

The Department of Vermont Health Access Medical Policy

Subject: Physical, Occupational, and Speech Therapy Services

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Description of Service or Procedure

“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 Pathology (SLP). 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.

Note: Not all services listed in the State Practice Acts are medical in nature. Medicaid utilizes a medical model which only covers medically necessary rehabilitative therapy services. Medical Necessity is defined in Medicaid Rule 7103.

VT Medicaid covers therapy services for beneficiaries with a range of medical diagnoses, including neurological, musculoskeletal, integumentary, cardiopulmonary, developmental, and psychological disorders, providing that the treatment of the diagnosis falls within each discipline’s practice act and meet the criteria below. The documentation must provide clearly medical diagnoses in order to receive coverage under Vermont Medicaid (Medicaid Rule 7103, Medical Necessity).

All services must be performed by state licensed therapists. All services billed as PT, OT, or SLP services must be performed by individuals who are licensed physical, occupational, or speech language pathologists. There is no “incident to” billing for therapy services (Provider Manual); therefore, there can be no billing for aides or for other disciplines such as athletic trainers or massage therapists. PT Assistants and OT Assistants are licensed in the state of Vermont and their services may be billed to Vermont Medicaid. Speech Assistants are not licensed in the State

of Vermont and their services can not be billed to Vermont Medicaid. Therapists may bill for Physical, Occupational, or Speech therapy services provided by students who are enrolled in an accredited therapy program and are treating Medicaid beneficiaries under the auspices of an internship for that program, when:

- The student is working under the direct line of sight supervision of a licensed therapist of the same discipline, AND
- Where the therapist is cosigning all documentation.

ORDERS/REFERRALS: Therapy services must be performed under a physician’s, physician’s assistant (PA-C), or a nurse practitioner’s (NP) order. It is the Department of Vermont Health Access (DVHA) expectation, and best practice, for the therapist to send the prescriber their initial therapy evaluation, for endorsement of the plan of care. This must be kept on file in the Therapy practice. If the initial order is received from a specialist, the therapist must work with that specialist to determine when future endorsements should be transferred to the primary care provider, to allow documentation to reside in the beneficiary’s medical home.

Codes that are Non-Reimbursable as Primary Diagnoses for Physical, Occupational, and Speech Therapy Services

The diagnoses on claims and on requests for therapy services must be the same, and must reflect the underlying medical condition for the therapeutic intervention provided.

Diagnostic codes that are considered **not reimbursable** when used as a primary diagnosis are those which:

- Are no longer valid codes in the AMA list of diagnostic codes OR
- Are not clearly medical in nature OR
- Are not specific and therefore prevent meaningful clinical review OR
- Are a symptom of an underlying medical diagnosis OR
- Are a symptom of a medical diagnosis, where treatment of the symptom alone may be harmful to the beneficiary.

This list is not all inclusive because of the number of codes and the frequency with which they change.

27800	30924	3122	3131	3139	3155	7197	78452	79923
27801	30928	3123	3132	31500	3158	72887	78460	79929
27802	30929	3123	31321	31501	3159	7500	78461	7993
2781	3093	31234	31322	31502	317	78079	78605	7999
3090	3094	31235	31323	31509	3180	7831	78650	
3091	30983	31239	3133	3151	3181	78340	7992	
3092	30989	3124	3138	3152	3182	78342	79921	
30921	3099	3128	31382	3153	319	7836	79922	
30922	3120	3129	31383	31531	33183	78440	79923	
30923	3121	3130	31389	31539	71950	78449	79924	

V codes must not be used as the primary condition except in the rare instance when a surgical aftercare V code is the only viable option. These codes may be used as secondary diagnoses.

Disclaimer

Coverage of therapy services is limited to that outlined in Medicaid Rule that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

[7203](#) Outpatient Services

[7317](#) Rehabilitative Therapy Services

[7401](#) Home Health Agency Services

[5351](#) VHAP Benefits

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>

Coverage Position

Physical, Occupational, and Speech Therapy (PT, OT, and ST) may be covered for beneficiaries:

- When this service is prescribed by a medical provider operating within his/her scope of practice and the State Practice Act, and VT Medicaid rule, who is knowledgeable in the area of Rehabilitation Medicine and who provides medical care to the beneficiary, AND
- Who meet the clinical guidelines below; AND
- Where the service is directly related to an active treatment of a medical condition designed by the MD/PA-C/NP, AND
- When such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required, AND
- When the service is reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition. (Medicaid Rule 7401.3)

Coverage Guidelines

Adult Clinic-Based Coverage:

For adults in Medicaid and VHAP: "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 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”

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.

