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

**AHS Bulletin No: 10-13**

Secretary of State's ID Number: 10P-032

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

**DATE:** 1/20/2011

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

**CHANGES ADOPTED EFFECTIVE: 3/1/11**

**TYPE OF RULE CHANGE**

**Adopted Rule Changes**

X **Final Proposed Rule Change**

**Proposed Rule Change**

**RULE REFERENCE(S):**

**5351 7203 7317 7401 7405**

This rule is being implemented as a permanent version of the emergency rules found in Bulletins 10-03 and 10-21, 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.

***Specific Changes after Implementation of Emergency Rule***

| **Section** | **Description of Change** |
|---|---|
| ALL PAGES | "Office of Vermont Health Access" changed to "Department of Vermont Health Access", "OVHA" changed to "DVHA" |
| 7317 | Paragraph beginning "Therapy services must be…" moved to second paragraph and changed to read, "Rehabilitative therapy services must be…" Paragraph beginning "Rehabilitative Therapy Service…" moved from 7317.1 to second paragraph of 7317. Paragraph beginning "Services provided by a home health agency…" moved from Limitation section of 7317 to first paragraph of new section 7317.3. Paragraph beginning "In making its prior authorization decision…" moved from section of 7317.1 to second paragraph of new section 7317.3. |
| 7317.3 | New subsection clarifying that home health is not subject to the 30 visit limit and to specify prior authorization requirements for home health beyond initial 4-month period and beyond one year. Paragraph beginning "Prior authorizations for therapy services…" changed to read, "Prior authorizations for rehabilitative therapy services…" Second paragraph moved from section 7317.1 to last paragraph of section 7317.3. |
| 7401.2 | Reference to Medicaid Rules "7317-7317.2" deleted and replaced with reference to new Medicaid Rule subsection "7317.3". |

***Specific Changes since the Filing of Proposed Rule Change***

| **Section** | **Description of Change** |
|---|---|
| 5351 | Subsection A., number 8: Deleted "*outpatient therapy services…*" and replaced with "*rehabilitative therapies…" the* remainder of the sentence reworded as follows: "*… (occupational therapy, physical therapy, and speech therapy), home infusion therapies, and nutrition therapy.*"; number 15. beginning: "*prescription drugs and over-the-counter drugs…*" deleted from number 15. and added to number 17; item number 17. beginning: "*over-the-counter and prescription smoking cessation…*" deleted from number 17. and added to number 15. |
| 5351p.2 | Subsection B.: deleted period at end of first sentence and added a colon; number 1: deleted semicolon at end of sentence and added a period; number 2: deleted semicolon and word "*and*" at end of sentence and added a period; and number 6: added a period to the end of the sentence. |

| | |
|---|---|
| 7317.1 | Subsection number "*7317.1*" added before paragraph titled "*Limitations*"; deleted bullets before sentences beginning "*Quantity limits…*" and "*These service limitations…*"; previous section 7317.1 "*Rehabilitative Therapy Services for Beneficiaries Under Age 21"* moved to subsection B. under new section 7317.1 – Limitations; deleted from second sentence: "*above*" and replaced with "*below*" and deleted reference to "*7317*" and replaced with reference to "*7317.2*"; previous section 7317.2 "*Rehabilitative Therapy Services for Beneficiaries Age 21 and Older"* moved to subsection A. under new section 7317.1 – Limitations; first sentence under subsection A. Rehabilitative Therapy Services for Beneficiaries Age 21 and Older deleted "*Only*" from beginning of sentence, and second sentence under subsection A. deleted "*for therapy services*", and deleted period at end of sentence and replaced with a colon. |
| 7317.2 | Section "*7317.2*" added before paragraph titled "*Prior Authorization Requirements:*" |
| 7317.3 | Prior Authorization Requirements: second paragraph, first sentence deleted "*Department*" and replaced with "*DVHA*"; third paragraph, first bullet, deleted "*and*" at the end of sentence and replaced with "*or*". |
| 7401.3 | From first sentence deleted: *"…by Medicaid…"*; and from subsection B.: deleted period at end of first sentence and added a colon. |
| 7405 | Third paragraph, second sentence: added "*the*" before "outpatient claim form…". |

***Responses to Public Comments***

A public hearing was held on September 3, 2010 from 10:00 a.m. - 12:00 p.m. in the Large Conference Room at the Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, Vermont. There were no attendees.

