide eating disorder treatment providers on enrollment with Vermont Medicaid. If you have any enrollment questions, please contact the Provider Services Unit of Gainwell Technologies at 800.925.1706. Please refer to the provider rep map to find the Gainwell representative who can assist you: https://vtmedicaid.com/assets/resources/ProviderRepMap.pdf.

Eating Disorder Treatment Providers				
Services	**Provider Type**	**Provider Specialty**	**Revenue Code**	**HCPCS Code**
PHP (4-6 hr.)	001	S05	912	H0035
PHP (10 hr.)	001	S05	913	H0035
IOP	001	S05	905	S9480
Residential	T23	S04	128	N/A
Inpatient	001	S05	124	N/A

The Vermont Medicaid fee schedule can be found at https://vtmedicaid.com/#/feeSchedule.

For Fee Schedule definitions please reference https://vtmedicaid.com/#/feeSchedule/definitions.

If there are questions regarding rates and reimbursement, please contact the DVHA reimbursement unit at ahs.dvhareimbursement@vermont.gov.

Section 3 Definitions

3.1 Utilization Management

The DVHA conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with pre The Department of Vermont Health Access (DVHA) conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively, and efficiently. The DVHA clinicians use clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. To ensure that services are provided at an appropriate level of care and within the appropriate utilization of resources, the DVHA has adopted InterQual ® Criteria. The InterQual tool provides resource efficient evidence based clinical decision support across the levels of care.

InterQual® Guidelines are available to providers on the Vermont Medicaid website https://vtmedicaid.com/#/home, by navigating to the Transactions Menu and choosing the Login option. After log-in, look for the link to Smart Sheets in Secure Options drop-down menu. InterQual® Guidelines are updated annually.

Vermont State Medicaid Rules can be found at https://humanservices.vermont.gov/rules-policies/health-care-rules.

3.2 Prior Authorization

Prior authorization (PA) is a process used to ensure the appropriate use of health care services. The goal of PA is to ensure that the proposed health service, item, or procedure meets the medical necessity criteria; that all appropriate, less expensive, and/or less restrictive 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. See the Vermont Medicaid General Billing and Forms Manual, Section 2, Prior Authorization for Medical Services for more information. https://vtmedicaid.com/#/manuals

Section 4 Eating Disorder Treatment Admissions

4.1 Admission Process

Members, whose primary insurance is Vermont Medicaid, admitted to a facility for inpatient or residential levels of care for eating disorder treatment services are assessed prior to admission by the admitting facility (provider) to determine medical necessity as defined by InterQual Criteria for inpatient and residential levels of care. All admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax the Vermont Medicaid Admission Notification Form for Inpatient Psychiatric & Detoxification Services for In and Out of State Providers: https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms to the DVHA via fax at 1.855.275.1212. Along with this form, the provider will submit the initial assessments, admission notes and supporting clinical documentation demonstrating medical necessity. The DVHA will do an initial review for authorization upon admission and will do concurrent reviews for continued coverage.

The DVHA does not require prior authorization (PA) or concurrent review for Partial Hospital Program (PHP) or Intensive Outpatient Program (IOP) levels of care specific to eating disorder treatment. Members admitted to PHP or IOP levels of care are assessed prior to admission by the admitting facility (provider) to determine medical necessity as defined by InterQual criteria for residential level of care. Providers will submit claims directly to Gainwell for reimbursement of services rendered. Please reach out to Gainwell with any questions at 800.925.1706.

4.2 Concurrent Review

Notification to the DVHA utilization reviewer (UR) (within 24 hours or the next business day of the admission) begins the concurrent review process. The provider is responsible for faxing the clinical documentation from the medical record to demonstrate the need for inpatient level of care to the DVHA for review to 1-855-275-1212. See Section 7 below for additional contact details. The UR will use the documentation provided to assess the member's acuity level using the InterQual® tool. The UR will typically assign authorization in increments of 1 to 7 days. Notification of the authorization decision will be provided within 24 hours or 1 business day of receipt of the necessary clinical information required to complete a review. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for a specific number of additional inpatient days. Notification via fax must include additional clinical documentation to support the need for continued inpatient level of care. Failure to notify the UR (and fax the supporting documentation supporting additional inpatient days) results in the end of authorization. Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation via fax no later than 12:00 pm (noon) on the next business day. Every effort will be made to render an authorization decision at that time but no later than the end of the business day. Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with the decision, they may request a Reconsideration Review, see Section 3.2, Adjustment Requests, in the Vermont Medicaid General Billing and Forms Manual https://vtmedicaid.com/#/manuals. The DVHA expects that members will be discharged with scheduled follow-up appointments with treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointments or documentation of the member's refusal of appointments. The discharge plan will be

sent to the utilization reviewer and upon receipt a payment authorization will be entered into the Medicaid system.