It is important to use therapy visits judiciously so that all visits are covered appropriately. It is the responsibility of the therapists to track the number of visits.

Example 1: If a beneficiary is treated for a neck injury in February, it is incumbent upon the therapist to conserve visits so that there will be sufficient coverage for another injury occurring in July.

Example 2: A beneficiary has a condition requiring coverage by both PT and OT. The therapists must collaborate to ensure that the beneficiary will have appropriate coverage for both OT and PT treatment.

Adult Home Health Coverage:

“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 4 month period is subject to prior authorization review as specified below.

Prior authorization for [home health adult] 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) or
- The patient undergoes another acute care episode or injury, or
- The patient experiences increased loss of function or
- Deterioration of the patient’s condition requiring therapy is imminent and predictable.

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.” (Medicaid Rule 7317.3).

For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required.

Pediatric Coverage (Under Age 21):

Services are covered for up to 4 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 (Rule 7317.2)

Prior Authorization:

“To receive prior authorization for additional services a physician must submit a written request to the department with pertinent data showing the need for continued treatment, projected goals and estimated length of time. Prior authorization for therapy services will be granted only if:

- The service may not be reasonably provided by the patient’s support person(s), or
- The patient undergoes another acute care episode or injury, or
- The patient experiences increased loss of function, or
- Deterioration of the patient’s condition requiring therapy is imminent and predictable...” (Medicaid Rule 7317).

Note that there is **no retroactive prior authorization**, except:

- With late denial documentation from a primary insurance or
- With retroactive Medicaid coverage.

A clinical review will be initiated within 3 working days of receipt of the request. A Notice of Decision will be sent to the beneficiary, the therapist, and the prescribing provider. The request may be approved, denied, or placed in Informational Status if additional information is required. Requests in Informational Status are kept on file for 12 days pending additional information. If none is received, the request auto-denies. However, if the additional information required to complete the clinical review is received within 28 days from the initial request, the approval will be granted as follows:

- Early/on time request: approval begins on the first date of the upcoming certification period.
- Late request but within 28 days of the start of the certification period: approval begins on the date of the initial request.

If the additional information is received after 28 days from the initial request, a new prior authorization file is generated and subsequent approval is granted as of the date of the new request.

Example 1: A therapist requests coverage for certification period 6/2/10 to 10/1/10. She sends in her request on 5/15/10. The clinical review finds that certain information is missing from the request. A Notice of Decision is sent, informing the therapist that she needs to send the additional information by 5/27/10 or risk a denial. On 5/27/10, the request auto-denies due to lack of response. The therapist sends a response on 6/4/10. The authorization will be dated from 6/2/10 through 10/1/10 because she submitted the request before 28 days from the initial request.

Example 2: A therapist requests coverage for certification period 6/2/10 to 10/1/10. She sends in her request on 6/4/10, but performed a treatment on 6/3/10. The approved authorization covers dates 6/4/10-10/1/10, and the visit on 6/3/10 will not be covered.

Example 3: A therapist requests coverage for certification period 6/2/10 to 10/1/10. She sends in her request on 5/15/10. The clinical review finds that certain information is missing from the request. A Notice of Decision is sent, informing the therapist that she needs to send the additional information by 5/27/10 or risk a denial. On 5/27/10, the request auto-denies due to lack of response. The therapist submits a new, complete response on 7/1/10. The authorization will be dated from 7/1/10 through 10/1/10, and the visits pro-rated, because she submitted the request after 28 days from the initial request.

Clinical guidelines for repeat service or procedure

Under 21: Medically necessary treatment is covered until the 21st birthday. The 4 month certification periods are based on the date of discipline specific initial evaluation for the acute care episode/injury, and continue regardless of discharge/readmission from a particular service provider or other coverage sources. Additional coverage can be obtained through the prior authorization process as described above.

Adults: Home Health: Additional coverage can be obtained through the prior authorization process as described above.

Adults: Outpatient services: There is no coverage beyond 30 combined OT, PT, and ST visits except for individuals with the 5 diagnoses listed above.

