



# PA Supplement

to the Provider Manual



**AGENCY OF HUMAN SERVICES  
DEPARTMENT OF VERMONT HEALTH ACCESS**



**HP Enterprise Services**

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## SUMMARY OF UPDATES

\*Please note: All changes/updates will be indicated in **red font**.  
For a detailed summary of all updates made to this Supplement, please refer to page 10.

**The following information has been added to this Supplement:**

<u>DATE UPDATED</u>	<u>TOPIC</u>	<u>PAGE NUMBER</u>
08/27/2010	Prior Authorization Listing	10
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**DISCLAIMER**

Discrepancies between the information contained in the posted supplement and the payment processing system will be resolved according to information currently within the system. The published information is current on the date that appears on the bottom of the page.

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NOTICE: The current Provider Manual and its Supplements can be accessed at [www.vtmedicaid.com/downloads/manuals.html](http://www.vtmedicaid.com/downloads/manuals.html). HP Enterprise Services recommends that providers check the Vermont Medicaid website periodically, for updates, to assure the accuracy of the information being referenced. If you do not have internet access and need assistance, contact the HP Provider Services Help Desk at 800-925-1706 or 802 878-7871.

Medicaid/DVHA Rules are available on line at [dvha.vermont.gov/for-providers](http://dvha.vermont.gov/for-providers).

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## **SECTION 1**

### **PRIOR AUTHORIZATION**

Prior authorization (PA) is a process used to assure the appropriate use of health care services. The goal of PA 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 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 1.5.1.

#### **SECTION 1.1 SERVICES AND ITEMS REQUIRING PRIOR AUTHORIZATION**

Some services and items require PA. A complete listing of the codes, with PA requirement is in the fee schedule and can be accessed on the DVHA's website [dvha.vermont.gov/for-providers/claims-processing-1](http://dvha.vermont.gov/for-providers/claims-processing-1). All prescription drugs are reviewed by MedMetrics (see the Pharmacy section at [dvha.vermont.gov/for-providers](http://dvha.vermont.gov/for-providers)).

Requests for items/services requiring PA are sent to:

DVHA, Clinical Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05495  
Fax : 802-879-5963

See section 2 for contact information.

#### **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, PA must be secured before the first day of service.

#### **1.4 PRIOR AUTHORIZATION REQUIREMENTS**

The DVHA PA criteria and regulations can be found in Medicaid Rule 7102. These rules and procedures govern PAs performed by the DVHA and its agents. DVHA rules are available online at [dvha.vermont.gov/budget-legislative](http://dvha.vermont.gov/budget-legislative).

PA is necessary if our eligibility system indicates that there is not other insurance coverage for the service or item. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item.

##### **1.4.1 OTHER INSURANCE (OI)**

Vermont Medicaid is the payer of last resort. Providers must pursue and apply all third party

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payment resources prior to billing Vermont Medicaid (see Third Party Liability, Section 1.3 of Provider Manual).

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service:

**OI Denial for Non-Covered or Benefits Exhausted-** The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

- The provider does not need to appeal to the primary insurer before billing Medicaid when the item/service is not covered or benefits are exhausted.
- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer's denial attached.

**OI Denial for Not Medically Necessary** - The provider and/or beneficiary is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or beneficiary is required to seek review by the BISHCA if the cost of the item or service exceeds \$100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the BISHCA's support of the denial. The provider should not submit any additional documentation than what was reviewed by the primary insurer.

- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the BISHCA's support of the denial attached.

**Medicare Qualified Independent Contractor** - For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies, with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

## **1.5 PRIOR AUTHORIZATION EXCEPTIONS**

Medicaid Rule 7102 allows two general exceptions to securing authorization prior to the date of service. (See 1.5.1). Other specific exceptions for 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 Vermont

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Medicaid, do not require PA. 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 DVHA 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 DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in the minimum allowable period for the service.

2. Authorization in advance does not have to occur if the service or item is rendered for immediately needed care as defined below. However, the request for PA must be faxed to the DVHA Clinical Unit by the next business day. 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 medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA 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, OCCUPATIONAL THERAPY, SPEECH THERAPY (PT, OT, ST) EXCEPTION**

Payment for PT/OT/ST requires PA for services extending beyond 4 months from the original date of service. If the DVHA 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 DVHA is not the primary insurer at any time in the first three months and becomes primary afterwards,

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authorization must be approved within thirty days of the DVHA 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, Vermont 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 Vermont Medicaid, and all rules for obtaining services must be followed for the primary carrier. If the rules are not followed, Vermont 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. See section 1.4.1.

