VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Utilization Management and Authorization Requirements

Issuance Date: September 22, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

42 CFR 431.54(e)

Vermont statute or rule:

Medicaid rule: 7013 (medically necessary)

Purpose:

The purpose of this SOP is to document the mission essential functions of the DVHA Clinical Integrity Unit (CIU). The DVHA CIU Care Managers conduct numerous utilization management and review activities to ensure that quality services and appropriate levels of care are being provided to Vermont Medicaid Members. These services include acute inpatient mental health treatment, inpatient detoxification, and Applied Behavioral Analysis (ABA). Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule, 7013, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration of member's diagnosis or condition and must conform to generally accepted practice and parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. The DVHA CIU is also responsible for Team Care (Patient Review and Restriction Program). Federal Medicaid Law (42 CFR 431.54 (e)) guides Vermont's Policies regarding members who over-utilize or misuse Medicaid services. It states, "If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only". The CIU is available to assist with needs such as adding prescribing doctors or pharmacies to the enrolled members approved lists. Please refer to Team Care (Patient Review and Restriction Program)

Procedure:

Utilization management: The DVHA conducts numerous utilization management and review activities to ensure that services provided to members increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice. DVHA and DMH staff utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. Approved criteria for the services in this supplement include the following:

- Change Health Care, LLC InterQual® Criteria
- DVHA Clinical Practice Guidelines
- Vermont State Medicaid Rules

All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA the ***VT Medicaid Admission Notification Form for Inpatient Psychiatric & Detoxification Services***:

- Mental Health forms

Enrolled providers requiring rate negotiations are referred to the Reimbursement unit once the admission is approved. All providers must be enrolled with Vermont Medicaid to receive authorization. Non-enrolled providers are referred to the provider management module.

Notification to the DVHA Care Manager (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. The Care Manager will use the documentation provided to assess the member's acuity level using the InterQual ® tool. The Care Manager will assign authorization, typically 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.

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.

Revision History:

Date	Summary of Revisions
03/16/2020	New SOP
03/17/2020	Edits suggested by OMU, new draft
03/17/2020	Approval by area director
02/28/2022	Revisions/Updates
04/17/2023	Revisions/Updates

Table 1 Revision History