Type of service or procedure not covered (this list may not be all inclusive)

- Treatments beyond the 30 visit adult outpatient limitation described above.
- Treatments that are experimental or investigational.
- A preliminary treatment leading to a service that is not a covered benefit. (For example, a goal of independence with a pool or gym program is not covered because Medicaid does not cover pool or gym memberships.)
- Treatment related to vocation, return-to-work, or education/academic goals. There are other more appropriate coverage sources for vocational and educational treatment goals and plans, such as Vocational Rehabilitation, worker's compensation, and the public education system.
- Treatment related to avocational/recreational/sports/leisure goals do not demonstrate medical necessity.

Coding/Billing Information

PT/OT/ST Services and the Medicare Cap:

Due to the Deficit Reduction Act 03, Medicare took the unusual step of limiting benefits for PT, OT and ST services provided by independent therapists. When a patient reaches the payment cap imposed by Medicare on independent therapists, therapy is still covered by Medicare through hospital outpatient departments and home health agencies. Therefore, Medicaid does NOT become the primary payer and the independent therapist should refer the patient to the hospital or home health agency. Vermont Medicaid will continue to reimburse coinsurance and deductible on approved crossover claims.

Other Insurance:

“Vermont Medicaid is the payer of last resort. Providers are required to apply all third party payment resources prior to billing Medicaid...including Medicare, private/group health insurance plans, accident insurance, military and veteran's benefits, and worker's compensation.” (Medicaid rule 7108)

“We consider coverage under Medicaid rules if the other insurance denies because the item or service is not included in the coverage contract.item or service is not included in the coverage

contract. If the other insurance has denied for a reason other than not included in the coverage contract, the beneficiary or provider must first go through all required levels of the insurance plan's appeal process, as well as the external review from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), if eligible and available. If the billed amount is less than \$100, BISHCA will not hear the appeal so the final insurance plan appeal is sufficient ... The beneficiary must meet the timeframes specified by BISHCA for the external appeal. Medicare beneficiaries or their providers must appeal through the Qualified Independent Contractor level prior to requesting that Medicaid cover the service or item. If these appeals are all denied, the beneficiary's provider may ask Medicaid to make an independent assessment of coverage and medical necessity and, if approved, cover the item or service. The Medicaid decision will be based on the same documentation submitted for the previous appeals. For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies... Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination." (Medicaid Rule 7105.1).

“Other Insurance Denial for Non-covered or Benefits Exhausted: The provider is required to submit to the DVHA the prior authorization request with all standard documentation, the notice of denial from the primary insurer that indicates the item or services is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will review.” (Provider Manual 1.4.1) DVHA becomes primary insurance and Medicaid rules apply. The PA rules provide a 30-day transition period to assure continuity of service. Effective 9/01/06, the DVHA will not pay claims beyond the transition period unless the service has received prior authorization. “If the primary insurance is indicated on your prior authorization notice the provider is not obligated to attach that insurance denial to each [claims] submission. This will enable electronic billing of the claims covered in the PA period.” (RA letter: 8/25/06). Denial documentation must be included with requests for prior authorization.

“Denial for lack of medical necessity: The provider is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the vendor is required to seek review by the BISHCA...If the denial stands, then the vendor may submit to the DVHA. The request to the DVHA will include copies of all of the original documentation and the denials from the primary insurer and the BISHCA. The vendor cannot submit any additional documentation than that which was reviewed by the primary insurer...The DVHA will reject a request if there is reason to believe that the other insurance received incorrect or incomplete information on which to base its decision.” (Provider Manual 1.4.1 and Medicaid Rule 7105).

Primary insurance and the outpatient adult 30 visit limit: To ensure fairness for all beneficiaries, the 30 visit limit applies whether or not the beneficiary also has a primary insurance. For example, a beneficiary has a primary insurance that covers 21 visits. Medicaid will cover the additional 9 visits provided they are medically necessary.

“It is strongly recommended that provider determine OI [other insurance]/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.” (Provider Manual, 1.4.1)

Billing and Visit Length:

Certain therapy procedure codes have 15 minute time increments. For providers who bill with procedure codes, note that the number of units of 15 minute procedure codes used must not exceed the amount of time spent in actual treatment during the visit. For example, if the service provided took one hour, the therapist cannot bill for 2 units of gait training, 2 units of therapeutic exercise, and 2 units of neuromuscular re-education because that totals 90 minutes, even if the therapist spent 20 minutes performing each procedure. The number of units of procedure codes must be adjusted to correctly reflect the actual time of the visit.

