

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
Department of Vermont Health Access (DVHA)**

**AHS Bulletin No: 10-21**

Secretary of State's ID Number: 10E-14

**FROM:** Susan Besio, Ph.D., Director  
Department of Vermont Health Access

**DATE:** 10/18/10

**SUBJECT:** State Fiscal Year 2011 Coverage Changes

**CHANGES ADOPTED EFFECTIVE:** 10/29/10

**TYPE OF RULE CHANGE**

**Emergency Rule Changes**

**RULE REFERENCE(S):**

**5351            7203            7317            7401            7405**

This emergency rule is being implemented as directed by (H.789) Act 156 of the 2009 -2010 Legislative Session, An Act Making Appropriations for the Support of Government.

**Sec. E.309.14 EMERGENCY RULEMAKING; MEDICAID**

(a) In order to administer Sec. E.309.1(a) [benefit limits] and (b) [high-tech imaging] of this act relating to limiting the annual number of covered visits for physical therapy, occupational therapy, speech therapy, emergency room services, instituting a prior authorization for imaging, and limiting the monthly number of drug tests, and Sec. E.309.11 [Medicare drug benefit], the agency of human services shall be deemed to have met the standard for adoption of emergency rules as required by 3 V.S.A. §844(a). Notwithstanding 3 V.S.A. §844, the agency shall provide a minimum of five business days for public comment in advance of filing the emergency rules as provided for in 3 V.S.A. §844(c).

All changes are for those in VHAP and for adults in Medicaid, as specified below. The definition of adult was not specified, so DVHA used the EPSDT definition of adult (person 21 and older). This definition is consistent with existing rules that differentiate service coverage based on an adult/child definition (Rules 7312, 7313, 7316, 7406.1, and 7410).

**Sec. E.309.1 MEDICAID; BENEFIT LIMITATIONS; RATES**

(a) The department of Vermont health access may impose the following limitations and process requirements on benefits for adults in Medicaid and VHAP:

(1) Physical, occupational, or speech therapy visits may be limited to 30 visits per year, except that the department shall allow additional visits through the prior authorization process for individuals with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn. This limit shall not apply to therapy services provided by home health agencies.

(2) Urine drug tests may be limited to 8 tests per month. The department of Vermont health access shall adopt SAMSHA guidelines, as available, for appropriate use of urine drug tests, including the frequency of testing, and shall develop protocols for exceptions to the limitation to 8 tests.

(3) Emergency room visits may be limited to 12 visits per year, except that the department shall not include in the limitation emergency room visits resulting in the individual being admitted to the facility, resulting in the individual being transferred to another inpatient facility, or during which the individual becomes deceased.

(b) The department of Vermont health access may institute a prior authorization process for high-tech imaging, including scans such as computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), positron emission tomography-computed tomography (PET-CT). The prior authorization process shall not apply to x-ray, ultrasound, mammogram, or dual x-ray absorptiometry (DXA) images and shall not apply to imaging ordered by emergency departments or during an inpatient admission.

*Note: All coverage rules were effective July 1, 2010 through emergency rule 10-03, however the implementation of prior authorization for high-tech imaging services found in Rule 7405 began on September 1, 2010.*

***Specific Changes to Rule Sections***

<b>Section</b>	<b>Description of Change</b>
5351	Changes were made to update the page with a correct listing of covered and non-covered services. The term “primary care provider” was replaced with “health care provider”. The section on wrap-around coverage was removed. It only had two items in it and one was discontinued years ago. The other item was moved up into the section preceding it.
7203	Outpatient Services had language added that tells where the PA information for radiologic and laboratory services can be found. It removed most of the therapy language and directed that the language can now be found in 7317. Inhalation therapy was separated out of the rehabilitative therapy language and individually listed.
7317	This is a new rule section specific the occupational therapy, physical therapy, and speech therapy, that incorporates all the changes specified in Act 156. <i>Since filing emergency rule 10-03 - under “Prior Authorization Requirements:”, third paragraph, first bullet, the word “and” replaced with “or”.</i>
7401	The therapy services list was consolidated to match the name of the new Rule 7317. PA language was specified in the DME section, just to make it clear that some DME does require PA. Section “j” was deleted because the home health provision of rehabilitative therapy is covered in the new Rule 7317. Subsection 7401.4 was deleted as it was PA language for rehabilitative therapy, and also included in Rule 7317. The three sections below it were renumbered.
7405	Radiology PA language was added for imaging services. Limitation was added for the number of drug tests allowed in a month. Since these are Medicaid rules, and also referenced in the VHAP rules, the word “Medicaid” was removed from the body of the text. The word “recipient” was replaced with “beneficiary”. We corrected the spelling of “hematological”.

