

The Department of Vermont Health Access Medical Policy

Subject: Physical, Occupational, and Speech Therapy Services

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***Please note: Most current content changes will be highlighted in yellow.**

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 Therapists 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 covers only medically necessary therapy services. Medical Necessity is defined in Medicaid Rule 7103.” Medicaid Rule 7317 covers Rehabilitative Therapy Services.

Vermont Medicaid covers therapy services for beneficiaries with a wide range of medical diagnoses, providing that:

- the treatment falls within each discipline’s practice act,
- is the least expensive medically appropriate care for the condition,
- and meet the criteria below.

All services must be performed by a licensed physical, occupational, or speech therapist enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with the Vermont State Practice Act. All services billed as PT, OT, or ST services must be performed by individuals who are licensed in physical, occupational, or speech language pathology. 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 therefore their services cannot be billed to Vermont Medicaid. Therapists may bill for Physical, Occupational, or Speech therapy services provided by physical, occupational, and speech therapy students who are enrolled in an accredited therapy program and who 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. Note that for Clinical Fellowship Year (CFY) speech language pathologists, cosignature is required.

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

Diagnosis codes on the claims and on requests for extended therapy services must match. The codes must include the underlying medical condition for the therapeutic intervention provided, in addition to any therapy-specific diagnostic codes.

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

- Are no longer valid codes in the American Medical Association (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.

These codes may be used as secondary diagnoses.

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

Please note: For all services provided on date of service 10/1/2015 and thereafter must be submitted with ICD-10 codes.

ICD-10 Codes:

E65	E663	F4320	F4324	F439
E6601	E668	F4321	F4325	F4541
E6609	E669	F4322	F4329	F4542
E661	F430	F4323	F438	F54

F630	F919	M255631	R262	R480
F632	F930	M25632	R448	R489
F633	F938	M25639	R449	R498
F6381	F939	M25641	R450	R499
F6389	F940	M25642	R451	R530
F639	F941	M25649	R453	R531
F78	F942	M25651	R454	R5381
F79	F948	M25652	R4581	R5383
F8089	F949	M25659	R4582	R620
F809	F639	M25661	R4586	R6250
F810	F988	M25662	R4587	R6259
F8181	F989	M25669	R4589	R632
F8189	G44209	M25671	R460	R635
F819	G933	M25672	R461	R6882
F88	M2560	M25673	R462	R69
F89	M25611	M25674	R463	R99
F910	M25612	M25675	R464	
F911	M25619	M25676	R465	
F912	M25621	M6281	R466	
F913	M25622	R0602	R467	
F918	M25629	R079	R4782	

In addition, for adults only (21 years and older):

ICD10

- F70
- F71
- F72
- F73F800
- F801
- F8089F809
- F82
- Q381

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

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, enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with Vermont State Practice Act, who is knowledgeable in the area of Re/habilitation Medicine and who provides medical care to the beneficiary, AND
- When the clinical guidelines below are met, AND
- Where the service is directly related to an active treatment of a medical condition designed by a qualified medical provider, AND
- When such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required, AND
- When the treatment is reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition. (Medicaid Rule 7401.3J; 7317)

Coverage Guidelines

Adult Clinic-Based Coverage:

Vermont Medicaid Rule 7317.1:

“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.

Note: Effective date of service June 1, 2014 and thereafter, independently practicing speech language pathologists who are active, enrolled Vermont Medicaid providers may provide covered services to beneficiaries of all ages. Previous coverage only extended to beneficiaries under 22.

Home Health Coverage: Adult and Pediatric:

“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.” (Medicaid Rule 7317.3)

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

Non-Home Health Pediatric Coverage (Under Age 21):

For treatment other than through a home health agency, as of July 1, 2012 the initial eight visits **from the start of the beneficiary’s condition** are allowed, per therapy discipline, before prior authorization is required. Providers must request prior authorization in advance of the 8th visit if additional therapy visits are medically necessary. Providers must determine the first date of discipline-specific therapy by any discipline-specific provider for the condition, regardless of coverage source. Subsequent authorizations will be based on that start of care date.

If the individual has been seen in the past for the condition, and 8 visits have already been performed in the past, the current provider shall:

- See the beneficiary for the initial evaluation
- Contact the DVHA on the SAME DAY
- Submit documentation to request coverage **WITHIN 24 HOURS.**

Note: This is not a visit limitation; it is a method of earlier oversight.