Therapists are advised to keep an accurate record of treatment times on file to appropriately reconcile claims with treatment times.

CODING:

Hospitals and home health agencies bill using the revenue codes and procedure codes:

- 420-4 for PT
- 430-4 for OT
- 440-4 for ST

Note that 1 unit=1 visit for home health agency billing.

Outpatient clinics bill using the procedure codes:

Therapists may petition the DVHA for consideration of additional procedure codes.

29065	29550	95834	97110
29075	29580	95851	97112
29086	29581	95852	97113
29105	29590	96105	97116
29125	29700	96110	97124
29126	29705	96111	97139
29130	29730	96125	97140
29131	29740	97001	97150
29200	29750	97002	97530
29240	64550	97003	97532
29260	92506	97004	97542
29280	92507	97010	97597
29358	92508	97012	97598
29365	92526	97014	97602
29405	92597	97016	97605
29425	92605	97018	97606
29435	92606	97022	97750
29440	92607	97026	97760
29445	92608	97028	97761
29450	92609	97032	97762
29505	92610	97033	97799
29515	92611	97034	
29520	95831	97035	
29530	95832	97036	
29540	95833	97039	

Additional Adult and Pediatric Information For Providers

Documentation:

Therapy evaluations are expected to be comprehensive. Therapists are expected to have an understanding of local medical, psychosocial, and state agencies including Vocational Rehabilitation, and to make appropriate referrals to assist the beneficiary in their return to a full and productive life post injury. These contacts must be documented in the information sent to DVHA.

Therapy goals must clearly demonstrate medical necessity, and be functionally based, beneficiary-oriented, measurable and objective, and age appropriate.

Therapy plans of treatment, including frequency, must be research based, comprehensive, and have a focus on beneficiary/family education regarding self-management of the condition(s) and personal responsibility. There must be a discharge plan in place at the onset of treatment.

Required Documentation: Each prior authorization request must include the following documentation:

- Beneficiary name
- Birth date
- Beneficiary Medicaid number/unique identifier
- Supplying provider name and provider number(s)
- Attending physician name and provider number(s)
- Diagnoses and dates of onset which must match the diagnoses on the claim forms submitted
- Information on the dates/events complicating therapy
- The date of initial therapy for the acute care episode/injury (see below)
- Treatment frequency
- Patient-oriented goals with objective and measurable parameters
- Research based treatment plan that includes beneficiary/caregiver education and a discharge plan
- Objective, measurable results of previous treatment goals
- Professional signature of the therapist and the prescribing physician/nurse practitioner/physician's assistant. (Therapy Extension Form Instructions)

The therapy office/department must have the initial physician/PA-C/ NP order/referral on file as well as the MD/PA-C/NP approval of the care plan established upon evaluation.

Additional information that may be required includes:

- “The patient’s complete medical record,
- A response to clinical questions posed by the department,
- The practitioner’s detailed and reasoned opinion in support of medical necessity,
- A statement of the practitioner’s evaluation of alternatives suggested by the department and the provider’s reason for rejecting them.” (Medicaid Rule 7102.2)

Therapists are advised to keep an accurate record of treatment times on file to appropriately reconcile claims with treatment times.

Errors in Documentation: All corrections to the medico-legal record, including the Therapy Extension Form, must be a single line strike-out initialed by the therapist; no erasures, scribbles, or use of liquid paper (white-out) are acceptable.

Note: Determining the date of initial therapy for the acute care episode/injury:

For beneficiaries under 21 and adults treated by home health: All certification periods are based on the date of initial PT, OT or ST evaluation of the acute care episode/injury which is being treated, regardless of which agency provided the service and regardless of coverage by other resources. Therefore, it is imperative to determine this date. This date can be obtained upon Intake from the beneficiary, the physician record, or the previous therapy provider.

Pediatric Therapy

Because federal law supersedes state law, the Vermont Medicaid rule regarding visit limitations (30 combined PT, OT, and ST visits per calendar year for clinic based services) does not apply to children.

There are special issues regarding the coverage of children's therapy services. These include:

- issues related to coverage for school age children, who may be eligible for therapy services through their public school system ("school model services"), some of which may be covered by Medicaid in addition to "medical model services" which are received in the home/community setting;
- The multitude of state and federal agencies that have rules and regulations regarding children's health;
- The inherent vulnerability of children in their position as dependents.

Given these issues, some additional guidelines have been formulated to help clarify therapy coverage for children.