***Responses to Public Comments***

A notice of the rule changes was published in the Burlington Free Press on October 19, 2010, and uploaded to DVHA’s website on October 19, 2010. The written comment period was from October 20, 2010 to October 26, 2010, as required in (H.789) Act 156.

Through emergency rule 10-03, DVHA previously received comments from The Vermont Medical Society, Medicaid Advisory Board members, Vermont Family Network, and Office of Health Care Ombudsman.

Their comments are summarized below along with DVHA's responses.

#### Rule 5351

**Comment:** For VHAP beneficiaries to have to get a referral from their primary care physician to get all laboratory and radiology services is a substantive change not authorized by the legislation, which authorizes a prior authorization requirement, not a referral requirement, and for high-tech imaging, not all laboratory and radiology services. Does this section mean that a beneficiary, referred to a dermatologist by a primary care physician, has to go back to the primary care physician to get lab services approved which the dermatologist has ordered?

**Response:** Rule 5351 separates services into the two categories of "referral required" and "self-referred". Laboratory services and radiological services have to be listed as "referral required", since an individual cannot "self-refer" for either laboratory or radiological services, that is, they have to be ordered by a qualified health care provider. It is agreed that the current wording does not address this same issue for other services in the "referral" list (ie. prescriptions), therefore, we have changed "primary care provider" with "health care provider". In doing that, we had to add clarification that a referral from the primary care provider is required to access services of other physicians.

#### Rule 7203

**Comment:** None Received

#### Rule 7317

**Comment:** This new section is a little confusing because it not only imposes the 30 therapy visit limit but also moves the language from the Home Health Agency Services rule, 7401, to this section. As a result, it is not clear enough that home health agency services are exempt from the 30 visit cap.

**Response:** It is very specific, although to make it stand out more, the items under the "Limitations" section were converted to a bulleted list, and the sentences "Services provided by a home health agency are covered for up to four months based on a physician's order, for beneficiaries of any age. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified below." were moved up to the first bullet.

**Comment:** The first paragraph under Limitations is too broad and thus problematic. The language of the Appropriations Act does not authorize the imposition of these limits on all state health insurance programs, which is the implication of this proposed regulation. Beneficiaries who are on state premium assistance programs should not be subject to this limitation.

**Response:** Medicaid and VHAP are the only state "health insurance" programs. These rules govern those two programs. [DVHA] provides other types of assistance programs, like pharmacy assistance and commercial insurance premium payment assistance, and these rules do not change the rules of any of those programs. Changes in Medicaid and VHAP rules do not change products offered by commercial insurers.

**Comment:** It should be clearer that the 30 visit cap does not apply to beneficiaries under age 21.

**Response:** It is clear. The only place the 30 visit cap can be found is in section 7317.2 - Rehabilitative Therapy Services for Beneficiaries Age 21 and Older.

**Comment:** It is a concern that it was an oversight that Cerebral Palsy (CP) was not included in the list of 5 diagnoses/conditions proposed to be exempt from the OT/PT/SLP limitations. For many people with a CP diagnosis, regular therapy is needed. If an individual with CP has an injury or episodic flare up or illness on top of the chronic condition, it would be very medically necessary to have additional OT/PT/SLP -- and inappropriate to limit it as this rule proposes.

**Response:** The vast majority of the therapy coverage requests that [DVHA] receives are for children, which are not subject to the limitation. For adults, [DVHA] typically get requests for short term therapy for wheelchair evaluations, bracing evaluations, evaluations for a communication device, training of new caregivers, and home safety evaluations. For adult conditions, such as CP, InterQual generally allows three courses of 8-12 visits for a total of 24-36 visits, which would cover needs of the vast majority of adult individuals with CP. Rarely does the [DVHA] get requests for long term adult coverage.

Rule 7401

**Comment:** None Received

Rule 7405

**Comment:** It is “hematological” not “hemotological”.

**Response:** That is correct and has been fixed.

**Comment:** Per §E. 309.1 (b), the law only permits the Department to institute a prior authorization process for “high-tech imaging” services. The law does not permit the Department to establish a prior authorization program for “all outpatient radiology services”, except “ultrasounds, s-rays and mammograms”, as stated in the proposed emergency rule. The prior authorization rule should be reworded to apply only to “high tech imaging” services. The list of covered radiology services does not include “computed tomographic angiography (CTA) “per § E. 309.1 (b). The list of exceptions in §7405 does not include “dual x-ray absorptiometry (DXA) images” per § E. 309.1 (b).

