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Vermont Medicaid Physical Therapy/Occupational Therapy/Speech Language Therapy Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

Rehabilitative and Habilitative (re/habilitative) 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. Re/habilitative 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. Vermont Medicaid covers only medically necessary therapy services. Medical Necessity is defined in Medicaid Rule 7103. 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
- meet the criteria below

All services must be performed by a licensed PT, OT, or SLP 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 SLP services must be performed by individuals who are licensed in PT, OT, or SLP. 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 PT, OT, or SLP services provided by PT, OT, and SLP students who are enrolled in an accredited therapy program and who are treating Vermont 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, co-signature is required.

Section 2 Re/habilitative Therapy

Vermont Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in a preponderance of current peer reviewed medical literature.

All treatment must demonstrate medical necessity. See Section 4.7 below for specific examples.

2.1 Adult Coverage

Physical, Occupational, and Speech Language Pathology (PT, OT, ST) outpatient services for Vermont Medicaid eligible adults are limited to 30 combined visits per calendar year. See Section 4.1 for exceptions.

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.

The limit does not apply to services provided in inpatient facilities or by home health agencies.

Home Health Services: Physical, Occupational, and Speech Language Pathology home health services are covered for up to 4 months based on a physician's order, for a medical condition. Provision of therapy services beyond the initial 4-month period is subject to prior authorization.

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance was applied to the deductible, prior authorization is required for over 30 outpatient visits or for home health services.

2.2 Members Under Age 21

Home Health Services: Physical, Occupational, and Speech Language Pathology home health services are covered for up to 4 months based on a physician's order, for a medical condition. Provision of therapy services beyond the initial 4-month period is subject to prior authorization.

For treatment other than through a home health agency, the Department of Vermont Health Access is changing the Prior Authorization requirements effective 1/1/2020 for beneficiaries under the age of 21 from 'beyond eight therapy visits per discipline' to 'beyond eight therapy visits per discipline per calendar year. Provision of therapy services beyond the initial 8 visits is subject to prior authorization.

Providers must request prior authorization in advance of the 8th visit if additional therapy services are necessary.

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance was applied to the deductible, prior authorization is required for over 8 visits.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

Section 3 Coverage Position

PT, OT, and SLP services may be covered for beneficiaries:

1. When this service is prescribed by a medical provider* who is enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with their Vermont State Practice Act, who is knowledgeable regarding Re/habilitation Medicine, and who provides medical care to the beneficiary, AND
2. When the clinical criteria below are met, AND
3. Where the service is directly related to the active treatment of a medical condition designed by a qualified medical provider, AND
4. When the treatment requires such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required, AND
5. When the treatment is reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition. (Medicaid Rule 7317; HCAR Rule 4.231.4(h) (1) (A) and (B). https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar)

*Note: medical providers who may prescribe PT, OT, and SLP services are: medical doctors, doctors of osteopathy, naturopaths, physician assistants, dentists, and nurse practitioners.

Section 4 Coverage Criteria

Please Note: Pediatric rules apply until the date before the 21st birthday. Adult rules apply from the 21st birthday onward.

https://humanservices.vermont.gov/rules-policies/health-care-rules

4.1 Adult Clinic-Based Coverage

Per 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 acute diagnoses, and only if the beneficiary meets the criteria found in Medicaid Rule 7317:

- Spinal cord injury
- Traumatic brain injury
- Stroke
- Amputation
- Severe Burn

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. Changing programs or eligibility status within the calendar year does not reset the number of available visits. If a beneficiary turns 21 within a calendar year, visits done when under 21 will be counted toward the 30 allowed visits.

4.2 Home Health Coverage: Adult and Pediatric

Per Medicaid Rule 7317.3, and HCAR Rule 4.231, Re/habilitative therapy services provided by a home health agency are covered for up to four months based on a physician's order, for beneficiaries of any age. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified below.

The initial four-month period is based on condition. 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. For Vermont Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required.

4.3 Pediatric Non-Home Health Agency Coverage

For treatment other than through a home health agency, Department of Vermont Health Access is changing the Prior Authorization requirements effective 1/1/2020 for beneficiaries under the age of 21 from 'beyond eight therapy visits per discipline' to 'beyond eight therapy visits per discipline per calendar year.'

Providers must request prior authorization in advance of the 8th visit if additional therapy visits are medically necessary. Subsequent authorizations will be based on that start of care date.

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

4.4 Obtaining SAME DAY coverage

If a child has received therapy treatment within the past calendar year for 8 outpatient visits by any practitioner of the same discipline, or if 4 months of Home Health therapy services have already been performed in the past for the same condition, the current provider shall:

- See the beneficiary for the initial evaluation

- Contact the DVHA on the SAME DAY
- Submit documentation to request coverage WITHIN ONE BUSINESS DAY

4.5 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).