- **All treatment must be medically necessary under federal as well as state law.** It is necessary to demonstrate that a treatment is medically necessary by having a *clear medical diagnosis*. Diagnoses that are vague or too general do not help demonstrate medical necessity and make it difficult for reviewers to determine if the therapy being requested is medically appropriate for the beneficiary. For example, a diagnosis of 'disorder of the nervous system, not otherwise specified' is so vague that a reviewer would not be able to determine if the treatment being requested is appropriate. Another example is 'muscle weakness'. Many individuals are weak from lack of exercise, but they do not have a medical problem and their weakness does not need treatment by a therapist. Sometimes, families/physicians resist diagnoses, or sometimes a clear diagnosis can not be made. In these circumstances, the therapist must work with the physician to provide a clearly medical diagnosis/condition. *For example, a doctor refers a child with a 'developmental delay.' The therapist notes that the child has hypotonia and discusses this finding with the physician. The physician determines that the hypotonia is significant enough to impact the child's ability to function and that it is a medical condition. The therapist notes this on the therapy authorization form and the billing form.*

- **All treatment, including treatment frequency, should be established by evaluation and be unique to the specific needs of the individual, not the convenience of the provider.** *For example, a therapy provider who sees all clients once a week regardless of their condition is not providing services unique to the needs of the individual.*
- **All treatment must include training for the child's care providers, to maximize the therapeutic effects of the treatment, and to minimize caregiver dependence on intensive professional level services.** Lay people can be taught therapy concepts and techniques for their unique child, and become competent and confident in following through with the techniques. The therapist's knowledge is required to evaluate and re-evaluate the therapeutic program, provide instruction to the caregivers, and to adjust the program to meet the unique needs of the child. Training of the child's care providers must begin with the very first visit and must be clearly documented in the visit notes. The expectation is that as caregiver competence and confidence increases, the need for high-intensity professional level services will gradually decrease over time to a level that provides for programmatic upgrades and ongoing family education. *For example, a therapy evaluation is done on a child with cerebral palsy. The family has many needs and questions initially, so the therapist determines that it is appropriate to begin at an intensive frequency of twice per week. As the family and other caregivers (such as daycare personnel, personal care attendants, and early interventionists) participate in the treatment process and learn the concepts and techniques to manage the child's needs, the frequency of professional services decreases gradually. The caregivers become more competent and confident, and require less direct support. Gradually, the frequency is decreased to a level of twice per month, to upgrade the goals, ensure that all equipment needed is available and fits well, and provide additional education to the caregivers as circumstances change.*
- **If an individual has a new acute care episode/condition, which significantly changes the treatment plan and goals, then a new start of care date is given, a new diagnosis code is utilized in documentation and billing, and no therapy authorization is needed for the 4 months of treatment per discipline.** *For example, a child with severe contractures receives tendon lengthening surgery. He had been receiving treatment at a frequency of twice per month for equipment adjustment and caregiver education regarding the home program. After the surgery, there are new precautions, new goals, and a new plan. The change in program is significant. The surgery results in a new Start of Care date and a new billing diagnosis. No therapy authorization is needed for the first 4 months of treatment per discipline. The therapist determines that an increased frequency of care is warranted, and begins treatment at twice per week. After the child has recovered from the post-op period, and caregivers are trained in the new care plan, the therapist requests a frequency of weekly for 2 months and then twice per week for 2 months, with appropriate goals and plan.*
- **Infants and very young children change rapidly in the first years of life.** Caregivers may need a higher intensity of professional assistance initially, both because they need to learn the concepts and techniques of care, but also because of the rapidity of growth and development. **As the changes gradually slow, the frequency of skilled therapy services can decrease as well.** *For example, a child with a mitochondrial disorder needs a high frequency of professional level services initially, to obtain equipment, educate the*

caregivers, and set up the home program. As the child grows and changes rapidly in the first year, the caregivers have many questions about how to provide care. Over time, their questions become fewer, the changes become more gradual, and the caregivers become more competent and confident in the care. The frequency of skilled services decreases accordingly.