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

Through the comment period in this bulletin the DVHA received additional written comments from Rutland Regional Medical Center and additional comments from the Vermont Medical Society.

There were no comments received through the filing of emergency rule in Bulletin 10-21. The comments from the emergency rule in Bulletin 10-03 and this permanent rule (Bulletin 10-13) are summarized below along with DVHA's responses.

*Comments from Bulletin 10-03:*

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, nationally recognized evidence-based clinical criteria 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.

*Comments from Bulletin 10-13:*

Rule 7317

**Comment:** We request consideration of allowing additional visits for patients with a new acute episode/condition. For example, in the case of a patient who has a stroke and uses all 30 visits, and subsequently suffers from a fall resulting in hip fracture, additional visits would be necessary. This would be consistent with other insurers and industry practice, for example Blue Cross Blue Shield of Vermont (11/09) "covers Occupational, Physical, and Speech Therapy only for up to 30 Outpatient sessions combined per calendar year or up to six months after initiation of therapy for a particular Episode, whichever comes first." Episode is defined as the Acute onset of a new illness or injury or the Acute exacerbation of an old illness or injury. We request consideration of additional qualifying diagnoses to include: f. cerebral palsy-visits per episode of care: 6-90*, g. multi-trauma-visits per episode of care: 6-70, h. cancer-visits per episode of care: 6-70, and i. Parkinson's/ALS/Huntington's/Upper motor neuron-visits per episode of care: 6-50

**Response:** The rule change was drafted in response to the language written in legislation per Sec. E.309.1(a)(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." DVHA utilization data does not suggest that the additional requested diagnoses are frequent for therapy requests over 30 visits. Also the American Physical Therapy Association ranges for physical therapy visits cited for the requested diagnoses are very broad upper and lower limits and also include children. Therapy services for children are not subject to the limitation. Consistent with a previous DVHA response from above, for adult conditions, our nationally recognized evidence based criteria 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 these conditions.

Rule 7405

**Comment:** Exempting physicians whose requests are routinely granted makes sense; please bird dog this and make sure it is put into action promptly.

**Response:** We will use the "Gold Card" system offered by MedSolutions and this will be implemented as soon as we have enough data to identify providers with exceptional referral histories.

**Comment:** How long before I can qualify for a gold card?

**Response:** We want to balance our desire to do this quickly with our need to ensure that the system is fair and objective. It would be premature to give an effective date at this point, but we will not let this option languish. Physician referral patterns will be actively monitored from day-one.

**Comment:** Include a threshold test for the prior authorization requirement – that would exempt physicians who order very few of these tests ever – for example – one MRI/MRA per year; prior authorization should not be required if the physician only rarely orders a scan

**Response:** MedSolutions has an excellent system for validating the clinical necessity of high-tech imaging studies. A provider who orders very few of these studies has the most to gain from the education and feedback MedSolutions provides.

**Comment:** How will this program be cost effective since Vermont doctors receive low reimbursement from Medicaid and already are very conservative about ordering scans?

**Response:** We acknowledge the quality of care our physicians provide. Our reports, which will be publicly available, will objectively show if this process is cost-effective.

**Comment:** If this program is well run, it will give physicians some ammunition to use for demanding patients and a little protection from malpractice actions.

**Response:** Thank you for including this comment.

**Comment:** Half-hour time estimate of the time it takes to obtain approval came up more than once.

**Response:** MedSolutions will answer prior authorization (PA) requests in a timely manner. If a provider experiences service outside the ranges indicated below, they should call our Provider relations number (800-925-1706 or 878-7871). Emergent requests can be handled retroactively. Urgent

requests will be answered in an average of four business hours, but no longer than one business day. 98% of all routine requests will be answered in three business days.

