

ITEM 2.a. OUTPATIENT HOSPITAL SERVICES

Emergency Care

Emergency Care shall be administered in accordance with 42 CFR 447.53(b)(4).

Rehabilitative Therapies

Physical, occupational and speech/language therapies are described on page 4e of Attachment 3.1-A.

Diagnostic Testing

Diagnostic testing is limited to those tests ordered by a physician for determining the nature and severity of an illness or medical condition. Administratively necessary or court ordered tests are not covered, unless they are medically necessary.

Psychiatric Partial Hospitalization

Psychiatric partial hospitalization is covered as a hospital service for those programs which have received and meet the conditions of a Certificate of Need for the Vermont Health Care Authority.

**Deleted:** Outpatient therapy services, whether occupational therapy, physical therapy or speech pathology services, or any combination of therapies, are limited to thirty (30) therapy visits per calendar year. Exceptions to this limit must be prior approved. ¶  
¶ All therapy providers meet the provider qualification described in 42 CFR 440.110.¶

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ITEM 11. PHYSICAL THERAPY AND RELATED SERVICES

A, B, & C Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders are covered as follows:

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For beneficiaries under age 21, prior authorization is required beyond eight therapy visits per discipline (physical, occupational, or speech therapy).

Deleted: 1) . to those provided in the outpatient department of a hospital\*\*, nursing facility\*or Medicare certified rehabilitation agency; by private practitioners who are active Medicaid providers; and by staff therapists of a home health agency;¶  
¶  
\* PT, OT, and ST for an inpatient of the nursing facility are covered in the nursing facility per diem.

For beneficiaries age 21 and older, thirty (30) therapy visits per calendar year and include any combination of physical therapy, occupational therapy and speech/language therapy. Exceptions to this limitation must be prior approved.

All therapy providers meet the provider qualification described in 42 CFR 440.110

PT, OT, and ST for an inpatient of the nursing facility are covered in the nursing facility per diem.

Deleted: \*\* PT, OT and ST for outpatients of a hospital are covered as described in Item 2(iii)(c) on page 2a(1b) of Attachment 4.19-B.¶  
¶

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Analog or Digital hearing aids are limited to one hearing aid per ear every three years for specified degrees of hearing loss outlined below. Prior authorization is required for more frequent requests for a hearing aid. Hearing aid repairs are limited to one repair/modification per aid per year. Prior authorization is required when a second or subsequent repair/modification is requested within 365 days of a previous repair/modification. Hearing loss will have to meet one of the following conditions or if otherwise necessary under EPSDT; prior authorization is required for other degrees of hearing loss:

- a. Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.
- b. Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.
- c. Hearing loss in the better ear is greater than 40dB base on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

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