Per Medicaid Rule 7317:

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

Retroactive prior authorization:

There is no retroactive prior authorization, except:

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

Timetable:

A clinical review will be initiated within 3 working days of receipt of an actionable request. An actionable request includes the basic information required to enter the request into the Vermont Medicaid computer system. A Notice of Decision (NOD) 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 all of the additional information required to complete the clinical review is received within 28 days from the initial request, and the review results in an approval, 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).

Dual Eligible beneficiaries: Limitations and prior authorization requirements do not apply when Medicare is the primary payer.

Start date: The start date of a PA commences with the receipt of all the administrative information required to process the PA request ("an actionable request.") In order to prevent a delay in the start date, the request **must** have all the information on the appropriate form completed, including the PA request form signed by the Vermont Medicaid enrolled Provider.

Documentation for Authorization Requests: Therapists should utilize the Vermont Medicaid Request for Extension of Rehabilitation Therapy Services form. The form is available at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

Physical, Occupational and Speech Therapists who choose to submit extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

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

- Beneficiary name
- Birth date
- Beneficiary Vermont 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, collaboration as describe above, 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.

4.5.1 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid beneficiary.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

4.5.2 Errors in Documentation

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

4.5.3 Electronic signatures

Electronic signatures are acceptable.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at https://dvha.vermont.gov/providers

4.6 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 documents 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.

4.7 Clinical Guidelines for Repeat Service or Procedure

4.7.1 Under 21

Medically necessary treatment is covered until the 21st birthday. As of 1/1/2020, certification periods for outpatient services are based on the date of discipline-specific initial evaluation 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.

4.7.2 Adults and Children: Home Health

Additional coverage can be obtained through the prior authorization process as described above.

4.7.3 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. For those conditions only, prior authorization can be obtained through the prior authorization process as described above.

4.7.4 Type of service or procedure covered

In addition to the information provided above, services are covered that:

- Clearly demonstrate medical necessity, AND

- are research based: supported by a preponderance of current, peer reviewed medical literature, AND
- are focused on a collaborative approach to medical care, to ensure continuity of care across disciplines and over time

4.7.5 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, reflex integration treatment, dry needling, 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 Vermont 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, because it does not demonstrate medical necessity.
- Treatment when the discipline performing the service is not the most appropriate discipline covered by Vermont Medicaid.
- Treatment for conditions that are not clearly medical in nature.
- Concurrent services: Requests for concurrent services by providers from the same discipline will not be covered.

Section 5 Coding and Billing Guidelines

5.1 Diagnosis Codes that are Non-Reimbursable as Primary Diagnoses for Physical, Occupational, and Speech Language Pathology Services

Diagnosis codes on the claims and on prior authorization requests must match. The primary diagnosis codes listed must be for the underlying medical condition for the therapeutic intervention provided. Other therapy-specific diagnostic codes can also be listed as secondary.

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
- Are not clearly medical in nature
- Are not specific and therefore prevent meaningful clinical review
- Are for a symptom of an underlying medical diagnosis
- Are for a symptom of a medical diagnosis, where treatment of the symptom alone may be harmful to the beneficiary
- Demonstrate that PT, OT or SLP services are not the most appropriate service for the condition. 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

5.2 ICD-10 Codes That are Not Covered as Primary Diagnosis Codes for Therapy Services

E65	E6601	E6609	E661	E663	E668	E669
F411	F430	F4320	F4321	F4322	F4323	F4324
F4325	F4329	F438	F439	F4541	F4542	F54
F600-F609	F630-F6309	F632	F633	F6381	F6389	F639
F78	F79	F8089	F809	F810	F812	F8181
F8189	F819	F88	F89	F910	F911	F912
F913	F918	F919	F930	F938	F939	F940
F941	F942	F948	F949	F639	F988	F989
G44209	G479	G933	M2560	M25611	M25612	M25619
M25621	M25622	M25629	M255631	M25632	M25639	M25641
M25642	M25649	M25651	M25652	M25659	M25661	M25662
M25669	M25671	M25672	M25673	M25674	M25675	M25676
M6281	M629	M959	P926	R0602	R079	R262
R419	R448	R449	R450	R451	R453	R454
R4581	R4582	R4586	R4587	R4589	R460	R461
R462	R463	R464	R465	R466	R467	R4782
R479	R480	R489	R498	R499	R530	R531
R5381	R5383	R620	R6250	R6251	R6259	R632
R635	R6882	R6889	R69	R898	R899	R99

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

ICD10

F650-F659	F681-F688	F70	F71	F72	F73	F78
F79	F800	F801	F802	F8089	F809	F82
Q381						

5.3 Revenue and Procedure Codes for Hospitals, Outpatient clinics, and Home Health Agencies

Home health agencies bill using the revenue codes:

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

1 unit = 1 visit for home health agency billing.