#### **1.5.4 REHABILITATIVE THERAPY**

Provision of PT/OT/ST beyond four months requires PA. PA will be granted when the need for continuing care is shown. The need must meet the requirements of Medicaid Rule 7102.2. Authorizations may be approved for any period beyond four months and up to 12 months from the original start date.

Provision of PT/OT/ST beyond the 12-month limit requires PA, and will be granted when the following criteria are met (Medicaid Rule 7401.4):

The service may not be reasonably provided by the patient's support person(s), and one of the following criteria:

- 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 PEDIATRIC BENEFICIARIES**

All medical reviews for therapies, including pediatric beneficiaries will be conducted by the DVHA. Request for therapy services for pediatric beneficiaries beyond the first year of care, must be forwarded to: DVHA, Clinical Unit, 312 Hurricane Lane, Suite 201, Williston, VT 05495. PA requests may also be faxed to 802-879-5963.

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 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 (Medicaid Rule 4100, 7103 & 7410).

#### **1.6 REQUIRED DOCUMENTATION FOR PRIOR AUTHORIZATION REQUESTS**

At a minimum, the documentation required to support a PA 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 of fax cover sheet should be clearly marked as a PA Request If

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a request for PA is denied and a provider has questions or needs additional information, contact the DVHA Clinical Unit.

### **1.7 PRIOR AUTHORIZATION RESPONSES**

Under Medicaid Rule 7102.4, the DVHA is obligated to make its review determinations within three working days of obtaining all necessary information. However, the longest wait time for a decision is 28 days. A request must be decided within 14 days of receipt. That time frame may be extended up to another 14 days if the beneficiary or provider requests an extension or if the extension is needed to obtain additional information and is in the beneficiary's best interest. A notice of decision will be issued within 28 days of receiving the initial PA request even if all necessary information has not been received. Written confirmation will be sent within 24 hours. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

### **1.8 PAYMENT DECISION REVIEW PROCESS**

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

1. PA disapproval by the DVHA or its agents (other than medical necessity determinations);
2. PA decisions about the "immediate need" for durable medical equipment;
3. PA disapproval because documentation was inadequate;
4. Error in manual pricing;
5. Purchase versus rental decisions for durable medical equipment.

The DVHA will not review any decision other than those listed above.

Although this process is not an appeals process, the DVHA's position that providing a "second look" for certain decisions may help improve accuracy. Any affected provider may ask that the DVHA reconsider its decision. Such a request for reconsideration must be made no later than 21 calendar days after the DVHA 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 DVHA should have found differently. The DVHA will base its reconsideration on the materials submitted by the provider in support of its reconsideration request and any additional information provided by the DVHA. It is expected that the request will contain all supporting documents. Supplemental information submitted after the reconsideration request is made, even if before decision, 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 may consider additional information, either verbal or written, from the provider or others, in order to further clarify the case. The Director of the DVHA, or a designee, will issue a written decision. The DVHA will notify the provider of its reconsideration decision within 30 calendar days of receipt of notice of the request for reconsideration by the provider or notify the provider that an extension is needed. There is no additional review or reconsideration after the DVHA Director or the designee has made a decision on reconsideration.

All requests for reconsideration must be addressed to:

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Director, Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

### **1.9 OUT-OF-STATE PSYCHIATRIC ADMISSION REQUESTS**

Beginning August 1, 2009, the DVHA implemented concurrent reviews of all inpatient psychiatric admissions (excluding beneficiaries enrolled in CRT) for Vermont Medicaid primary beneficiaries at out-of-state hospitals. The procedure for CRT admissions remains unchanged. All children and adolescents up to the age of 18 will continue to require a screening by the Local Community Mental Health Center prior to admission. For adults, prior to admission, the referring physician should notify the DVHA Clinical Unit directly at: (802) 879-5903.

All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission and all elective admissions will require prior notification prior to admission. Admitting facilities must complete the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services* and fax it to the DVHA at (802) 879-5963.