- **Infants and young children with complex medical needs often have multiple professional disciplines providing services simultaneously. Vermont Medicaid expects that the professionals are collaborating with each other, and that their goals demonstrate good communication by avoiding both overlaps and gaps in the treatment and training provided.** This extends beyond the therapists who work directly together to all the members of the child's team, including Early Interventionists, nutritionists, physicians, nurses, personnel from VABVI (Vermont Association for the Blind and Visually Impaired) for the vision impaired, etc. *For example, a child born very prematurely comes home with support from nursing, a neonatologist, a pulmonary specialist, a nutritionist, a PT, an OT, and VABVI personnel. The family gets connected to the Children's Integrated Services-Early Intervention program (CIS-EI) and an Individualized Family Service Plan (IFSP) is created. The professional team communicates frequently, with the permission of the parents, to educate each other and exchange information on their goals and plans, and to avoid overlaps and gaps in care. The PT and OT note that they have written identical positioning goals and equipment goals on their request for a Medicaid extension. They discuss together who will be the 'lead' person in each of these areas, and the lead person writes the goal on their Medicaid extension form. The other discipline provides support, affirmation, and encouragement to supplement the training by the 'lead' therapist. In this case, the PT decides to take the lead with positioning issues, while the OT decides to take the lead with equipment issues. There is a specific positioning issue for the child's hands, which the OT feels she would prefer to address, so after discussion the OT writes a goal and plan specific to hand positioning.*
- **Current medical research supports learning, including motor learning, in the most natural and familiar environment for the child.** For children, this generally means their home and daycare when very young, with the addition of their school as they get older. Generalizing skills across different environments is very difficult for both children and families. Therefore, Vermont Medicaid supports and encourages treatment in the home and community environment, over the clinical environment. There are times when clinical equipment that can not be brought into the home is necessary for the treatment. If this is not the case, then it is felt that the use of a clinic is often for the convenience of the therapist and not for the benefit of the child. The use of the Clinic model should be questioned when it is not apparent that specialized clinical equipment is necessary to provide treatment. *For example, a child with spina bifida who has just received new reciprocating gait orthoses needs to use the parallel bars to begin gait training. As parallel bars can not be brought to the home, the child goes to a therapy clinic for initial training. As soon as the child advances to the use of a walker or crutches, however, the treatment switches to the home so that the child and the family see that walking is not just an activity done in a clinic, but is an activity that is performed in the familiar*

surroundings of the home, with the real obstacles that will be faced such as rugs, pets, and toys on the floor.

Note: if the child has a primary insurance, the primary insurance's benefits apply. For example, if the primary insurance requires that a child who is not homebound is not covered for home health services, then VT Medicaid honors that requirement.

- Vermont schools participate in a 'child find' to determine in part if there are children who require special services. Before a child turns 3, the medical model therapist is expected to take an active role in educating the caregivers on the process of connecting the family to School Model Services and beginning the evaluation process. This will help demystify the process, and smooth the transition. It is important to discuss the differences between an IFSP and an IEP (Individualized Education Program) if this is appropriate to the case. Families should be educated in the differences between school and medical model therapy services. **School model services support the child in accessing their Free and Appropriate Public Education ("FAPE") in the Least Restrictive Environment ("LRE"). Medical Model services focus on providing medically necessary treatment specific to the home and community and in particular, family education.** Some school based services are high intensity; some are more consultative in nature, depending upon the child's needs, the support available to the student, and the level of training that school personnel require. It is often the case, just as in the medical model, that frequency starts off at a higher level, and then as school personnel becomes more confident and competent, and as the child becomes more familiar with the school environment, and as the developmental changes gradually slow, that the frequency of therapy services changes accordingly. **It is the task of the medical model therapist, because their relationship with the child and family are already established, to actively prepare and facilitate the introduction of the child and family into the school system.** It is also the task of the medical model therapist to help the family learn to differentiate between the school and medical model services. *For example, a child with high level autism is 2½. The medical model therapists begin the process of educating the family about school model service's and help them connect with the school district. They talk about the evaluation process, IEPs, 504s, EST plans, and other ways that a child may access therapy services in the school. They compare the IEP with the IFSP so families understand the difference. They talk with the family about the school model of therapy services and how it differs from the medical model of services. Both medical and school model therapists participate in transition meetings to help smooth the transition. The school and medical model therapists communicate together, with the permission of the parents, to avoid gaps and overlaps in the child's treatment. The medical model therapists feel that there are many home and community issues that still need to be addressed, so they continue to treat the child after school starts.*
- Some children do not qualify for an IEP. They may still receive therapy services via a 504 plan, or an EST plan. Also, they may see a school based therapist for an assessment or an evaluation even if they do not qualify for any plan. **If a medical model therapist feels a child has needs that may impact his/her school performance, the medical model therapist should contact the school, with the permission of the parent and all necessary release forms in place, to share the concerns.** The school can then determine if a school model therapy assessment is warranted. *For example, a child with a mild foot*