Prior Authorization:

To receive prior authorization for additional services a physician must submit a written request to the Department of Vermont Health Access (DVHA) with pertinent data showing the need for continued treatment, projected goals and estimated length of time. (Medicaid Rule 7317.2)”

“ 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).

When the DVHA 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 provision of these services is covered, provided such oversight is medically necessary.” (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 an actionable 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 for Informational Status are kept on file for 12 days pending additional information. If none is received, the request 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 initial request: approval begins on the date of the initial request.

If the necessary 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 (Medicaid rule 7102).

Clinical guidelines for repeat service or procedure

Under 21: Medically necessary treatment is covered until the 21st birthday. The certification periods are based on the date of discipline-specific initial evaluation for the condition, and continue regardless of discharge/readmission from a particular service provider or a change in 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 per calendar year, except for individuals with the 5 diagnoses listed above. Prior authorization can be obtained through the prior authorization process as described 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. (Medicaid rule 7317)
- Treatments that are experimental or investigational. *Treatment techniques that do not have adequate research support at this time include, but are not limited to: sensory integration, craniosacral therapy, myofascial and visceral release, hippotherapy for conditions other than cerebral palsy, auditory integration therapy, hyperbaric oxygen treatment for brain injury, and facilitated communication.* (Medicaid rule 7102.2G)
- 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.) (Medicaid rule 7102.2F)
- 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 does not demonstrate medical necessity.

Coding/Billing Information

PT/OT/ST Services and the Medicare Cap:

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.” (Provider Manual)

Vermont Medicaid will reimburse coinsurance and deductible on approved crossover claims. For pediatric beneficiaries who have a high deductible: submit requests for Medicaid coverage during the period when the primary insurance is being applied to the deductible.

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..." (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) 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 Department of Banking, Insurance, Securities, and Health Care Administration (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.” **Note that BISHCA is now called the Vermont Department of Financial Regulation (VDFR).** (Provider Manual and Medicaid Rule 7105.1). 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)

Billing and Visit Length:

Certain therapy procedure codes have 15 or 30 minute time increments. For providers who bill with procedure codes, note that the number of units of **timed** codes used must not exceed the amount of time spent in actual treatment during the visit. A maximum of 4 units of the 15- minute **codes** are allowed per treatment session **Evaluation, re-evaluation, and other non-timed codes may be billed in addition to the timed codes during a single**

session. The code for wheelchair management including assessment is the exception to the 4-unit maximum.

It is also considered unlikely that there is a medical necessity for outpatient treatment sessions longer than one hour in duration. VT Medicaid will only cover one hour of outpatient therapy services, per discipline, per day.

All timed codes refer to the face-to-face time with the patient. A unit of time is attained when the mid-point is passed. For example: for a 15-minute code, an additional 8 minutes of the procedure must be performed before 2 units of the code can be billed.

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

Example: A beneficiary is seen for an hour long session of physical therapy services. The beneficiary receives an evaluation followed by 15 minutes of gait training, 30 minutes of therapeutic exercise, and 15 minutes of therapeutic activities. 4 timed units may be billed AND the evaluation may be billed. Note, however, that therapists who routinely bill for more than an hour of services by using untimed codes in addition to timed codes may be subject to review.

Example: A beneficiary is seen for a session of physical therapy services. Although the beneficiary receives 45 minutes of therapeutic exercise and 30 minutes of therapeutic activities, only 4 timed units may be billed. VT Medicaid will only cover one hour of therapeutic services.

CODING:

Hospitals and home health agencies bill using the revenue 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 including hospital outpatient clinics bill using the procedure codes:

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

29065	29200	29435	29540	29705
29075	29240	29440	29550	29730
29086	29260	29445	29580	29740
29105	29280	29450	29581	29750
29125	29358	29505	29582	64550
29126	29365	29515	29583	92506
29130	29405	29520	29584	92507
29131	29425	29530	29700	92508

92526	95834	97012	97110	97598
92597	95851	97014	97112	97602
92605	95852	97016	97113	97605
92606	95992	97018	97116	97606
92607	96105	97022	97124***	97750**
92608	96110	97026	97139	97755*
92609	96111	97028	97140	97760
92610	96125	97032	97150	97761
92611	97001	97033	97530	97762
92618	97002	97034	97532	97799
95831	97003	97035	97535*	
95832	97004	97036	97542	
95833	97010	97039	97597	

*(only for technology which is currently covered by Vermont Medicaid)

** (except: work or disability related functional capacity evaluation)

*** this code can only be used with other procedure codes, where there is a comprehensive plan of treatment. Massage therapy alone is not a covered benefit (Medicaid Rule 7307).