### **1.10 OUT-OF-STATE URGENT/EMERGENT INPATIENT HOSPITAL ADMISSIONS (Excluding Designated Border Hospitals)**

All urgent and emergent inpatient admissions to out-of-state (OOS) hospitals require notification to the DVHA Clinical Unit of the admission within 24 hours or the next business day. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. The admitting hospital must fax a completed *Vermont Medicaid Admission Notification Form for Out of State Hospitals Form* and clinical documentation to the DVHA at (802) 879-5963.

The hospital is required to notify the DVHA upon patient discharge.

### **1.11 OUT-OF-STATE ELECTIVE INPATIENT HOSPITAL ADMISSIONS (Excluding Designated Border Hospitals)**

All elective inpatient admissions to out-of-state hospitals require a prior authorization from the DVHA Clinical Unit before admission. The admitting facility must fax a completed *Vermont Medicaid Out of State Preadmission Form* and clinical documentation which must include an explanation of why this care cannot be performed within the State of Vermont to (802) 879-5963. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

### **1.12 IN-STATE PSYCHIATRIC ADMISSION REQUESTS**

Beginning August 1, 2009, the DVHA implemented concurrent reviews of all in-state psychiatric inpatient admissions for Vermont Medicaid primary children and adolescents, and young adults ages 18 and up to the age of 22 (excluding beneficiaries enrolled in CRT) to the Brattleboro Retreat. All admissions will continue to require a screening by the local Community Mental Health Center prior to admission. The procedure for CRT admissions and concurrent review remains unchanged.

## **SECTION 2**

### **PRIOR AUTHORIZATION LISTING**

The services and items that require prior authorization are listed in the Fee Schedule posted at: [dvha.vermont.gov/for-providers](http://dvha.vermont.gov/for-providers). Some DME items are subject to quantity limits that can be

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extended with PA. A listing of the codes that have quantity limits and their limits is located in the DME Fee Schedule. **Effective September 1, 2010, select outpatient elective diagnostic imaging procedures require prior authorization; please see the Diagnostic Imaging Program Guidelines & list of radiology CPT codes requiring prior authorization located at [vtmedicaid.com/Downloads/manuals.html](http://vtmedicaid.com/Downloads/manuals.html).**

Contact numbers for the reviewers:

<b>DVHA Clinical Unit</b>	(802) 879-5903
Fax	(802) 879-5963
Dental	(802) 879-5903
VDH-MH	(802) 241-2604

**Pharmacy, Point of Sale**

Medmetrics Clinical Call Center	(800) 918-7549
Medmetrics Fax	(866) 767-2649

**Elective Diagnostic Outpatient High Tech Imaging**

MedSolutions Customer Service	(888) 693-3211. 8a.m. to 9 p.m., M-F
MedSolutions Fax	(888)693-3210
Internet PA Requests	<a href="http://www.medsolutionsonline.com">www.medsolutionsonline.com</a>

Fax forms can be obtained at [www.medsolutionsonline.com](http://www.medsolutionsonline.com) or by calling MedSolutions Customer Service. Diagnostic Imaging Program Guidelines and a complete list of CPT codes requiring prior authorization can be accessed at [vtmedicaid.com/Downloads/manuals.html](http://vtmedicaid.com/Downloads/manuals.html).

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## **DETAILED SUMMARY OF UPDATES 08/27/2010**

\*Please note:

-Sections below containing text in **red font** are *additions* to current policy. Previous verbiage will be noted, when applicable).

-Section headings below in **red font** are *new* sections\*

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### **SECTION 2** (page 10)

#### **PRIOR AUTHORIZATION LISTING**

The services and items that require prior authorization are listed in the Fee Schedule posted at: [dvha.vermont.gov/for-providers](http://dvha.vermont.gov/for-providers). Some DME items are subject to quantity limits that can be extended with PA. A listing of the codes that have quantity limits and their limits is located in the DME Fee Schedule. **Effective September 1, 2010, select outpatient elective diagnostic imaging procedures require prior authorization; please see the Diagnostic Imaging Program Guidelines & list of radiology CPT codes requiring prior authorization located at [vtmedicaid.com/Downloads/manuals.html](http://vtmedicaid.com/Downloads/manuals.html).**

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**Added** red text

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**07/26/2010**

***Replaced:*** The Office of Vermont Health Access (OVHA) with the **Department of Vermont Health Access (DVHA)**, throughout manual.

