4.103 Prior Authorization (1/1/2026, GCR 24-105)

4.103.1 Definitions

For purposes of this rule, the following definitions apply:

(a) "**Prior authorization**" is a process through which a request for coverage of a service is submitted to Vermont Medicaid for review and approval before the service is provided in order for the service to be covered.

(b) "**Pharmacy benefit**" means the covered Vermont Medicaid services described in HCAR 4.207, titled "Prescribed Drugs."

4.103.2 Criteria for Utilizing Prior Authorization

(a) Vermont Medicaid requires prior authorization for any service that has an imminent harm code. The list of imminent harm codes can be found on the Department of Vermont Health Access (DHVA) website.

(b) Vermont Medicaid may require prior authorization if it determines that one or more of the following criteria are met:

(1) The service is of questionable medical necessity as determined by Vermont Medicaid.
(2) Vermont Medicaid determines that use of the service requires monitoring to manage the expenditure of Medicaid program funds.
(3) Less expensive medically appropriate alternatives to the service are generally available.
(4) The service is investigational or experimental.
(5) The service is not already determined to be covered for beneficiaries who are under the age of 21 pursuant to the requirement of HCAR 4.106, titled, "Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services."
(6) The request is for coverage of routine patient costs for services furnished in connection with participation in a qualifying clinical trial pursuant to 42 USC 1396(a)(30)(hereinafter referred to as "routine patient costs related to a qualifying clinical trial").
(7) The service is newly developed or modified.
(8) Vermont Medicaid determines that monitoring a service of a continuing nature is necessary to prevent the continuation of the service when it ceases to be beneficial.

4.103.3 List of Services Requiring Prior Authorization

(a) Prior authorization is required for some services. A list of services that require prior authorization can be found on the DVHA website.
(1) Services, other than the pharmacy benefit, that require prior authorization are identified in the Fee Schedule in the Vermont Medicaid Portal, which is available on the DVHA website.
(2) Pharmacy benefits that require prior authorization are identified in the Preferred Drug List, which is available on the DVHA website. Some preferred and all non-preferred drugs are subject to prior authorization as described in the Preferred Drug List.

4.103.4 Prior Authorization Determinations

(a) Vermont Medicaid will approve a request for prior authorization of a covered service if it determines that the service meets the following criteria:
(1) Medical necessity for covered services criteria as set forth in HCAR 4.101, titled "Medical Necessity for Covered Services,"
(2) Is appropriate and effective to the medical needs of the beneficiary,
(3) Is timely, considering the nature and present state of the beneficiary's medical condition,
(4) Is the least expensive, appropriate service available,
(5) Is FDA-approved or authorized, if the service is FDA regulated,
(6) Is subject to a manufacturer's rebate agreement and meets applicable criteria in the Preferred Drug list, if the service is a prescribed drug,
(7) Is not a preliminary procedure or treatment leading to a service that is not covered by Vermont Medicaid,
(8) Is not the repair of an item that is not covered by Vermont Medicaid,
(9) Is not experimental or investigational,
(10) Is furnished by a provider working within their scope of practice, and
(11) Is not solely for the convenience of the beneficiary or the beneficiary's caretaker or provider.

(b) Prior authorization is determined on a case-by-case basis.

(c) Vermont Medicaid is responsible for determining questions of coverage and medical necessity. Vermont Medicaid may contract with external organizations to assist with prior authorization determinations but Vermont Medicaid is the final authority for these decisions.

(d) A prior authorization request must include a completed prior authorization form that has been submitted by a Vermont Medicaid-enrolled provider. Additional information necessary to show that the service meets the relevant criteria may be required, including the following items:
(1) The beneficiary's relevant medical records,
(2) The beneficiary's plan of care,
(3) A statement of long-term and short-term treatment goals,
(4) A response to clinical questions posed by Vermont Medicaid,

(5) A second opinion or an evaluation by another provider, at Vermont Medicaid's expense,
(6) The provider's detailed and reasoned opinion in support of medical necessity,
(7) A statement of the alternatives considered and the provider's reasons for rejecting them, and
(8) A statement of the provider's evaluation of alternatives suggested by Vermont Medicaid and the provider's reasons for rejecting them.

4103.5 Prior Authorization Requirements and Waiver

(a) When a service is subject to prior authorization, Vermont Medicaid will not pay for the service unless approval is given in advance of receipt of the service except if Vermont Medicaid determines the service meets the standards for waiver set forth at HCAR 4.103.5(b).