**Comment:** An hour and a half estimated time for denied requests based on experience with private insurers.

**Response:** MedSolutions will answer PA requests in a timely manner. If a provider experiences service outside the ranges indicated below, they should call our Provider relations number (800-925-1706 or 878-7871). Emergent requests can be handled retroactively. Urgent requests will be answered in an average of four business hours, but no longer than one business day. 98% of all routine requests will be answered in three business days.

**Comment:** No expertise cited for pediatric studies (such as AAP or a pediatric radiology specialty group); process should be based on actual data from reliable sources that speak to pediatric cases, concern that children will be shoe-horned into adult criteria and vendor will claim the right to deny.

**Response:** MedSolutions does use specific criteria for pediatric patients. The criteria can be found at this link: http://www.medsolutions.com/our_difference/guidelines_index.php

**Comment:** This program micro-manages a group of physicians who already have one of the lowest rates of imaging in the country.

**Response:** The "Gold Card" system will help us single out exceptional providers and reduce their PA requirements.

**Comment:** This is one more rock in the pockets of primary care doctors who are already swimming so hard to stay afloat.

**Response:** The criteria used for PA determinations are the same for primary care providers and specialists.

**Comment:** CPT codes 1-46 on the list should NOT require prior authorizations (We've requested additional information about this).

**Response:** Based on their usage data, MedSolutions demonstrated that the inclusion of CT scans in this program is appropriate. On average, they have seen a 10%-15% increase. DVHA will continue to monitor the usage rate of this code to determine if it should stay on PA.

**Comment:** Three codes for CT colonography will hardly ever be used in the foreseeable future, and should be left out.

**Response:** We will assess the value of having these codes reviewed and modify the list if appropriate.

**Comment:** DVHA should monitor utilization linked to diagnosis and identify procedural outliers to include on the list instead of burdening docs with red tape for months/years before removing a code from the list.

**Response:** The usefulness of this PA process will be reviewed by the Managed Care Medical Committee (Refer to tab for listing of members).

**Comment:** MD/DOs tend to follow a methodical approach to work-up, and don't start with high tech imaging.

**Response:** This approach is generally supported by research and various medical societies. Providers who follow referral practices like this should have very high acceptance rates in this PA process.

**Comment:** Recommend that DVHA track utilization by provider type – concern that mid-level professionals with less training may default to over-testing.

**Response:** This is a good recommendation. We will be able to monitor use by provider type.

**Comment:** DVHA should provide VMS with an accounting every six months on how much DVHA has spent on the program, how much MDs have spent and what DVHA has saved.

**Response:** The cost-effectiveness of this program will be assessed at least annually. We will follow all of the reporting requirements described by the legislature.

**Comment:** Primary care docs see acute visits in the office saving everyone an ED visit, and now they will be dragged through the PA process.

**Response:** This PA process is designed for routine elective imaging. If a provider feels that the procedure is needed emergently and the person is not admitted to a hospital for observation or admission than MedSolutions does allow for retrospective reviews for these circumstances. If the person is admitted a retrospective PA will not be required.

**Comment:** Efficient answer for primary care docs will be to send patient to ED (for emergency referrals - rather than go through PA process).

**Response:** A patient should be referred to the Emergency Department (ED) only when an emergency is present and it is clinically appropriate for treatment to occur in the ED.

**Comment:** PCPs ordering emergent scans should not be required to wade through the PA process.

**Response:** This PA process is designed for routine elective imaging. If a provider feels that the procedure is needed emergently and the person is not admitted to a hospital for observation or admission than MedSolutions does allow for retrospective reviews for these circumstances. If the person is admitted a retrospective PA will not be required.

**Comment:** Time spent on PA process should be compensated.

**Response:** Compensation for the administrative costs associated with PA is not provided by any insurer. Utilization review is a standard practice to ensure the quality and appropriateness of medical services delivered to covered members.

**Comment:** Manual does not provide a timeframe for decisions on emergent requests; decisions on urgent requests will be made in one business day, which over a four- day weekend (such as Thanksgiving), could mean 5 days, and may not be timely.

