

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

AHS Bulletin No: 11-19

Secretary of State's ID Number: ##P-###

FROM: Mark Larson, Commissioner
Department of Vermont Health Access

DATE: 1/11/12

SUBJECT: Rehabilitative Therapy Services for Beneficiaries under Age 21

CHANGES ADOPTED EFFECTIVE: 04/14/12

TYPE OF RULE CHANGE

Adopted Rule Changes

Final Proposed Rule Change

X Proposed Rule Change

RULE REFERENCE(S):

7317

This proposed rule is being implemented per the recommendations of the DVHA Clinical Utilization Review Board (CURB).

The CURB was established by Act 146 Sec. C34. 33 V.S.A. Chapter 19, subchapter 6 during the 2010 legislative session. The Department of Vermont Health Access (DVHA) was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's public health care programs. Per 33 V.S.A. chapter 19, § 2031(c) The CURB has the following duties and responsibilities:

- (1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs;
- (2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

All changes are for those individuals under the age of 21 enrolled in Medicaid, as specified below. DVHA uses the EPSDT definition of child (individual under the age of 21). This definition is consistent with existing rules that differentiate coverage based on an adult/child definition (Rules 4100, 7312, 7313, 7316, 7406.1, and 7410).

The DVHA amends the following utilization control on rehabilitative therapy services for Medicaid beneficiaries under the age of 21:

Physical, occupational, or speech therapy visits are each amended from a period of 4 months to 8 visits before requiring a prior authorization. Provision of therapy services beyond the initial 8 visits is subject to prior authorization review as specified in Medicaid Rule 7317.2.

It is necessary to note that while service authorizations are being amended from 4 months to 8 visits without prior authorization; overall services are not being limited for individuals under the age of 21. The DVHA is changing the authorization process where it conflicts with language in Rule 7317. This rule change does not apply to home health rehabilitative therapy services.

Specific Changes to Rule Sections

Section	Description of Change
7317	7317.1: sentence one added “or coverage source”; and 7317.1, B.: sentence one deleted “Services are covered for up to four months” and added “Eight (8) therapy visits from the start of care date per diagnosis/condition for each type (physical therapy, occupational therapy and speech/language therapy)” are covered; and sentence two deleted “four month period” and added “8 visits”.

Responses to Public Comments Received from the Emergency Rule Filing

In the previously filed emergency rule on the same change a notice of the rule changes was published in the Burlington Free Press on October 19, 2011, and uploaded to DVHA’s website on October 19, 2011. The written comment period will be from October 20, 2011 to October 26, 2011. Comments on the substance of the rule change were received from the Vermont Association of Home Health Agencies, Vermont Developmental Disabilities Counsel, and Vermont Legal Aid, their comments and DVHA responses are summarized below:

Comment: Is home health included in the rule change?

Response: No, per the bulletin: this rule change does not apply to home health rehabilitative therapy services.

Comment: There has been a change in approval for Medicaid children’s therapy from 3 months to 8 sessions. For some children that would require the need to reapprove at 8 week intervals

Response: First the current period before authorization is required is 4 months and not 3 months; second there appears to be a misconception that there will be a need for a new PA every 8 visits; this is incorrect. The documentation required for PA after 8 visits is only for the initial request per acute care episode/condition; after which PA is required every 4 months thereafter which is unchanged from DVHA’s current PA procedure. For many children who need ongoing therapy, the change will only result in one extra PA for each discipline for the entire span of their childhood, 0-21 years.

Comment: This proposed Rule will reduce access to health care services for medically needy children. This proposed rule provides very little coverage before another round of paperwork begins. Immediately following an emergent illness or injury, doctors may prescribe therapy once or twice a week, or even more. Children with chronic health conditions often require ongoing therapy on a routine basis for a long period of time. The proposed rule will require some parents, who are already over-strained by having medically needy children, to obtain prior authorization potentially every month or two. This is burdensome, especially for parents of children with multiple medical conditions, for parents with low education, for low-income parents, and for parents with their own disabilities. These disadvantaged parents may not be able to keep up with the amount of increased paperwork that this prior authorization process requires. Failure to keep up with the paperwork would result in delaying or interrupting medically necessary services.

I am also concerned about provider paperwork fatigue. Some providers just can't keep up with the flow of documentation required by the health insurance industry. We remain concerned that some providers will not fill out the paperwork every 8 visits, thereby effectively denying the services to children who have ongoing therapeutic needs.

Response: It is the provider and not the parent who fills out the prior authorization form. While DVHA is very sympathetic to parents whose children require these special medical services, the parents will not be required to submit any paperwork. DVHA understands that many of the providers are actually supportive of the rule change. In some instances therapists have provided services that have subsequently been found to have been unneeded, billed improperly, and/or not supported by best practice. Timely prior authorization will avoid such problems. Again, the documentation required for PA after 8 visits is only for the initial request per acute care episode/condition; after which PA is required every 4 months thereafter which is unchanged from DVHA's current PA procedure. For many children who need ongoing therapy, the change will only result in one extra PA for each discipline for the entire span of their childhood, 0-21 years.

Comment: This proposed rule should not be implemented using emergency rules.

Response: The department has withdrawn emergency rules.

Comment Period

A public hearing is scheduled on Friday, March 2, 2012 from 10:00 AM to 12:00 PM in the Department of Vermont Health Access (DVHA) Large Conference Room, 312 Hurricane Lane, Suite 201, Williston, Vermont.

Written Comments may be submitted no later than 4:30 p.m. on Friday, March 9, 2012 to Greg Needle, DVHA, 312 Hurricane Lane, Suite 201, Williston, Vermont 05495, via email: greg.needle@ahs.state.vt.us, or by Fax: (802)-879-5651.

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]

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.

04/14/12

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7317

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 or coverage source. 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

Eight (8) therapy visits from the start of care date per diagnosis/condition for each type (physical therapy, occupational therapy and speech/language therapy) are covered based on a physician's order. Provision of therapy services beyond the initial 8 visits 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.