(b) For covered services designated as needing prior authorization, Vermont Medicaid will waive the requirement if it determines that the service that was provided without prior authorization is a covered service and meets one of the following criteria:
(1) The service was required to treat an emergency medical condition, or
(2) The service was provided:
(A) before the individual's Vermont Medicaid eligibility was determined, and
(B) within the retroactive coverage period.

4.103.6 Prior Authorization Process

(a) Specific and general prior authorization forms can be found on the DVHA website.

(b) The prior authorization process begins when Vermont Medicaid receives a written prior authorization request from a Vermont Medicaid-enrolled provider.

(c) Vermont Medicaid will act in good faith to obtain any additional necessary information promptly so that it can determine, within the relevant timeframes described at HCAR 4.103.6(e), (f), and (g), whether the request will be approved or denied.

(d) Any decision to deny a prior authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(e) Time requirements for prior authorization determinations on services other than covered outpatient drugs that are part of the pharmacy benefit and described at Section 1927 of the Social Security Act (hereinafter referred to as "covered outpatient drugs") and routine patient costs related to a qualifying clinical trial, as described at HCAR 4.103.2(b)(5):
(1) Standard Time. Vermont Medicaid will make a prior authorization determination and provide notice, compliant with HCAR 8.100.3(a)-(b), titled "Internal Appeals, Grievances, Notices, and

State Fair Hearings on Medicaid Services," as expeditiously as the beneficiary's condition requires, but not more than seven days from Vermont Medicaid's receipt of the request for prior authorization.

(2) Expedited Time. When a provider indicates, or Vermont Medicaid determines, that the standard time for a prior authorization determination could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, Vermont Medicaid will make an expedited decision and provide notice, compliant with HCAR 8.100.3(a)-(b), titled "Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services," as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for the service.

(3) Extensions of Time.

(A) The standard and expedited timeframes for a prior authorization determination on services other than covered outpatient drugs, as described at HCAR 4.103.6(e), may be extended up to 14 days if:

(i) The beneficiary or provider requests the extension, or

(ii) Vermont Medicaid justifies a need for additional information and shows that the extension is in the beneficiary's best interest (e.g., more medical documentation is required and without it, the request would be denied).

(B) If Vermont Medicaid meets the criteria for extending the time for standard and expedited prior authorization determinations, it will:

(i) Give notice to the beneficiary of the reason to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with the decision to extend the timeframe, and

(ii) Issue and carry out its decision as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.

(4) Maximum Time for Prior Authorization Determinations on services other than covered outpatient drugs, as described at 4.103.6(e), and routine patient costs related to a clinical trial, as described at HCAR 4.103.2(b)(5). The maximum time, including any extensions, for Vermont Medicaid to decide to approve or deny a prior authorization request is:

(A) 21 days from receipt of a request for a standard prior authorization determination (seven days plus 14 day extension), or

(B) 17 days from receipt of a request for an expedited prior authorization determination (72 hours plus 14 day extension).

(f) Prior authorization requirements, including time requirements, for covered outpatient drugs, as described at HCAR 4.103.6(e).

(1) Vermont Medicaid will:

(A) Provide a response by telephone or telecommunication device within 24 hours of a request for prior authorization, and

(B) Except with respect to excluded drugs listed in Section 1927(d)(2) of the Social Security Act, provide for the dispensing of at least a 72-hour supply of a covered outpatient drug, as

described at 4.103.6(e), when prior authorization has not been secured and the need to fill the prescription is determined to be a medical emergency. Prior authorization will still be needed for further dispensing.

(g) Prior authorization requirements, including time requirements, for routine patient costs of a beneficiary when related to a clinical trial, as described at HCAR 4.103.2(b)(5). Vermont Medicaid will provide a response within 72 hours of a request for prior authorization without regard to the geographic location or network affiliation of the health care provider treating the beneficiary or the principal investigator of the qualifying clinical trial. Extensions of time are permitted pursuant to HCAR 4.103.6(e)(3).

(h) Notice requirements. Vermont Medicaid will notify the requesting provider and give the beneficiary written notice of any decision to deny a prior authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Such notice will be consistent with HCAR 8.100.3, titled “Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services,” or, if the service is a covered outpatient drug, as described at HCAR 4.103.6(e), then consistent with Section 1927(d)(5)(A) of the Social Security Act.