Note: Re-evaluation codes should only be used when there are new clinical findings, when there is a significant change in the patient’s condition, or when there has been a failure to respond to the treatment provided. Periodic ongoing assessment does not constitute a re-evaluation and must not be billed using a re-evaluation code.

Additional Adult and Pediatric Information for Providers

Documentation:

The DVHA has developed the DVHA Therapy Extension Request Form for your convenience. If you prefer not to use this form, please provide all the information listed below, and utilize the DVHA Therapy Cover Sheet. These forms are available on our website at: <http://dvha.vermont.gov/for-providers>.

Therapy evaluations are expected to be comprehensive. Evaluation tools must provide measurable, objective parameters to demonstrate the degree of functional impairment and provide a baseline for comparison during the clinical review process. Therapists are expected to have an understanding of local medical, psychosocial, state, and other resources, 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.

- *Treatment techniques that do not have adequate research support at this time include, but are not limited to: sensory integration, craniosacral therapy, myofascial and visceral release, hippotherapy for conditions other than cerebral palsy, auditory integration therapy, hyperbaric oxygen treatment for brain injury, and facilitated communication.*

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, diagnosis codes, and dates of onset, which must match the diagnoses on the claim forms submitted
- The date of initial therapy for the condition (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 any previous treatment goals
- Professional signature of the therapist and the referring provider.
- Measurable progress to date.

The therapy office/department must have the initial referring provider referral on file as well as the referring provider approval of the treatment 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 DVHA,
- The practitioner’s detailed and reasoned opinion in support of medical necessity,
- A statement of the practitioner’s evaluation of alternatives suggested by the DVHA 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, use of liquid paper (white-out) or computer deletions are acceptable.

Determining the date of initial therapy for the condition:

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 condition 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.

For additional guidance for pediatric therapy, see Appendix A.

Authorization Process Checklist:

Provider fully completes the appropriate sections of the Therapy Extension Request Form OR comparable documents and the DVHA Therapy Cover Sheet, with all the required documentation as described above and in the instructions attached to the form.

Provider sends to MD for endorsement of the care plan immediately for a new request, 2 weeks before the due date for ongoing treatment.

Provider sends complete document to DVHA for clinical review.

- DVHA turn-around time for clinical review is 3 days given complete documentation.

If the request is put in Informational status, all requested information is sent to DVHA within 12 days.

The clinical review generates a Notice of Decision form explaining the authorization/denial.

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This document has been classified as public information.

APPENDIX A

Guidance for Pediatric Therapy Practitioners

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,
- the multitude of state and federal agencies that have rules and regulations regarding children's health; and
- The inherent vulnerability of children in their position as dependents.

Given these issues, some additional information is provided below to help clarify therapy coverage for children. The level of treatment as described below is in no way aspirational: it is practiced successfully every day by therapists throughout Vermont.

- **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 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. *For example, a doctor refers a child to therapy with a diagnosis of: "lack of normal physiological development." 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 documents this diagnosis on the therapy authorization form and the claims 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 condition is not providing services unique to the needs of the individual.*

- **All treatment must include direct training for the child’s family and care providers, to maximize the therapeutic effects of the treatment, maximize self-determination, 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 therapist evaluates 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 participate in the treatment process and learn the concepts and techniques to manage the child’s needs, the need for 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 is available and fits well, and to provide additional education to the caregivers as circumstances change.*
- **If an individual has a new 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 first 8 visits of outpatient treatment or 4 months of home health treatment per discipline.** *For example, a child with severe contractures due to cerebral palsy 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 primary billing diagnosis. No therapy authorization is needed for the first 8 visits of outpatient therapy or 4 months of home health treatment per discipline. The therapist determines that an increased frequency of care is warranted, and begins treatment at twice per week. The new diagnostic code is added to the claim form and the therapy authorization request documentation. 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 month 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. *For example, a child with a traumatic brain injury returns home with support from OT, PT, and ST, at home and school, and Vermont Association for the Blind and Visually Impaired (VABVI) personnel. 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 very similar positioning goals and equipment goals on their request for a Medicaid extension. They discuss the care plan. 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 can be 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 cannot 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 cannot 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 and pets.*