**Response:** We will ensure that the manual clearly states these timelines.

**Comment:** Recommend that manual include a link to the provider manual and cite a page number for information about the Appeals and Grievance process.

**Response:** We will include a link.

**Comment:** Is additional information available about the "National subject matter expert panel"?

**Response:** The National Subject Matter Expert Panel includes:

**Jim Andrews, MD**
Radiologist
Assistant Professor
Vanderbilt University Medical Center
Nashville, TN

**Doug Phillips, MD**
Neuroradiologist
Professor of Radiology
Weill Cornell Medical College
New York Presbyterian Hospital
New York, NY

**Michael Nelson, MD**
Radiologist and breast MRI specialist
Associate Professor
Department of Radiology
University of Minnesota
Minneapolis, MN

**Bruce LeForce, MD**
Neurologist
Parkway Neurology Associates (priv. pract.)
Knoxville, TN

**Jeff Creasy, MD**
Neuroradiologist
Associate Professor of Radiology
Program Director, Neuroradiology Fellowship
Vanderbilt University Medical Center
Nashville, TN

**Tom Magee, MD**
Musculoskeletal radiologist
Neuroskeletal Imaging Insts. of Orlando
Neuroskeletal Imaging Insts. of Merritt Is.
Neuroskeletal Imaging of Winter Park

**Russell Hoverman, MD**
Medical Oncology
Hematology
Medical Director
VP of Managed Care for Texas Oncology
Medical Director of Managed Care for
US Oncology in Texas

**Ed Coleman, MD**
Professor of Radiology
Vice Chair Dept. of Radiology
Director of Nuclear Medicine Division
Duke University
Durham, NC

**Deepak Awasthi, MD**
Neurosurgeon
Louisiana Brain/Spine Clinic
Thibodaux, LA

**W. Anthony Lee, MD**
Director of Endovascular Services
Christine E. Lynn Heart and Vasc. Inst.
Boca Raton, FL

**David Maron, MD**
Cardiologist
Associate Professor of Medicine
Vanderbilt University Medical Center
Nashville, TN
Executive Committee for COURAGE trial

**Stephanie Spottswood, MD**
Pediatric Radiologist
Associate Professor
Dept. of Radiology
Vanderbilt University Medical Center
Nashville, TN

**Jeffrey B. Carter, MD, DMD**
Oral Surgical Institute
Nashville, TN

**Stephen E. Parey, MD**
Otolaryngology
Middle Tennessee ENT Specs
Columbia, TN

**Comment:** In Training section, indicate that training is available on request: "Please contact 888-693-3211 to request training or for information about training resources"

**Response:** We will incorporate this into the manual.

**Comment:** Who is on the DVHA Medical Committee?

**Response:** The DVHA Managed Care Medical Committee includes:

Core membership:

1. Medicaid Medical Director (Co-Chair)
2. Director, Clinical Operations
3. Director, Program Integrity
4. Director, Managed Care Operations(Co-Chair)
5. Deputy Director
6. Health Programs Administrator, Health Programs Integration
7. Field Director, VCCI

Additional ad hoc members may include:

1. Director, Data
2. Director, Pharmacy
3. Director, Policy
4. Director, Provider Relations

**Comment:** In the first bullet in program evaluation section specify that this information will include the following information required by law (citation removed to save space).

**Response:** All reporting requirements described in statute or rule will be available. In fact, we will have additional reporting tools available beyond those required by law. All reports will be available to providers (although some may be stripped of information that identifies specific providers or members).

**Comment:** What is time frame for access to a MedSolution physician? (Brochure says to call to request a discussion).

**Response:** When a peer-to-peer consult is requested, MedSolutions attempts to find the best physician to take the call and can usually schedule the call on the same day. If the requesting physician needs to speak with a MedSolutions physician immediately, MedSolutions will find any available physician to take the call immediately.

