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Vermont Medicaid Physical Therapy/Occupational Therapy/Speech Language Pathology 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 Language Pathology (SLP). The definition and meanings of Occupational Therapy, Physical Therapy, and Speech Language Pathology 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 HCAR 4.101. Vermont Medicaid covers therapy services for members 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; 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. Documentation submitted to DVHA by PT or OT assistants must be cosigned by the member's PT or OT of record. 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 members 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 by a preponderance of current peer reviewed medical literature.

Telehealth services are a covered benefit. Best practice allows for the type of physical examination, tests, and measures which result in establishment of the diagnosis, management plan, and outcome measures. It includes a plan to allow for in-person visits if required, and the ability to monitor patient safety. There may be circumstances where an evaluation is done via telehealth when necessary to prevent delays in essential care. If the testing required to complete a thorough evaluation requires physical contact with the patient, telehealth-only service is not indicated. If the management plan requires the use of physical agents such as ultrasound, electrical stimulation, or light, or manual therapies such as joint mobilization, telehealth-only services are not indicated.

All treatment must demonstrate medical necessity.

Section 3 Coverage Position

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

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 member, **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 for services related to oral issues, and nurse practitioners.

Section 4 Coverage Criteria

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

4.1 Adult Outpatient Coverage

Beginning January 1, 2025, the number of outpatient PT, OT, and SLP visits allowed for adult members prior to needing prior authorization will be 60 combined PT, OT, and SLP outpatient visits per calendar year. These changes will include all members regardless of ACO attribution and regardless of medical condition.

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 member turns 21 within a calendar year, visits done when under 21 will be counted toward the 60 allowed visits before prior authorization is required.

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.

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 members 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 start of care date for the condition documented as primary. 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.

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.

4.3 Pediatric Non-Home Health Agency Outpatient Coverage

Beginning January 1, 2025, no prior authorization will be required for outpatient PT, OT, and SLP services. These changes will include all members regardless of ACO attribution.

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.

4.4 Obtaining SAME DAY Coverage

If an adult member has received therapy treatment within the calendar year for 60 outpatient visits by any PT, OT, and/or SLP, 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 member for the initial evaluation
- Contact the DVHA before or on the SAME DAY
- Submit documentation to request coverage WITHIN ONE BUSINESS DAY

4.5 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 60 adult outpatient visits or for home health services.

To receive prior authorization for additional services a physical or occupational therapist, or speech language pathologist must submit a written request to the Department of Vermont Health Access (DVHA) with pertinent data showing the medical necessity for continued treatment, objective measurable progress to date, projected goals, a plan of care with treatment specifics, and estimated length of time to reach the goals.

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 … 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 in a timely manner with 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 member, the therapist, and the referring 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 14 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 authorization period.

- Late 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 members: 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 required to complete the medical review, as listed below.

The DVHA has developed the DVHA Re/habilitation Therapy (PTOTST) Prior Authorization Request Form for your convenience. If you choose not to use the DVHA form, please submit documentation that addresses all the data points on the DVHA form, an initial evaluation/re-evaluation note, and a current progress note that demonstrates objective, measurable progress to date and current plan of care.

Prior authorization forms are available at the DVHA website at: https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

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

- Member name
- Birth date
- Member Vermont Medicaid number/unique identifier
- Supplying provider facility and provider facility's Medicaid number
- Referring physician/ advanced practice provider name and provider number
- Diagnoses, diagnosis codes, and dates of onset, which must match the diagnoses on the claim forms submitted. The initial diagnosis must be the underlying medical condition driving the medical need for treatment, not a sign or symptom
- The date of initial therapy for the condition (see above)
- Treatment frequency
- Patient-oriented goals with objective and measurable parameters
- Research based treatment plan that includes member/caregiver education, care coordination with other disciplines and previous therapist{s), and a discharge plan
- Objective, measurable results of any previous treatment goals
- Professional signature of the therapist
- Measurable progress to date

The therapy facility must have the initial referring provider referral on file.

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 member.

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 Electronic Signatures

Electronic signatures are accepted by Vermont Medicaid. All corrections to the medico-legal record, including the DVHA Prior Authorization Request 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.

4.6 Authorization Process Checklist

- Supplying provider fully completes the appropriate sections of the Therapy Prior Authorization Request Form OR comparable documents with all the required documentation as described above and, in the instructions, in addition to the form.
- For Home Health only: Supplying provider sends documents to referring provider for endorsement of the care plan.
- Supplying provider sends complete documents to DVHA for clinical review.
- If the request is put in Informational status, all requested information is sent to DVHA within 14 days or if required, and is in the best interest of the member, up to 28 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.