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### **1.4 PRIOR AUTHORIZATION REQUIREMENTS** (page 4)

The DVHA PA requirements only apply when the DVHA is known to be the primary payer for the service or item. If our system indicates that there is not other insurance coverage for this service or item, PA is necessary.

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PA is necessary if our eligibility system indicates that there is not other insurance coverage for the service or item. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item.

Added above red text

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**1.4.1 OTHER INSURANCE (OI)** (page 5)

1.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim as “non-covered” or “benefits exhausted”, the provider does not need to appeal to that primary insurer before billing Medicaid. However, if the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request authorization from the DVHA in the regular manner (fax all standard documentation required for a clinical review) and include a copy of the other insurer’s (or Medicare’s) denial.

2.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim for other reasons (such as “not medically necessary”, “pre-existing condition” or “waiting period not met”), the provider must first appeal to the primary insurer. Only after all OI/Medicare appeals (through the Qualified Independent Contractor level and Banking Insurance, Securities & Health Care Administration (BISHCA) if eligible and available) are denied can the provider then request coverage by Vermont Medicaid. All documentation showing the original claim, appeal and denial must be attached. However, if the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request retroactive authorization from the DVHA in the regular manner (fax all standard documentation required for a clinical review) and include copies of the other insurer’s or Medicare’s denials and appeals.

In order for providers to determine whose rules will apply, it is imperative that providers understand how to find and interpret the information available. Providers can access this information via the Vermont Medicaid website (www.vtmedicaid.com) or the Voice Response System (VRS) 802 878-7871. Please see the Provider Manual for further information. Vermont Medicaid is the payer of last resort.

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**1.4.1 OTHER INSURANCE (OI)**

Vermont Medicaid is the payer of last resort. Providers must pursue and apply all third party payment resources prior to billing Vermont Medicaid (see Third Party Liability, Section 1.3 of Provider Manual).

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service:

**OI Denial for Non-Covered or Benefits Exhausted-** The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

-The provider does not need to appeal to the primary insurer before billing Medicaid when the item/service is not covered or benefits are exhausted.

-If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer’s denial attached.

**OI Denial for Not Medically Necessary -** The provider and/or beneficiary is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains

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denied by the primary insurer, the provider and/or beneficiary is required to seek review by the BISHCA if the cost of the item or service exceeds \$100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the BISHCA's support of the denial. The provider should not submit any additional documentation than what was reviewed by the primary insurer.

-If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the BISHCA's support of the denial attached.

**Medicare Qualified Independent Contractor** - For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies, with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

Added: above red text

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**05/24/2010**

**TABLE OF CONTENTS** (page 3)

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 Help Desk at: 800-925-1706 or 802-878-7871.

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Added: The current Provider Manual and its Supplements can be accessed at [www.vtmedicaid.com/downloads/manuals.html](http://www.vtmedicaid.com/downloads/manuals.html). HP Enterprise Services recommends that providers check the Vermont Medicaid website periodically, for updates, to assure the accuracy of the information being referenced. If you do not have internet access and need assistance, contact the HP Provider Services Help Desk at 800-925-1706 or 802 878-7871.

Medicaid/OVHA Rules are available on line at [ovha.vermont.gov/for-providers](http://ovha.vermont.gov/for-providers).

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**1.1 SERVICES AND ITEMS REQUIRING PRIOR AUTHORIZATION** (page 4)

Some services and items require PA. A complete listing of the codes, **with PA requirement is in the fee schedule** and can be accessed on the OVHA's website ([ovha.vermont.gov/for-providersclaims-processing-1](http://ovha.vermont.gov/for-providersclaims-processing-1)). All prescription drugs are reviewed by MedMetrics (**see the Pharmacy section at [ovha.vermont.gov/for providers](http://ovha.vermont.gov/for providers)**).