**Response:** We agree and the sections have been rewritten.

**Comment:** The proposed emergency rule does not address the requirement in §E.309.1(b)(1) - (b)(9).

**Response:** That is correct. Those sections of the statutes direct [DVHA] to take specific actions around the prior authorization process, and the vendor requirements if a vendor is chosen to make prior authorizations. These actions and vendor requirements are not appropriate for covered service rules. The provisions in §E.309.1(b)(1) - (b)(9) will be captured in the provider handbook. Prior to implementation, there will be information sent out to providers and a link will be created from [DVHA’s] clinical guidelines page to the vendor’s site where the guidelines will be posted.

**Comment:** The rule cross-references Medicaid Rule 7102, and should additionally cross-reference Medicaid Rule 7101, which includes a number of important requirements for utilization review and management.

**Response:** The cross-reference to Medicaid Rules 7102, which is the prior authorization rule, has been removed. Utilization review and management rules already exist, and cross-referencing them in connection with prior authorization requirements is not relevant.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

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5351

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**5351 Benefits**

VHAP - Limited is an interim fee-for-service benefit package that covers a limited number of VHAP services until the beneficiary is enrolled in VHAP - Managed Care. The VHAP - Limited benefit package, including limitations and/or exclusions, is described in procedures found at P-4003.

The VHAP - Managed Care benefit package, including limitations and/or exclusions, is described in procedures found at P-4005. VHAP - Managed Care beneficiaries can access services through the following ways:

**A. Services Requiring Plan Referral**

In VHAP - Managed Care the following services must have a referral from the beneficiary's health care provider:

1. inpatient hospital care;
2. outpatient services in a hospital or ambulatory surgical center;
3. non primary care physician services require referral from primary care provider;
4. maxillofacial surgery;
5. cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;
6. home health care;
7. hospice services by a Medicare-certified hospice provider;
8. outpatient therapy services (home infusion therapies, occupational therapy, physical therapy, speech therapy, and nutrition therapy);
9. prenatal and maternity care;
10. ambulance services;
11. medical equipment and supplies;
12. skilled nursing facility services for up to 30 days length of stay per episode;
13. mental health and chemical dependency services;  
NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
14. podiatry services;
15. prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
16. laboratory and radiology services, and
17. over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office of Vermont Health Access.

Up to five refills are permitted if allowed by state and federal law.

#### B. Self-Referral Services

In VHAP - Managed Care the following services may be accessed by beneficiaries without a referral from a health care provider.

1. one routine annual gynecological exam and related diagnostic services (as specified by the plan);
2. one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
3. one routine eye examination every 24 months.
4. chiropractic coverage for manipulation of the spine.
5. family planning services (defined as those services that either prevent or delay pregnancy).
6. emergency room services

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7203     Outpatient Hospital Services

“Outpatient hospital services” are defined as those covered items and services indicated below when furnished in an institution meeting the hospital services provider criteria (7201), by or under the direction of a physician, to an eligible beneficiary who is not expected to occupy a bed overnight in the institution furnishing the service.

Covered items and services include:

- Use of facilities in connection with accidental injury or minor surgery. Treatment of accidental injury must be provided within 72 hours of the accident.
- Diagnostic tests given to determine the nature and severity of an illness; e.g., x-rays, pulmonary function tests, electrocardiograms, blood tests, urinalysis and kidney function tests. Laboratory and Radiologic services may be subject to limitations and/or prior authorizations as specified in Medicaid Rule 7405.
- Diabetic counseling or education services; one diabetic education course per beneficiary per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator. Additional counseling sessions with a diabetic educator may be covered with prior authorization. Medicaid also covers one membership in the American Diabetes Association (ADA) per lifetime.
- Rehabilitative therapies (physical, occupational, and speech) as specified in Medicaid Rules 7317-7317.2.
- Inhalation therapy
- Emergency room care. Use of the emergency room at any time is limited to instances of emergency medical conditions, as defined in 7101.3(a)(13).

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### 7317 Rehabilitative Therapy Services

Rehabilitative Therapy services include diagnostic evaluations and therapeutic interventions that are designed to improve, develop, correct, prevent the worsening of, or rehabilitate functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Rehabilitative Therapies include Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) (also called Speech/Language Therapy or Speech Language Pathology). The definition and meanings of Occupational Therapy, Physical Therapy, and Speech Therapy can be found in the State Practice Acts at 26 V.S.A. §2081a, §3351, and §4451.