For the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing, via fax, the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient treatment providers, and if required, the appropriate state liaison from the Department of Mental Health (DMH), the Department of Disability, Aging and Independent Living (DAIL), the Department of Children and Families (DCF), and/or the Vermont Department of Health (VDH). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and identification of expected discharge date upon admission.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the DVHA UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DAIL, DCF, and/or VDH) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for a specific number of additional inpatient days. The provider is expected at this time to provide, by fax, the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.

Section 5 Retrospective Authorization Requests

The DVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud.

It is the responsibility of the provider to notify the DVHA of an admission and to initiate and complete the concurrent review process. As such, the DVHA is under no obligation to perform retrospective authorization reviews due to lack of notification of admission or failure to request additional authorized days and provide the required clinical documentation via fax prior to the end of the previous authorization period (last covered day). Requests for retrospective authorizations, due to lack of notification or failure to request additional authorized days by the provider, are considered solely at the discretion of the DVHA. In the instance of a member whose Vermont Medicaid eligibility becomes retroactive to the time of the inpatient hospitalization, but who at the time of admission was not eligible for Vermont Medicaid, the provider may request that the DVHA or the DMH complete a retrospective review for authorization. The request for consideration of a retrospective authorization decision is made in writing to the DVHA. The supporting clinical documentation demonstrating that the level of care criteria was met for the days requested must be submitted for review via fax or mail. The DVHA UR staff will make every effort to render an authorization determination within 14 days of receipt of the necessary clinical documentation.

Requests for a retrospective authorization may be made to the DVHA Manager, Quality Improvement & Clinical Integrity by Toll-free fax at 1.855.275.1212 or in writing to:

The Department of Vermont Health Access
ATT: Quality Improvement and Clinical Integrity Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671

Section 6 Reconsideration Process

The DVHA will conduct an internal review of the following types of decisions directly affecting providers in response to requests by providers:

- PA denial by the DVHA or its agents (other than medical necessity determinations);
- PA denial because documentation was inadequate;
- Error in manual pricing.

The DVHA will not review any decision other than those listed above. Although this process is not an appeals process, it is the DVHA's position that providing a "second look" for certain decisions may help improve accuracy. Any affected provider may ask the DVHA to reconsider its decision. Requests must be made no later than 14 days after the DVHA utilization review clinician (reviewer) first gives notice, either written or oral, to the facility of the authorization decision. The DVHA will base the reconsideration of authorization decision on the clinical documentation from the medical record and written documentation from the attending physician demonstrating why the provider believes the DVHA should have found differently (based on the clinical presentation of the member). The fully completed REQUEST FOR RECONSIDERATION: MENTAL HEALTH AND APPLIED BEHAVIOR ANALYSIS SERVICES form https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms and all clinical documentation must be submitted via fax or mail to the reviewer. It is expected that the request will contain all supporting documents. Supplemental information submitted after the request for reconsideration of authorization is submitted, even if before the decision has been made, will not be considered by the DVHA except when the DVHA determines that extraordinary circumstances exist. Upon receipt of the request and supporting information, the DVHA will review all information received. The DVHA will notify the facility of its reconsideration of authorization decision within 14 days of receipt of notice of the request and the supporting clinical documentation from the medical record. A possible extension of up to 14 additional calendar days may be granted if the enrollee or facility requests an extension or the DVHA justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. If a facility disagrees with the DVHA regarding the reconsideration of authorization decision, the facility's physician and/or Medical Director may request to speak with the DVHA Chief Medical Officer, or the designee for a final review of the authorization decision (aka doc to doc review). Such requests must be made in writing to the DVHA utilization review clinician within 5 business days of the notification of the reconsideration of authorization decision. The request must include the service and or rate the provider is requesting be reviewed, the name and contact information for the provider who is requesting the review, and the name and contact information for scheduling purposes.

- The provider is responsible for responding to the DVHA proposed schedule of review times within 3 business days. Failure to respond to the proposed times within 3 business days will result in the reconsideration of authorization decision being upheld.
- If a provider is unable to attend a scheduled doc to doc review, it is the provider's responsibility to contact the DVHA utilization review clinician to request a rescheduled appointment within 3 business days. Failure of the provider to request a rescheduled appointment within 3 business days will result in the reconsideration of authorization decision being upheld.

- If a provider fails to attend three scheduled doc to doc reviews for a particular member and service, this will result in the reconsideration of authorization decision being upheld and no additional opportunities to schedule a doc to doc review for the service in question will be afforded. There is no additional review or reconsideration after the DVHA Chief Medical Officer, or the designee has decided on the reconsideration of authorization request.

Section 7 Contact Information

- Admission Notifications: 855.275.1212 (Toll-free Fax)
- Department of Vermont Health Access (DVHA): https://dvha.vermont.gov/department-vermont-health-access-contact-information
- DVHA Utilization Review staff are available from 8 am to 4 pm Monday through Friday (excluding State holidays).
- Questions regarding claims and billing issues should be directed to the Provider Services Unit of Gainwell Technologies at 800.925.1706.

Section 8 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.