Added: above red text

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**1.5 PRIOR AUTHORIZATION EXCEPTIONS** (page 5)

Changed: Medicaid Rule from M106 to 7106

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**1.5.4 REHABILITATIVE THERAPY** (page 7)

**Changed:** Medicaid Rule from M106.3 to **7102.2**

**Changed:** Medicaid Rule from M710.5 to **7401.4**

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**1.5.5 PRIOR AUTHORIZATION FOR PEDIATRIC BENEFICIARIES** (page 7)

**Changed:** Medicaid Rule from M100, M107 & M770 to **4100, 7103 & 7410**

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**1.7 PRIOR AUTHORIZATION RESPONSES** (page 7)

**Changed:** Medicaid Rule from M106.5 to **7102.4**

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**09/17/2009**

**1.10 OUT-OF-STATE URGENT/EMERGENT INPATIENT HOSPITAL ADMISSIONS (Excluding Designated Border Hospitals)**

All urgent and emergent inpatient admissions to out-of-state (OOS) hospitals require notification to the OVHA Clinical Unit of the admission within 24 hours or the next business day. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. The admitting hospital must fax a completed *Vermont Medicaid Admission Notification Form for Out of State Hospitals Form* and clinical documentation to the OVHA at (802) 879-5963.

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The hospital is required to notify the OVHA upon patient discharge.

**1.11 OUT-OF-STATE ELECTIVE INPATIENT HOSPITAL ADMISSIONS (Excluding Designated Border Hospitals)**

All elective inpatient admissions to out-of-state hospitals require a prior authorization from the OVHA Clinical Unit before admission. The admitting facility must fax a completed *Vermont Medicaid Out of State Preadmission Form* and clinical documentation which must include an explanation of why this care cannot be performed within the State of Vermont to (802) 879-5963. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

\*\*\*\*\*

**07/14/2009**

**SECTION 1.1 SERVICE AND ITEMS REQUIRING PRIOR AUTHORIZATION** (Page 4)

Some services and items require PA. A complete listing of the codes **can be accessed on the OVHA's website (<http://ovha.vermont.gov/for-providers>)**. All prescription drugs are reviewed by Medmetrics.

**Deleted:** ...and reviewers can be found in Section 2. In addition...  
...First Health Services Corp. See the Pharmacy Provider Manual for complete details

\*\*\*\*\*

**1.4 Prior Authorization Requirements** (Page 4)

The OVHA prior authorization criteria in regulations can be found in **Medicaid Rule M106**.

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**Deleted:** ...section M106 of the Welfare Assistance Manual (WAM)  
Copies of the OVHA regulations are available at the OVHA website  
<http://ovha.vermont.gov/for-providers>.

See the Provider Manual for details on how to use the verification systems.

\*\*\*\*\*

1.4.1 **OTHER INSURANCE** (Page 5)

1.) When the Vermont Medicaid beneficiary's primary insurer (including Medicare) denies a claim as "non-covered" or "benefits exhausted", the provider does not need to appeal to that primary insurer before billing Medicaid. However, if the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include a copy of the other insurer's (or Medicare's) denial.

2.) When the Vermont Medicaid beneficiary's primary insurer (including Medicare) denies a claim for other reasons (such as "not medically necessary", "pre-existing condition" or "waiting period not met"), the provider must first appeal to the primary insurer. Only after all OI/Medicare appeals (through the Qualified Independent Contractor level and BISHCA if eligible and available) are denied can the provider then request coverage by Vermont Medicaid. All documentation showing the original and appeals' denials must be attached. However, if the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request retroactive authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include copies of the other insurer's or Medicare's denials and appeals.

In order for providers to determine whose rules will apply, it is imperative that providers understand how to find and interpret the information available. Providers can access this information via the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com)) or the Voice Response System (VRS). Please see the Provider Manual for further information. Vermont Medicaid is payor of last resort.

\*\*\*\*\*

1.5 **Prior Authorization Exceptions** (Page 5)

Medicaid Rule M106 allows two general exceptions...

**Deleted:** WAM section...

\*\*\*\*\*

1.5.2 **Immediate Need Exception** (Page 5)

...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 **the minimum period for the service.**

**Deleted:** 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, **the request for PA must be faxed to the OVHA Clinical Unit the next business day...**

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**Deleted:** ...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.

\*\*\*\*\*

### **1.5.3 Conversion from Other Insurance for Physical Therapy, Occupational Therapy, Speech Therapy (PT/OT/ST) Exception** (Page 6)

Payment for PT/OT/ST requires PA for services...

**Deleted:** Payment for physical therapy...

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).”

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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 HP 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.