deformity is being seen by a medical model therapist. The therapist is concerned that this problem may affect the child's ability to participate safely in physical education class and at recess. With the parent's permission, the medical model therapist calls the school and mentions her concerns. The school agrees to cover an assessment. The school model therapist observes the child in physical education class and at recess, and makes recommendations to the PE teacher and the recess personnel. She then calls the medical model therapist to update her about what has occurred. The school model therapist also sends a note home to parents to apprise them of what she has done.

- Some families decide not to access the school system. **The medical model therapist should then make clear to the family that medical model Medicaid can never take the place of school model services.** The family needs to understand that the medical model therapist can not receive Medicaid coverage for academically related treatment. Families should be encouraged to work with their school districts to see what might be available for support. *For example, a student with Asperger's syndrome is home schooled. The family does not want the child to be in school for classes, but after meeting and problem-solving with the school district, they decide that they will bring their child in to the school for school model speech services. The speech language pathologist arranges for a time at the end of the school day, when things are less chaotic, for the child to receive his services.*
- Medical model therapists are not covered by Vermont Medicaid to provide **consultation:** to discuss cases with teachers, paraeducators, or any other school personnel. **Consultation** should be covered by the school district. The medical model therapist is expected to provide **collaboration:** to discuss the case with the school model therapist of the same discipline. Collaboration is necessary for quality care and to avoid gaps and duplication of services. Collaboration also helps prevent confusion. *For example, a medical model therapist tries to contact the school model therapist regarding her treatment techniques for a child with autism. The medical model therapist advocates, and is using, Applied Behavioral Analysis and discrete trial learning techniques. The school model therapist does not respond to the calls. The school model therapist advocates, and is using, a Floor time model. The child is confused at the different approaches; the parents don't know what they should be doing. The child's progress is delayed because of the confusion.*
- Upon collaboration with the school based therapist, **the Medical Model therapist must clearly delineate the distinctions between her program and the school based services provided to the child in her Medicaid documentation.** This documentation must demonstrate that both parties have an awareness of each other's treatment techniques, plans and goals. It also must demonstrate that the programs are such that they avoid gaps and unnecessary overlaps, and avoid significant differences in treatment techniques that might cause confusion and concern to the child, families and caregivers. *For example, a child with rheumatoid arthritis is working on grip issues for pencils and crayons with her school based occupational therapist. The home based therapist is focusing on grip issues for ADL (activities of daily living) skills, such as using buttons, zippers, and eating utensils. The therapists clearly communicate to each other so each will know what the other is doing, and can support and affirm each other's program to the child's caregivers.*

- **Medical Model therapists must understand that even though a child may not have a school therapist, children work on skills every day in school that may have a relationship to Therapy, but may not require professional therapy services. They must remember that teachers, school psychologists, and special educators are all highly skilled, highly trained, licensed professionals who are also capable of helping children acquire skills.** *For example, a 6 year old child with ADHD has handwriting issues. The home based Occupational Therapist wants to work intensively with the child on handwriting skills at home. She reports that she needs to work on these skills because the child “doesn’t have OT services at school.” She does not acknowledge that the child’s teacher is a licensed, highly skilled professional who teaches handwriting skills every day in her classroom. The teacher states that if she feels she can not help this child, she will ask for an evaluation by the school Occupational Therapist. Teaching handwriting skills is generally done by classroom teachers, who have resources available to them if they require the assistance. The medical model OT should therefore not bill Medicaid for treatment of handwriting issues.*
- **Vermont Medicaid does not support multiple therapists per discipline working simultaneously with a child.** Children with a high level of special needs typically have enormous medical and school model teams. Communication is a serious challenge between essential team participants in each setting and across settings. Communication becomes further challenged by having multiple therapists per discipline, simultaneously. There is no research evidence to support the medical need for multiple therapists per discipline working with a child simultaneously. *For example, a child with cerebral palsy is receiving home physical therapy to improve his gait, strength, and function. He also receives services from his primary physician, a developmental pediatrician, a nutritionist, a vision expert, an occupational and a speech therapist, an orthotist, a durable medical equipment provider, a home health nurse, a medical social worker, an audiologist, and a personal care attendant. In school, he receives services from a physical therapist, an occupational therapist, a speech therapist, a special educator, a classroom teacher, and an individual assistant. The child has a surgery that results in the need for an aquatic therapy environment to promote gravity lessened movement. The child is transitioned to a physical therapy clinic with an aquatic environment. The therapist that offers the aquatic environment is a licensed physical therapist who can also provide gait, strength, and functional training either in the aquatic environment or on land. When the aquatic environment is no longer medically required, the child can resume coverage with the home health therapist.*
- Vermont Medicaid requires that treatment techniques used by therapists are supported by a high standard of current, peer reviewed medical literature and research. **Vermont Medicaid does not cover treatments that are ‘experimental and investigational’, meaning that they have inadequate research base.** *For example, a therapist goes to a course and learns a new technique. The course instructor provides testimonials and anecdotal evidence, but provides only her own research to support the technique. The instructor’s research involved only 9 children, did not have a control group, and the testers were not double blinded. The therapist can not anticipate that Vermont Medicaid will cover this treatment until its efficacy is demonstrated by a higher level of research, and is replicated by other researchers. For questions regarding whether certain therapy*

