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 ~~primary~~ health care provider:

1. inpatient hospital care ~~(emergency and urgent admissions only, as determined by the admitting physician)~~;
2. outpatient services in a ~~general~~ 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, ~~and~~ 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

~~16~~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~~ Department 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 ~~their~~a ~~primary~~ 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

~~C. Wrap-Around Benefits~~

~~In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary’s primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:~~

~~1. eyeglasses furnished through OVHA's sole source contractor (coverage of all eyewear is suspended indefinitely);~~
~~2. family planning services (defined as those services that either prevent or delay pregnancy).~~

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~~, inhalation~~) ~~related directly and specifically to an active written treatment plan established and periodically reviewed by the physician. The plan must be reasonable and necessary to the treatment of the individual's illness or injury; rehabilitative therapies will be routinely covered for the first four months on physician certification. Provision of therapy services (physical, speech or occupational) beyond the initial four-month period is subject to prior authorization review. To receive prior authorization for these services during the eight-month period immediately following the initial four-month period, 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.~~as specified in Medicaid Rules 7317-7317.2.
  ~~Prior authorization for physical, speech, or occupational therapy services beyond one year from the onset of treatment will be granted only if the beneficiary meets the criteria found at 7401.~~
- 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).

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.

Rehabilitative 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.

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.

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).

~~Prior authorization for therapy services will be granted only:~~

- ~~if the service may not be reasonably provided by the patient's support person(s), and~~

- ~~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.~~

~~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

7317.3 Rehabilitative Therapy Services: Home Health

Rehabilitative therapy 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.

Prior Authorization Requirements:

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 the initial four-month period, professional oversight of the support person's provision of these services is covered, provided such oversight is medically necessary.

Prior authorization for rehabilitative therapy services beyond one year will be granted only:

- if the service may not be reasonably provided by the patient's support person(s), and
- 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.

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;
- ~~physical~~ rehabilitative therapy services (as specified in Medicaid Rule 7317.3~~-7317.2~~);
- ~~occupational therapy;~~
- ~~speech therapy;~~
- 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.

7401.3 Conditions for Coverage (Continued)

- It specifies the type and frequency of needed service. e.gie. 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.

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 ~~owned by~~ 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.~~5~~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.

~~7401.3 Conditions for Coverage (Continued)~~

~~J. Requirements Specific to Therapy Services~~

~~Physical, occupational, and speech therapy services are covered for up to four months based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. 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.~~

~~Therapy services provided outside the home and requiring equipment that cannot be brought to the home are covered provided that the agency has met certifying standards for that service under Medicare.~~

~~7401.4 Prior Authorization Requirements~~

~~Provision of therapy services (physical, speech or occupational) beyond the initial four-month period is subject to prior authorization review. To receive prior authorization for these services during the eight-month period immediately following the initial four-month period, 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 beyond one year from the onset of treatment will be granted only:~~

- ~~if the service may not be reasonably provided by the patient's support person(s), and~~
- ~~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.~~

~~Provision of rented durable medical equipment may be subject to prior authorization (see 7505.4).~~

~~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.~~

7401.~~5~~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.~~6~~5 Qualified Providers

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

7401.~~7~~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.

7405 Laboratory and Radiology Services

Covered laboratory and radiology services include the following:

- Microbiological, serological, ~~hemotological~~ hematological and pathological examinations; and
- Diagnostic and therapeutic ~~X-rays, including computerized axial tomography (CAT scans)~~imaging services; and
- Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations.

~~Medicaid c~~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", ~~Medicaid~~ coverage for the technical component is included in the per diem hospital reimbursement. When the place of service is "hospital outpatient", ~~Medicaid~~ coverage is included in the hospital reimbursement on outpatient claim form for the technical component. ~~Medicaid r~~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 ~~Medicaid recipient~~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.