

# **Physical, Occupational and Speech Therapy Changes for Adults Covered by Vermont Medicaid and VHAP: Information for Therapy Practices**

## **Outpatient Facilities**

Effective July 1, 2010, Physical, Occupational, and Speech Therapy outpatient services for **adults** are limited to 30 combined visits per calendar year. Prior authorization for therapy visits beyond 30 combined visits in a calendar year can be requested for beneficiaries with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn. The limit does not apply to services provided in inpatient facilities or by home health agencies; inpatient facilities and home health agencies should follow the rules and processes currently in place.

Adult: Medicaid beneficiaries age 21 and older, and VHAP beneficiaries age 18 and older.

Limitations are stated as follows:

Changing programs or eligibility status within the calendar year does not reset the number of available visits.

Limitations and prior authorization requirements do not apply when Medicare is the primary payer.

## **Frequently Asked Questions**

1) Has there been any change in the documentation required for Prior Authorization (PA) or the procedure for requesting a PA?

- No change in the actual documents used for PA. From 7/1/10-12/31/10 no PA is required for the first 15 visits; PA is required for any subsequent visits. Beginning 1/1/11, PA is limited to the 5 diagnoses listed above after the initial 30 combined calendar year visits.

2) Are current Prior Authorizations (PAs) being honored until they expire?

Yes, PAs will be issued through 6/30/10.

3) What if a beneficiary has already had more than 30 visits before 7/1/10?

- Visits that occurred prior to the change in benefit will not be applied against the new benefit limitation. See question #1 for the period from 7/1/10-12/31/10.

4) What if a beneficiary had no visits or less than 30 visits before 7/1/10?

- To account for the 7/1/10 start, after 15 visits, the therapist can request additional coverage via the PA process. Consideration of up to an additional 15 visits for all diagnoses, except the 5 listed above which can receive coverage greater than 30 visits when medically necessary, will be given. This procedure will only be valid until 12/31/10. Effective 1/1/11, there will be no PA for any diagnosis other than the 5 listed above.

- 6) If the beneficiary sees PT, OT and ST in one day, is that considered 1 visit or 3 visits?
- 3 visits.
- 7) How are “calendar years” determined?
- The calendar year will be January 1-December 31.
- 8) What if the beneficiary uses up all 30 visits with one medical issue, and then has another medical issue that requires therapy services?
- It is important to use therapy visits judiciously so that all visits are not exhausted when more might be needed in the future. Effective 1/1/11, no further authorization will be given except for the 5 conditions listed above.
- 9) How does one discipline know how many visits another discipline or provider may have used?
- It is imperative that all therapists communicate with each other so that visits are covered appropriately. It is the responsibility of the therapists to track the number of visits.
- 10) How can therapists best focus their treatment to meet therapy goals within the 30 visit limit?
- Focus on beneficiary/caregiver education on self-management of the condition.
  - Focus on functional goals that have objective, measurable criteria.
  - Use evidence based, Best Practice patterns.  
All treatment plans and goals must demonstrate medical necessity. Practice patterns demonstrating overuse of services will be subject to audit, and recoupment if appropriate.