techniques are considered experimental or investigational, contact DVHA at (802) 879 6396.

- **Caregivers and families must directly participate in the therapy sessions to maximize their ability to follow through with the home program, for optimal therapeutic results.** *For example, a child with a head injury initially receives a high level of therapy services. The caregivers often leave the room during the therapy sessions, feeling that therapy is “the job of a professional” and that “this is their time for a break”. The caregivers then do not have a clear understanding of the therapy program, even though they discuss the results of each treatment with the therapist. Their follow-through with the home program is compromised because they have not seen the program modeled for them and have not had opportunities to provide return demonstrations to the therapist. The child feels that therapy is something that happens at the clinic, and has no meaning outside of the clinic venue. When the therapist feels that the child has plateaued in her improvements, and wants to begin decreasing the frequency of services, the caregivers are furious and insist that the therapist must continue at the high level of services provided initially. The therapist feels trapped into providing a level of services that is no longer medically necessary. This may have been avoided if the course of therapy is discussed initially and at every re-evaluation, and if the family/caregivers have been highly involved in the treatment program.*

Note: it is a DVHA expectation that a majority of visits will occur with the family present so that families can be trained in therapeutic procedures and activities. Daycare personnel are less consistent than family; it is not sufficient for therapists to be educating daycare providers and not family members in the home programming.

- **Vermont Medicaid provides a high level of support for Personal Care Attendant (PCA) Services.** PCAs are paid by the State of Vermont to provide for personal care services, including follow-through with therapy programs. It is an expectation that therapists inquire if the child has a PCA. It is an expectation that the therapist provides direct training for the PCA to ensure proper follow through of the home program. Children can benefit from additional opportunities to practice new skills, exercises, and activities prescribed by the therapist. The best way for the PCA to learn the home program is for the PCA to receive instruction from the therapist directly, by periodically attending therapy sessions. *For example, a child on the autism spectrum has been allowed 25 hours of PCA services per week. The PCA comes periodically to occupational and speech therapy sessions and is instructed in the home program. The PCA then can support the family and therapist by following through with the home program.*
- A primary goal of all therapists must be to promote independence for children and their caregivers. **Vermont Medicaid supports therapists in helping children and families reach goals of independence and self-reliance. Vermont Medicaid does not support practices and practice patterns which result in chronic dependence on professional practitioners.** *For example, a child with a head injury initially receives a high level of therapy services. The therapists discuss the course of treatment with the family, emphasizing the vital importance of the family in participating in every treatment session and of following through with their program. They discuss the need for frequent services initially, and then a gradual taper as the caregivers become more confident and competent. The child and family do a great job at following through, and therapy*

progresses well. When the child is re-evaluated, new goals are established, and the therapist finds that the family is doing a great job with the home program and feels confident in their ability to follow the program. They agree to the therapist's plan to decrease the frequency of services. They know that the therapist is available to reassess should the situation change in any way. After a year of high frequency treatment, they are ready for a lower intensity of professional services. They know that this does not mean their child is being deprived of services; they know that this means that the child has progressed nicely, and that they are doing a great job. They know this because the therapist has made this clear to them. A lower level of services demonstrates that the program has successfully helped the child and family reach a greater level of independence and self-reliance!

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