Outpatient clinics including hospital outpatient clinics bill using the procedure codes:

29065	29075	29085	29086	29105	29125	29126	29130
29131	29200	29240	29260	29280	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520
29530	29540	29550	29580	29581	29582	29583	29584
29700	29705	29730	29740	29750	64550	92506	92507
92508	92526	92597	92605	92607	92608	92609	92610
92611	92618	95831	95832	95833	95834	95851	95852
95992	96105	96110	96111	96125	97010	97012	97014
97016	97018	97022	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113	97116	97124***
97139	97140	97150	97161	97162	97163	97164	97165
97166	97167	97168	97530	97532	97535*	97542	97597
97598	97602	97605	97606	97750**	97755*	97760	97761
97762	97799						

*This code is covered only for technology which is currently covered by Vermont Medicaid.

**This code is covered except for work or disability related functional capacity evaluations.

***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 reevaluation and must not be billed using a re-evaluation code.

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

5.4 Outpatient Therapy Modifiers

Vermont Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

- GN = Services delivered under an outpatient speech-language pathology plan of care
- GO = Services delivered under an outpatient occupational therapy plan of care
- GP = Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). Vermont Medicaid therapists need only reference the code list itself; do not use the column information.
http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

All therapy services (including codes listed as "Sometimes Therapy") that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

Some codes on this list are "Always Therapy" services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.

Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.

These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.

Modifiers may be reported in any order.

Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.

5.5 Correct Coding

Procedure Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.

Diagnosis Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. "Unspecified" diagnosis codes must be avoided whenever possible. The primary diagnosis code submitted must be the code for the underlying condition driving the care plan. Other pertinent diagnoses, including "therapy diagnoses" can be included but cannot be listed as the primary diagnosis code. A list of diagnosis codes that are not covered as primary diagnoses is included in the DVHA Therapy guidelines, available at: https://dvha.vermont.gov/providers.

Section 6 Billing Information

6.1 Other Insurance

Vermont Medicaid is the payer of last resort. Providers are required to apply all third-party payment resources prior to billing Vermont Medicaid. Examples of other payment resources include, Medicare, private/group health insurance plans, accident insurance, military and veteran's benefits, and worker's compensation.

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

Medicare beneficiaries or their providers must appeal through the Qualified Independent Contractor level prior to requesting Vermont Medicaid coverage. If these appeals are all denied, the beneficiary's provider may ask Vermont Medicaid to make an independent assessment of coverage and medical necessity. The Vermont Medicaid decision will be based on the same documentation submitted for the previous appeals.

6.2 Other Insurance Denial for Non-coverage or Exhausted Benefits

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 that the item or services is not a covered benefit or that the benefit limit was exhausted, and all necessary documentation to support medical necessity. No appeal to the primary insurance is required. DVHA then becomes primary insurance and Medicaid rules apply. The PA rules provide a 30-day transition period to assure continuity of service. The DVHA will not pay claims beyond the transition period unless the service has received prior authorization. Denial documentation must be included with requests for prior authorization.

6.3 Other Insurance 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 for lack of medical necessity by the primary insurer, the provider is required to seek review by the Vermont Department of Financial Regulation (VDFR). 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 all denials. No additional documentation can be submitted. 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.

6.4 Children's Integrated Services-Early Intervention (CIS-EI)

If a child has a condition that qualifies for Vermont Medicaid coverage of therapy services and has no other insurance, Vermont Medicaid is the pay source. If the child does not have a condition that qualifies for Vermont Medicaid coverage, then the bill will go directly to CIS EI for coverage, with no need for a Vermont Medicaid denial.

6.5 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. Vermont Medicaid will cover up to the additional 9 visits provided they are medically necessary.

All providers must determine whether the beneficiary has other insurance/Medicare benefits before rendering the service to minimize the risk of non-coverage by both the other insurance/Medicare and the DVHA. It is recommended that insurance status be reviewed before or during each visit.

6.6 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. Vermont 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, 15 minutes of therapeutic exercise, and 15 minutes of therapeutic activities. 3 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. Vermont Medicaid will only cover one hour of therapeutic services.

Section 7 Additional Adult and Pediatric Information for Providers

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: https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

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. As part of their evaluation process, therapists are expected to collaborate with other medical professionals who are concurrently treating the beneficiary and discipline-specific providers who have seen the beneficiary in the past, to ensure continuity of care and to avoid care "silos." These contacts must be documented in the information sent to the DVHA. If the beneficiary declines to allow collaboration, this must also be documented in the information sent to the DVHA.

Therapy goals must clearly demonstrate medical necessity, 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.