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### **1.5.4 Rehabilitative Therapy** (Page 7)

...The need must meet the requirements of Medicaid Rule **M106.3**...

**Deleted:** WAM section...

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*Extension of services can be approved up to four additional months per request.*

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**1.5.5 Prior Authorization for Medicaid Pediatric Beneficiaries (Page 7)**

Medical necessity determination for children will continue to use the information on EPSDT provided in regulations **M100**, M107 and M770.

**Deleted:** *Effective August 1, 2003...*

\*\*\*\*\*

**1.5.6 Required Documentation for Prior Authorization Requests (Page 7)**

If a request for PA is denied and a provider has questions or needs additional information, contact the **OVHA Clinical Unit**.

**Deleted:** *...Person whose name appears on the Notice of Decision.*

The outside envelope or FAX cover sheet should be clearly marked as a PA Request. 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.

**Deleted:** *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.*

*...(the form received in the mail informing you of the decision).*

\*\*\*\*\*

**1.5.7 Prior Authorization Responses (Page 7)**

Under **Medicaid Rule M106.5**, the OVHA is obligated to make its review determinations within three working days of obtaining all necessary information. However...  
Written confirmation will be sent within 24 hours...

**Deleted:** *WAM 103.3(J)(2)  
...and to notify "the treating provider" by telephone.  
...of the telephone notification.*

However, the longest wait time for a decision is 28 days. A request must be decided within 14 days of the 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 best interest. A notice of decision will be issued within 28 days of receiving the initial PA request even if all necessary information has not been received.

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**1.5.8 Medicaid Payment Decision **Review Process** (Page 8)**

**Deleted:** *Reconsideration*

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

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**Deleted:** *for reconsideration*

The OVHA will not review any decision other than those listed above.

**Deleted:** *...reconsider its regulations or...*

Although this process is not an appeals process, the OVHA's **position** 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 **calendar** 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 **submitted** 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 **submitted** 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.

**Deleted:** *Believes  
Presented  
Sent in*

Upon receipt of the request with supporting information, the OVHA will review of the request, and the reasons supporting the provider's request. The OVHA may **consider** 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 notify the provider of its reconsideration decision within 30 **calendar** days of receipt of notice of the request for reconsideration by the provider **or notify the provider that an extension is needed.**

**Deleted:** *...The OVHA will undertake a good-faith  
...The OVHA will take into consideration...in order to make its best efforts...*

\*\*\*\*\*

**1.9 OUT-OF-STATE PSYCHIATRIC ADMISSION REQUESTS** (Page 8)

Beginning August 1, 2009, the OVHA implemented concurrent reviews of all inpatient psychiatric admissions (excluding beneficiaries enrolled in CRT) for Vermont Medicaid primary beneficiaries at out-of-state hospitals. The procedure for CRT admissions remains unchanged. All children and adolescents up to the age of 18 will continue to require a screening by the Local Community Mental Health Center prior to admission. For adults, prior to admission, the referring physician should notify the OVHA Clinical Unit directly at: (802) 879-5903.

All emergent and urgent admissions will require notification to the OVHA within 24 hours or the next business day of admission and all elective admissions will require prior notification prior to admission. Admitting facilities must complete the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services* and fax it to the OVHA at (802) 879-5963.

\*\*\*\*\*

**1.10 IN-STATE PSYCHIATRIC ADMISSION REQUESTS** (Page 9)

Beginning August 1, 2009, the OVHA implemented concurrent reviews of all in-state psychiatric

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inpatient admissions for Vermont Medicaid primary children and adolescents, and young adults ages 18 and up to the age of 22 (excluding beneficiaries enrolled in CRT) to the Brattleboro Retreat. All admissions will continue to require a screening by the local Community Mental Health Center prior to admission. The procedure for CRT admissions and concurrent review remains unchanged.

\*\*\*\*\*

**SECTION 2 PRIOR AUTHORIZATION LISTING** (Page 9)

**Deleted:** ...as of July 15, 2004

...are listed in the Fee Schedule posted at: <http://ovha.vermont.gov/for-providers>.

**Deleted:** [www.vtmedicaid.com](http://www.vtmedicaid.com)

OVHA Clinical Unit (802) 879-5903  
Dental (802) 879-5903

**Deleted:** *Clinical Reviewer*  
*Mail to Dental Health, Department of Health, Burlington*

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