Note: Not all services listed in the State Practice Acts are medical in nature. Medicaid only covers medically necessary rehabilitative therapy services. Medical Necessity is defined in Medicaid Rule 7103.

#### Limitations

- Services provided by a home health agency are covered for up to four months based on a physician's order, for beneficiaries of any age. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified below.
- Quantity limits on services are on a per beneficiary basis, regardless of program. Changing programs and/or eligibility during a calendar year does not reset the number of available visits.
- These service limitations and prior authorization requirements are not applicable when Medicare is the primary payer.

#### Prior Authorization Requirements:

Prior authorization is defined at Medicaid Rule 7102-7102.4.

To receive prior authorization for additional services a physician must submit a written request to the department with pertinent clinical data showing the need for continued treatment, projected goals and estimated length of time.

Prior authorization for therapy services will be granted only:

- if the service may not be reasonably provided by the patient's support person(s), or
- if the patient undergoes another acute care episode or injury, or
- if the patient experiences increased loss of function, or
- if deterioration of the patient's condition requiring therapy is imminent and predictable.

Therapy services must be:

- directly related to an active treatment regimen designed by the physician; and
- of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required; and
- reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition.

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In making its prior authorization decision, the department will obtain and take into consideration a qualified therapist's assessment when determining whether the service may be reasonably provided by the patient's support person(s). In addition, when the department has determined that therapy services may be reasonably provided by the patient's support person(s) and the patient otherwise meets the criteria for authorization of therapy services beyond one year, professional oversight of the support person's (s') provision of these services is covered, provided such oversight is medically necessary.

| 7317.1 Rehabilitative Therapy Services for Beneficiaries Under Age 21

Services are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified above (Medicaid Rule 7317).

| 7317.2 Rehabilitative Therapy Services for Beneficiaries Age 21 and Older

Only thirty (30) therapy visits per calendar year are covered and include any combination of physical therapy, occupational therapy and speech/language therapy.

Prior authorization for therapy services beyond 30 therapy visits in a calendar year will only be granted to beneficiaries with the following diagnoses, and only if the beneficiary meets the criteria found in Medicaid Rule 7317.

- Spinal Cord Injury
- Traumatic Brain Injury
- Stroke
- Amputation
- Severe Burn

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7401

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## 7401 Home Health Agency Services

Home health agencies provide a variety of services including skilled nursing, therapies, aide services and medical social work to beneficiaries in their home. This definition is consistent with the federal definition found at 42 CFR 440.70.

### 7401.1 Eligibility for Care

Coverage for home health agency service is provided to beneficiaries of any age. Coverage for targeted case management services is limited to at-risk children ages one to five.

### 7401.2 Covered Services

Home health agency services that have been pre-approved for coverage are limited to:

- skilled nursing care services;
- rehabilitative therapy services (as specified in Medicaid Rule 7317-7317.2);
- home health aide services;
- medical supplies, equipment and appliances suitable for use in the home; and
- targeted case management.

### 7401.3 Conditions for Coverage

Home health care services are covered by Medicaid when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met.

#### A. General Conditions

For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required. The patient's condition may be either an episode of acute illness or injury or a chronic condition requiring home health care under a physician's order.

Payment for home health services will not be made to any agency or organization that is operated primarily for the care and treatment of a mental disease.

#### B. Requirement for a Written Plan

Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patient. The plan relates the items and services to the patient's condition as follows.

- The plan includes the diagnosis and description of the patient's functional limitation resulting from illness, injury or condition.

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7401.3      Conditions for Coverage (Continued)

- It specifies the type and frequency of needed service. e.g.. nursing services, drugs and medications, special diet, permitted activities, therapy services, home health aide services, medical supplies and appliances.
- It provides a long-range forecast of likely changes in the patient's condition.
- It specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's oral orders.
- The plan is reviewed by the attending physician, in consultation with professional agency personnel every 62 days, or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature.
- The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a home health agency in the patient's place of residence.

## C. Location Where Service is Provided

The service or item is furnished in the beneficiary's place of residence. A place of residence includes beneficiary's own dwelling; an apartment; a relative's home; a place where patients or elderly people congregate such as senior citizen or adult day center; a community care home; and a hospital or nursing home but the last two only for the purpose of an initial observation, assessment and evaluation visit.

## D. Coverage of Initial Visit

An initial visit by a registered nurse or appropriate therapist to observe and evaluate a beneficiary either in the hospital, nursing home or community for the purpose of determining the need for home health services is covered. If physician-ordered treatment is given during the initial visit, the two services may not be charged separately.