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 Vermont 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 families/caregivers on the process of connecting the

family to school based Related Services. This will help demystify the process, and smooth the transition. It is important to discuss the differences between a One plan and an IEP (Individualized Education Program) if this is appropriate to the case. Families should be educated in the differences between school-based Related Services and home/community therapy services. **School -based Related Services support the child in accessing their Free and Appropriate Public Education (“FAPE”) in the Least Restrictive Environment (“LRE”). Home/community therapy services focus on providing medically necessary treatment specific to the home and community environment and training family/community based caregivers. It is an expectation of the home/community-based therapist, because the relationship with the child and family is already established, to actively prepare and facilitate the introduction of the child and family into the school system.** *For example, a child with autism is 2½. The home/community based therapists begin the process of educating the family about school model services and help them connect with the school district. They talk about the evaluation process, IEPs, 504 plans, Educational support (EST) plans, and other ways that a child may access therapy services in the school. They compare the IEP with the One plan the family understands the difference. They talk with the family about school-based Related Services and how they differ from the home/community based Therapy services. Both school and home/community therapists participate in transition planning to help smooth the transition. The school-based and home/community-based 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 the child continues to receive home/community based services in addition to school-based services.*

- Some families decide not to access the school system. **The medical model therapist must then make clear to the family that Medicaid-covered home/community based therapy services can never take the place of school-based therapy services.** The family needs to understand that the home/community based therapist cannot receive Medicaid coverage for academically related treatment. Families should be encouraged to work with their school districts to see what support might be available. *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-based speech therapy 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.*
- Home/community based therapists are not covered by Vermont Medicaid to provide **consultation with school based services:** to discuss cases with teachers, paraeducators, or any other school personnel. **Consultation** services must be covered by the school district. The home/community based therapist is expected to provide **collaboration:** to discuss the case with the school-based 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 home/community based therapist tries to contact the school model therapist regarding her treatment techniques for a child with autism. The home/community based therapist is using Applied Behavioral Analysis techniques. The school-based therapist does not respond to the calls. The school-based*

therapist 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 home/community-based therapist must clearly delineate the distinctions between his/her program and the school-based therapy 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 juvenile 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 activities of daily living (ADL) 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.*
- **Home/community-based therapists must understand that even though a child may not have a school-based 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 attention deficit disorder has handwriting issues. The home/community-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 cannot help this child, she will ask for an evaluation by the school-based Occupational Therapist. Teaching handwriting skills is generally done by classroom teachers, who have resources available to them if they require the assistance. The home/community-based OT must therefore not bill Medicaid for treatment related to handwriting.*
- **Vermont Medicaid does not support multiple therapists per discipline working simultaneously with a child.** Children with a high level of special needs typically have large home/community-based and school-based teams. Communication is a serious challenge between the many essential team members. 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 from home care 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 randomized control group, and the testers were not double blinded. The therapist cannot 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. Treatment techniques that do not have adequate research support at this time include, but are not limited to: sensory integration, craniosacral therapy, myofascial and visceral release, hippotherapy for conditions other than cerebral palsy, auditory integration therapy, hyperbaric oxygen treatment for brain injury, and facilitated communication.*
- **Families/caregivers 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 family/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 family/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 is ready to begin decreasing the frequency of services, the family/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. There is often a high turnover rate among daycare personnel which can result in less than optimal carry-over of the home program. It is not sufficient for therapists to be educating daycare providers and not family members in the home program.

- Vermont Medicaid provides a high level of support for Personal Attendant Care (PCA) Services.** PCAs are paid by the State of Vermont to provide for personal care services, including follow-through with home therapy programs. It is an expectation that therapists inquire if the child has a PCA during the initial evaluation. 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 and activities as 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 is in attendance during some 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 families/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!*