**Comment:** Call center closed on holidays – how will emergent/urgent requests be handled?

**Response:** MedSolutions offers a web-based portal which is available 24/7; however, MedSolutions also for retrospective review of emergent requests. Urgent requests will be answered in an average of four business hours with a maximum response time of one business day. Additionally, MedSolutions have staff on call 24/7 so if a provider calls MedSolutions outside their business hours, they will get this message, "If you are a provider and the patient's medical condition is urgent or emergent, please treat the patient as medically appropriate and submit your retrospective request for clinical review to MedSolutions at your earliest convenience. If you are a physician and need to speak with the on-call staff, please dial the pager # 877 557-8145".

**Comment:** Call center is open 8 am to 9 pm – how will emergent/urgent requests be handled after hours?

**Response:** MedSolutions offers a web-based portal which is available 24/7; however, MedSolutions also for retrospective review of emergent requests. Urgent requests will be answered in an average of four business hours with a maximum response time of one business day. Additionally, MedSolutions have staff on call 24/7 so if a provider calls MedSolutions outside their business hours, they will get this message, "If you are a provider and the patient's medical condition is urgent or emergent, please treat the patient as medically appropriate and submit your retrospective request for clinical review to MedSolutions at your earliest convenience. If you are a physician and need to speak with the on-call staff, please dial the pager # 877 557-8145".

**Comment:** Prior authorization criteria should be transparent, based on peer-reviewed published clinical standards and include citations for the sources of the standards.

**Response:** We agree. The clinical criteria used by MedSolutions meet all of those requirements.

**Comment:** PA responses should be timely, including timely access to clinical staff.

**Response:** We agree. DVHA will monitor MedSolutions for their response times. These reports will also be available to providers.

**Comment:** A gold-card process based on data will be developed that will exempt physicians whose prior authorization requests are routinely granted.

**Response:** We will use the "Gold Card" system offered by MedSolutions and this will be implemented as soon as we have enough data to identify providers with exceptional referral histories.

**Comment:** The vendor contract should not include incentives for reviewers to deny requests.

**Response:** MedSolutions will be paid based on the number of reviews they perform. The outcome of the reviews plays absolutely no role in MedSolutions' reimbursement or performance standards.

**Comment:** DVHA will conduct a satisfaction survey of health care professionals.

**Response:** MedSolutions will conduct this survey annually.

**Comment:** DVHA will track and report imaging rates, including administrative expense incurred by physician practices.

**Response:** DVHA will adhere to all reporting requirements described by the legislature.

**Comment:** The continuing increase in un-reimbursed administrative time and requirements is not sustainable for a private practice. The two alternatives to physicians in private practice are hospital based practices that can charge additional facility fees and FQHCs with cost-based reimbursement that exceeds the fee schedule.

**Response:** Compensation for the administrative costs associated with PA is not provided by any insurer. Utilization review is a standard practice to ensure the quality and appropriateness of medical services delivered to covered members.

**Comment:** A pediatrician suggested that, like emergency departments, primary care physicians' offices be able to order ACUTE scans without prior authorization for acute things like sports-related head injuries or sudden changes in mental status.

**Response:** We believe that retrospective reviews for emergency scans will meet this need. This process was designed for routine and elective imaging. We do not want the PA process to interfere with care during a medical emergency.

**Comment:** In one case where the physician requested authorization for an acute scan, under another insurer's program, it took the physician and practice staff a half-hour to get the scan approved. There is of course no reimbursement for this practice time, and docs in private practice cannot afford to spend their time this way, so the default is the emergency department

**Response:** DVHA will monitor MedSolutions to ensure that their response times are reasonable and consistent with those of other procedures which require PA.

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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 Department 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.

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. rehabilitative therapies (occupational therapy, physical therapy, and speech therapy), home infusion therapies, 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. over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year;
16. laboratory and radiology services, and
17. prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition.

"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 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 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).
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.

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).

## 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.

### 7317.1 Limitations

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.

A. Rehabilitative Therapy Services for Beneficiaries Age 21 and Older

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

Prior authorization 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

B. 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 below (Medicaid Rule 7317.2).

7317.2 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.

7317.3 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), 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.

## 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 7317.3);
- 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 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. ie. 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 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.

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.

## 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 the 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.