VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: CST – Service Determination

Issuance Date: April 26, 2023

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

42 CFR § 438, Subpart F

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals -

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

Vermont statute or rule:

- 7101 Medicaid Benefit Delivery
- 7102.2 Prior Authorization Determination
- 4.101 Medical Necessity
- 8.100 Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services

Purpose:

To document the process for benefit determination regarding health care service based on review of requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service by the appropriate decision maker.

Procedure:

Clinical Processing of prior authorizations

If the requested service requires PA, the CST reviews the request and processes it accordingly.

The Department of Vermont Health Access (DVHA) Clinical Prior Authorization (PA) process is designed to improve all aspects of clinical services and care received by Vermont Medicaid members in all health care settings. PA is a process of clinical review for specific services, items, or procedures to verify the following:

- Medical necessity,
- Consideration of less costly alternatives if appropriate,
- Conformity to generally accepted best practice parameters, and
- Compliance with regulations in Medicaid Rules and Health Care Administrative Rule (HCAR).

Required documentation:

- Completed copy of Medical Necessity Form, Uniform Medical Prior Authorization Form, a DVHA PA request form, or a written prior authorization request with provider signatures, and Vermont provider number and Medicaid member information.
- Clinical documentation supporting medical necessity, and
- All necessary procedure and diagnosis codes for service identification, number of units requested, and pricing if appropriate.

Prior Authorization response:

- The DVHA Clinical Services Team staff makes a determination and issues a notice of decision (NOD) to the requesting provider and member within three business days of receiving all necessary information per Medicaid Rule 7102.
- Provider is notified promptly if additional information is needed to complete the clinical review.
- A request for information may be extended up to 14 days if the member or provider requests, or if the extension is needed to obtain additional information and an extension is in the member's interest.
- Expedited Authorization: If a provider indicates, or DVHA determines, that the timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the DVHA must make an expedited decision and provide notice as expeditiously as the member's health condition requires and no later than three working days after receipt of the request. This may be extended up to 14 days if the member so requests, or if the extension is needed to obtain additional information and an extension is in the member's interest.

All decisions for a PA request must be rendered by the 28th day per Medicaid Rule 7102.4 and 42 CFR)

Internal Reconsideration Review Process

The first level of reconsideration is an internal secondary review by the CST. DVHA reconsiders an authorized decision based on the clinical documentation from the medical record and written documentation from the attending physician, demonstrating why the provider believes the DVHA should have made a different decision. If a provider disagrees with DVHA's secondary decision, the provider may then request a doctor-to-doctor review, wherein the facility's physician and/or Medical Director speaks with the DVHA designated physician for final review of the authorization decision. If a PA requires additional clinical documentation to complete the medical necessity review, it will be statused as outstanding, however, this process is the exception. Once the additional information is received, the PA request is reviewed. If the additional information does not support the medical necessity, then the PA request is denied.

The Medical Basis form is used to consolidate the necessary medical contact for the DVHA Physician.

Chief Medical Officer Review

- All determinations to deny or limit a service for an amount or duration of less than the requested quantity must be reviewed by the DVHA Chief Medical Officer, or Physician Consultant, or a health care professional with the appropriate clinical expertise for the service requested.
- All requests for services that do not have clinical criteria available must be forwarded for review to the DVHA Chief Medical Officer, Physician Consultant, or a health care professional with the appropriate clinical expertise for the service requested. The primary reviewer will include any evidence based clinical research from a credible nationally recognized organization.

All NODs must include according to 42 CFR the following:

- The action (i.e. approved, denied)
- The reason for action - clinical rationale for the decision, including the Vermont Medicaid Rule, Health Benefits Eligibility and Enrollment (HBEE), or Agency of Human Services Health Care Administrative Rules (HCAR) cited for all denied services.
- Appeal rights - standard verbiage on the back of the NOD

Waiver of Prior Authorization – per Rule 7102.3 (04/01/1999, 98-11F)

The requirement for a PA is waived by the department for a covered service if in the department's judgment, the service provided without prior authorization meets one or both of the following circumstances:

- The service was required to treat an emergency medical condition.
- The service was provided prior to the determination of Medicaid eligibility and within the retroactive coverage period.

EPSDT

Those members enrolled in Dr. Dynasaur or traditional Medicaid, under 21 years of age, qualify for EPSDT (Early and Periodic Screening, Diagnosis and Treatment). EPSDT is the child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services.

- For requests that align with EPSDT benefits, follow the standard procedure. If medical necessity is not demonstrated, it is documented in the Peer Review worksheet and forwarded to the DVHA Chief Medical Officer.
- For PAC 9 requests, a medical necessity determination is required and completed on a case by case basis. It is incumbent upon the provider to submit the necessary clinical information to support the request. To finalize the review process, the recommendation is documented in the Peer Review worksheet and forwarded to the DVHA Chief Medical Officer.

Peer to peer requests (doctor-to-doctor consultations)

Peer to peer requests (doctor-to-doctor consultations) are received by the COU/CST administrative staff. Staff making decisions on the benefit determination cannot be:

- Involved in any previous level of review,
- Involved in any previously made decisions,
- A subordinate of any individual meeting the above criteria.

Staff making decisions must also have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. The process provides an opportunity for providers to talk to an MD about the clinical determination that was made prior to the provider or member requesting an appeal or fair hearing.

The COU/CST administrative staff obtains the member's file in OnBase identifying the provider requesting a peer to peer and places it in the DVHA Chief Medical Officer or Medical Director Contracted staff envelope. An email is also sent to the DVHA Chief Medical Officer or Medical Director Contracted staff who denied the request, informing them of a requested a peer to peer from the provider and asking for available dates and times to schedule a meeting.

When a response is received from the DVHA Chief Medical Officer or Medical Director Contracted staff, the COU/CST/CST administrative staff contacts the requesting provider's office to schedule the peer to peer. COU/CST administrative staff schedules an appointment on the COU calendar with the DVHA Chief Medical Officer or Medical Director Consultant staff and the provider, including the member's name, PA #, provider's name and phone number to call in the body of the appointment.

The COU/CST administrative staff inserts a Medical Basis Statement to the member's file in OnBase and puts it in the DVHA Chief Medical Officer or Medical Director Consultant staff's envelope.

The DVHA Chief Medical Officer or Medical Director Consultant staff calls the provider at the scheduled time. If an email is sent to set up the peer to peer, it comes from the COU email address. The peer to peer medical necessity decision made at this meeting is final.

Exception Requests

The services listed below **are not subject** to the grievance rule at 8.100.8 and the internal appeal rule at 8.100.4. A Medicaid beneficiary may request a State fair hearing, pursuant to 8.100.5, regarding these services: (a) services funded with state-only dollars because federal participation is prohibited, and (b) services that are a coverage exception to Medicaid covered services.

Exception requests are meant for non-covered services. There is specific paperwork that requires completion by the Member and the prescriber. paperwork is in place of the Appeal Intake Form and is sent to the DVHA Exception Coordinator.

Revision History:

Date	Summary of Revisions
4/26/2023	Review, edits

Table 1 Revision History