## E. Requirements Specific to Nursing Care

Nursing care services are covered when the services are related to the care of patients who are experiencing acute or chronic periods of illness and those services are:

- ordered by and included in the plan of treatment established by the physician for the patient; and
- required on an intermittent basis; and
- reasonable and necessary to the treatment of an illness, injury or condition.

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**7401.3**      Conditions for Coverage (Continued)**F. Requirements Specific to Home Health Aide Services**

Services of a home health aide are covered when assigned in accordance with a written plan of treatment established by a physician and supervised by a registered nurse or appropriate therapist. Under appropriate supervision, the home health aide may provide medical assistance, personal care, assistance in the activities of daily living such as helping the patient to bathe, to care for hair or teeth, to exercise and to retrain the patient in necessary self-help skills. In cases where home health aides are assigned to patients requiring specific therapy, the home health aide must be supervised by the appropriate therapist; however, it is not necessary in these cases to require an additional supervisory visit by the nurse to supervise the provision of personal services. During a particular visit, the home health aide may perform household chores (such as changing the bed, light cleaning, washing utensils, assisting in food preparation) that are incidental to the visit. Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 62 days, and more frequently if necessary.

**G. Requirements Specific to Medical Supplies**

Medical supplies are covered when they are essential for enabling home health agency personnel to effectively carry out the care and treatment that has been ordered for the patient by the physician and used during the visit. These items include catheters, needles, syringes, surgical dressings, and materials used for dressings such as cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, and intravenous fluids and oxygen. Certain supplies are not covered; see 7401.5.

**H. Requirements Specific to Durable Medical Equipment**

The rental of durable medical equipment (DME) included on the list of DME items pre-approved for coverage (see 7505.2), that the home health agency owns and is used by a patient as part of the plan of care, is covered when the conditions of coverage, where applicable, as described in 7505.3 are met. Coverage of rental of a specific item of DME may be subject to prior authorization (see 7505.4). The DME coverage limitations described in 7505.5 also apply to DME provided by a home health agency.

**I. Requirements Specific to Targeted Case Management Services**

Targeted case management services are provided only to children ages one to five who are at-risk for unnecessary and avoidable medical interventions and who do not have another primary case management provider whose responsibility is to provide or coordinate the interventions included in this service. The Vermont Department of Health will review and determine how many targeted case management visits shall be authorized to at-risk children ages one to five.

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7401.4      Non-Covered Services

With the exception of services authorized for coverage via 7104, services not included under 7401.2 and services that do not meet criteria specified in 7401.2-7401.4, where applicable, are not covered.

Routine low-cost medical supplies, such as cotton balls and tongue depressors, are deemed to be included in the home visit charges and will not be paid for separately.

7401.5      Qualified Providers

Home health agency providers must be a Medicaid-certified provider and be enrolled with Vermont Medicaid.

7401.6      Reimbursement

Reimbursement for home health agency services is described in the Provider Manual. If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Medicaid reimbursement is requested.

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## 7405 Laboratory and Radiology Services

Covered laboratory and radiology services include the following:

- Microbiological, serological, hematological and pathological examinations; and
- Diagnostic and therapeutic imaging services; and
- Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations.

Coverage is extended to independent laboratories and radiological services approved for Medicare participation for services provided under the direction of a physician and certification that the services are medically necessary.

When the place of service is “hospital inpatient”, coverage for the technical component is included in the per diem hospital reimbursement. When the place of service is “hospital outpatient”, coverage is included in the hospital reimbursement on outpatient claim form for the technical component. Reimbursement for the professional component will be made only to a physician.

Anatomic pathology services form an exception to the place of service and component coverage. Total procedure codes may be used for anatomic pathology services performed by a laboratory outside the hospital in which the beneficiary is an inpatient or for an independent laboratory performing tests for registered inpatients.

### 7405.1 Limitations:

Laboratory services for urine drug testing is limited to eight (8) tests per calendar month for beneficiaries age 21 and older. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients.

### 7405.2 Prior Authorization - Radiology

The following outpatient high-tech imaging services require prior authorization:

- computed tomography (CT) (previously referred to as CAT scan);
- computed tomographic angiography (CTA);
- magnetic resonance imaging (MRI);
- magnetic resonance angiography (MRA);
- positron emission tomography (PET); and
- positron emission tomography-computed tomography (PET/CT).

The following imaging services do not require prior authorization:

- those provided during an inpatient admission;
- those provided as part of an emergency room visit;
- x-rays, including dual x-ray absorptiometry (DXA) images;
- ultrasounds; or
- mammograms.

### 7504.3 Prior Authorization - Laboratory

Exceptions to the limitations in 7504.1 must be prior approved.