

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

AHS Bulletin No: 11-19

Secretary of State's ID Number: 12P-004

FROM: Mark Larson, Commissioner
Department of Vermont Health Access

DATE: 03/12/2012

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

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 DVHA has withdrawn emergency rules.

Responses to Public Comments on this Proposed Bulletin

A public hearing was held 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 were accepted through 4:30 p.m. on Friday, March 9, 2012.

Written comments were received from the Disability Law Project (of Vermont Legal Aid, Inc. and Disability Rights Vermont), their comments and DVHA responses are summarized below:

Comment: “[The change] does run contrary to the federal intent of EPSDT which is to provide broader rather than narrower coverage for beneficiaries under age 21.”

Response: The proposed change does not narrow coverage for beneficiaries under age 21. Coverage continues unchanged and continues to be broader than coverage for adults.

Comment: We do not want to see more restrictions placed on adult services (and the two are a little hard to compare, as the adult 30-visit limit is for all therapies, rather than 8 visits per type of therapy and condition. Therefore, we would suggest raising the initial limit on EPSDT visits to be more consistent with the intent of the EPSDT mandate. One way to do this would be to have the same 30-visit overall limit across therapies before authorization for children, but without the tighter restrictions on visits past 30 that apply to adult beneficiaries...”

Response: The proposed change is NOT a limit on EPSDT visits as reported by the Disability Law Project. The proposed change is for an earlier clinical review to protect vulnerable children and families and to ensure appropriate treatment. The adult rule is a benefit limitation for select diagnosis. DVHA registered nurses and physical therapists in the Clinical Operations Unit work collaboratively with the treating provider to identify if there are alternative treatment approaches that are in line with evidenced-based guidelines that could be equally or more effective. The SFY 2011 budget initiative was implemented with the goals of reducing utilization

while concurrently ensuring quality of care. The DLP's proposal to use the "same overall visit limit" before prior authorization for children is more stringent in that it calls for a limit, which DVHA's rule proposal does not. There is no limit, only earlier clinical oversight.

Comment: "...Children receiving therapy services...start with an intensive period of visits...under the proposed change, the initial 8-visit limit will often be reached in 3-4 weeks, at times even sooner. The prior authorization request requires the provider to show the need for continued treatment and a projection of how much further therapy will be needed. However, after such a short time in treatment, it is unlikely that the beneficiary will have made any significant progress, or that the therapist will have a clear sense of the long-term course of treatment."

Response: DVHA supports intensive initial treatment to empower beneficiaries and their families when medically appropriate. Typically, therapists perform an evaluation, which includes goal setting and creating a plan of care, within the first visit or first few visits. The Governor appointed Clinical Utilization Review Board (CURB) chose eight (8) visits to allow therapists ample time to determine their plan of care and set goals. The oversight provided after eight (8) visits does not require that the child show progress after such a short time. The earlier clinical review by DVHA is part of the care planning process. If after additional treatment and ongoing assessment the therapist determines that there is a medical necessity for more visits, the prior authorization can be easily changed to approve additional visits based on the individual needs of the child.

Comment: "...In cases of intensive service the prior authorization process can take a significant period of time. We are aware of a number of cases where DVHA has delayed issuing a prior authorization in order to ask the therapist to provide extensive documentation to support a requested level of service or particular type of treatment. Because this is a prior authorization situation, continuing benefits are generally not available, in which case the therapist either has to stop providing services or provide the services with no guarantee of payment."

Response: DVHA must act on prior authorization requests in three (3) working days. If additional information is needed to complete the clinical review, the request is placed in *Informational* status for 12 days, allowing the therapist to produce the necessary additional documentation. Therapists and therapy facilities know that it is prudent to send their requests in advance in order to avoid disruption in coverage. A detailed guideline and prior authorization form has been provided that has all the prompts and instructions needed to avoid *Informational* Status and to expedite the prior authorization process. Therapists who have difficulty with the process are offered an inservice at their location, and personal assistance is available by phone or e-mail during all working hours to assist in the process. Additionally, whenever possible, outreach occurs to help therapists through the process. If the information needed to complete the review is forthcoming within 28 days, treatment performed during this time is covered by DVHA.

Comment: "While most prior authorizations go through without dispute, in cases of intensive service the prior authorization process can take a significant period of time. We are aware of a number of cases where DVHA has delayed issuing a prior authorization in order to ask the therapist to provide extensive documentation to support a requested level of service or particular type of treatment. If the case goes to an appeal or fair hearing, this period of limbo can potentially extend for several months, during which time the beneficiary will likely not be receiving services...we would ask that the rule make some provision for continuing benefits, or a contingency prior authorization, to ensure continuity of services in cases where there is a delay in issuing a prior authorization or when the case is under appeal."

Response: When a case is in appeal or fair hearing, coverage continues in full at the existing level.

When a case is in *Informational* status, once the needed information is received, the services provided during this time are covered. It is also important to clarify that DVHA authorizes coverage, not service provision. The decision not to provide services is one made by the provider.

Medicaid allows for continuation of services pending an appeal per the following conditions under Medicaid Rule 7110.2.3, Notices, Continued Services, and Beneficiary Liability:

B Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:
 - a. The managed care entity appeal was filed in a timely manner, meaning before the effective date of the proposed action;
 - b. The beneficiary has paid any required premiums in full;
 - c. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or service plan; and
 - d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.
2. Where properly requested, a service must be continued until any one of the following occurs:
 - a. The beneficiary withdraws the appeal;
 - b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
 - c. The managed care entity issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;
 - d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or
 - e. The time period or service limits of a previously authorized service has been met.

Beneficiaries may waive their right to receive continued benefits pending appeal.

Summary:

- The proposed rule does not limit therapy services to children in any way.
- The intent of the proposed rule is to ensure that children receive high quality, effective therapy services through earlier oversight.
- The change requested by DLP for 30 combined therapy visits would be onerous to the therapists and would not benefit children.
- There is no need for a delay in the PA process to allow therapists more evaluation time because any changes to the plan of care can be incorporated into the prior authorization at a later date.

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

Bulletin No. 11-19

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.