

Department of Vermont Health Access312 Hurricane Lane, Suite 201
Williston, VT 05495-2086<http://dvha.vermont.gov/>

[Phone] 802-879-5900

Agency of Human Services

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi.

Dokumentigan ama qoraalkan waa muhiim. Haddii aadan fahmin, waxaad u qaadaa xafiiskaaga degaanka si aad caawimaad u hesho.

ဤစာရွက်စာတမ်းသည် အရေးကြီးပါသည်။ သင်နားမလည်လျှင်၊ သင်၏နယ်မြေရုံးခန်းသို့အကူအညီရရန် ယူဆောင်သွားပါ။

यो दस्तावेज महत्त्वपूर्ण छ। यदि तपाईंले यसलाई बुझ्नुभएन भने, मद्दतको लागि यसलाई आफ्नो स्थानीय कार्यालयमा लिएर जानुहोस्।

Date: _____

Dear Beneficiary:

You asked us about paying for _____, which is not on the list of pre-approved items and services covered by Medicaid. This letter tells you how you can ask for coverage of any medical service, item, or procedure that is not now on the list of covered services or items. The relevant policies and forms are enclosed.

To ask for coverage:

- **fill out and sign the enclosed Beneficiary Request for Medicaid Coverage Exception (DVHA 211RC) and**
- **have your doctor or therapist fill out and sign the enclosed Request for Medicaid Coverage Exception - Medical Need Form (DVHA 211RCMN). You may also submit letters or forms from a physical, occupational, or speech therapist, or mental health provider, if applicable.**

You may attach statements to the DVHA 211RC from someone who knows your situation that tells how you might be harmed without the service or item. You may also send in more materials to show how the service or item will meet the conditions in the exception policy (Rule 7104).

Please send all information to:

Commissioner, Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2806

ATTN: Exception Coordinator

We will begin our review of your request as soon as we receive both forms and will make a decision within 30 days.

Excerpts from Vermont Medicaid Policy

7103 Medical Necessity

“Medically necessary” means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary’s diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

1. help restore or maintain the beneficiary’s health; or
2. prevent deterioration or palliate the beneficiary’s condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

7104 Procedure for Requesting Coverage of a Service or Item

Any beneficiary may request that the department cover a service or item that is not already included on a list of covered services and items. The request should be sent to the Director of the Office of Vermont Health Access (OVHA). The director will review the request and supporting documentation and make a good faith effort to obtain any additional information quickly to allow the commissioner to make a decision within thirty days. In no case will a request for a service or item be approved for coverage unless it is medically necessary.

Each decision shall result in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list of pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.

If the commissioner’s decision is to add the service or item to a pre-approved list of covered services, a PP&D memorandum will be issued delineating the addition. All such PP&D memoranda will be incorporated into the rule as soon as practical. An adverse decision from the commissioner may be appealed through the fair hearing process. An adverse decision may not be renewed by the same beneficiary until twelve months have elapsed since the previous final decision or until new documentation of the individual’s condition, a change in the individual’s condition, new medical evidence, or a change in technology has been demonstrated.

The Office of Vermont Health Access shall, semiannually, issue a PP&D memorandum updating the listing of all affirmative coverage decisions made under this procedure that do not result in the service or item that is authorized being added to a list of pre-approved services or items. This list shall include the commissioner’s coverage decisions, plus negotiated settlements and Human Services Board and Vermont Supreme Court decisions. Because this list shall be available for public inspection, it shall be composed in a manner that protects beneficiaries’ right to confidentiality. The department will ensure that all Medicaid beneficiaries who are similarly situated to the individual who has obtained coverage will be treated similarly with respect to coverage of the same service or item.

If, under this section, an individual requests that a service or item be covered, the following criteria will be considered, in combination, in determining whether to cover the service or item for the individual and/or to add it to a list of pre-approved services or items, with the following exception. If the service or item is subject to FDA approval and has not been approved (criterion #I below), the request for coverage of the service or item will be denied.

- A. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not approved?
- B. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?
- C. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered?
- D. Is the service or item consistent with the objectives of Title XIX?
- E. Is there a rational basis for excluding coverage of the service or item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage for a service or item solely based on its cost.
- F. Is the service or item experimental or investigational?
- G. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?
- H. Are less expensive, medically appropriate alternatives not covered or not generally available?
- I. Is FDA approval required, and if so, has the service or item been approved?
- J. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

* * * * *

The policy sections above are for information or guidance only. This page should not be returned to DVHA, and should not to be used instead of, or in addition to the Medical Need Form (211 RCMN).

Department of Vermont Health Access

Beneficiary Request for Medicaid Coverage Exception

(application form)

We must receive this signed application to process your request.

Please Print

Name:	
Address:	
City, state, zip code:	
Telephone number:	
Social Security Number:	
Medical provider's name:	Provider's phone number:

(Attach additional sheets if necessary.)

1. Describe the service or item requested for coverage:

2. Describe how you might be harmed without the service or item:

I hereby authorize any medical source to disclose to the Department of Vermont Health Access medical records or related information regarding my request for Medicaid coverage of a service or item.

The information submitted in this application is true and accurate to the best of my knowledge.

Beneficiary/Guardian's signature

Date

Please send all information to:

Commissioner, Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2806

ATTN: Exception Coordinator

Department of Vermont Health Access

Request for Medicaid Coverage Exception - Medical Need Form

PROVIDER: Complete this form only for those services or items that are **NOT** already covered by Medicaid.

Please print

Provider Name:	<u>Medicaid Provider #:</u>
Address:	
City, state, zip code:	
Telephone number:	
Patient's Name:	Social Security Number:
Requested Service or Item:	

Please write legibly or type. (Attach additional sheets if necessary)

1. The above-named patient is requesting Medicaid coverage of a service or item that is not on the list of services and items pre-approved for coverage. Please provide the clinical reasons that are the basis for your assessment that the service or item is medically necessary. *(Please submit the following information/records in your possession in support of this request: patient medical history; hospital discharge summary; emergency room report; operative, lab, x-ray and diagnostic reports; physical, occupational, speech, dental or mental health assessments; and a list of medications the patient is currently taking.)*

2. Describe the **unique** extenuating circumstances, if any, that can be *reasonably anticipated* to produce serious detrimental health consequences should the service or item not be provided to this individual. Please include a description of the **serious detrimental health consequences** that you anticipate. This information is critical for us to evaluate the request. Does not apply in this case.

Provider's signature

Date

Please return this form and all relevant supporting information to:

Commissioner, Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2806

ATTN: Exception Coordinator