4.7.2 Adults and Under 21: Home Health

Additional coverage can be obtained through the prior authorization process.

4.7.3 Adults: Outpatient Services

Additional coverage can be obtained through the prior authorization process.

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 coordinated approach to medical care, to ensure continuity of care across disciplines and over time **AND**
- are comprehensive in nature.

4.7.5 Type of Service or Procedure Not Covered

(This list may not be all inclusive)

- 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, cupping, 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, now known as HireAbility, Worker's Compensation, and the public education system.
- Treatment related to avocational/recreational/sports/leisure goals, because it does not clearly 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 without a clear rationale demonstrating medical necessity for concurrent care.

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 member.
- 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):

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

1 unit = 1 visit for home health agency billing.

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

16020	16025	16030	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	90901	90912	90913	92507	92508	92521	92522
92523	92524	92526	92597	92607	92608	92609	92610
92611	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***	97129****	97130****	97139	97140	97150
97161	97162	97163	97164	97165	97166	97167	97168
97530	97532	97535*	97542	97550*****	97551*****	97552*****	97597
97598	97602	97605	97606	97750**	97755*	97760	97761
97762	97763	97799	G0283				

*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).
**** These codes will be covered for members with moderate to severe brain injury and stroke.
***** These codes will be covered for the rare occasion when it is necessary to train caregivers without the member present. The standard for caregiver training is to do so with the member present. The therapist must clearly document the reason for the deviation in the standard of care.

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 language pathologists, occupational therapists 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. https://www.cms.gov/medicare/coding-billing/therapy-services/annual-therapy-update

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: treatment must be billed under the most specific code. Billing a non-covered service under a different code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.

Diagnosis Codes: 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.

Section 6 Billing Information

6.1 Other Insurance

Refer to section 1 of the Vermont Medicaid General Billing and Forms manual, https://vtmedicaid.com/#/manuals, for information about Other Insurance. For information regarding copays, please see section 1.5. For information regarding deductibles, see section 1.1. Note that when the entire allowed amount is applied to the primary insurance deductible, VT Medicaid rules regarding prior authorization apply. See section 4 of this manual.

6.2 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.

6.3 Primary Insurance and the Outpatient 60 Visit Limit

To ensure fairness for all members, the 60-visit limit before prior authorization is required applies whether or not the member also has a primary insurance.

For example, a member has a primary insurance that covers 21 visits.

Vermont Medicaid will cover up to the additional 39 visits before prior authorization is required, provided they are medically necessary.

All providers must determine whether the member 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.

6.4 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 timed 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. The exception is for wheelchair evaluations.

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 member is seen for an hour-long session of physical therapy services. The member 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 member is seen for a session of physical therapy services. Although the member 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 Information for Providers

The DVHA has developed the DVHA Re/habilitation Therapy (PTOTST) Prior Authorization Request Form for your convenience. If you choose not to use the DVHA form, please submit documentation that addresses all the data points on the DVHA form, an initial evaluation/re-evaluation note, and a current progress note that demonstrates objective, measurable progress to date and current plan of care. A physician endorsement of the current plan of care is also required for home health services only.

Prior authorization 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 member in their return to a full and productive life post injury. As part of their evaluation process, therapists are expected to coordinate care with other medical professionals who are concurrently treating the member and discipline-specific providers who have seen the member in the past, to ensure continuity of care and to avoid care "silos." These contacts must be documented in the medical record and in the information sent to the DVHA. If the member declines to allow care coordination, this must also be documented. Care coordination for children includes school and/or sports personnel such as coaches or athletic trainers, given parental permission. Care coordination for adults includes community resources such as the Department of Vocational Rehabilitation ("HireAbility") and the VT Center for Independent Living. Proper evaluation coding, with clear evidence regarding medical complexity, is required.

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

Therapy plans of treatment, including frequency, must be research-based, comprehensive, and have a focus on member/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. Plans must include specific treatment techniques and modalities that will be utilized.

Section 8 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

Section 9 Desk Audit

The Department of Vermont Health Access (DVHA) uses different utilization management strategies, including retrospective audits. Providers should maintain records accordingly. Please see the resources below for further information:

- Information about desk audits can be found in the General Billing and Forms Manual at: https://dvha.vermont.gov/providers/manuals.
- Additional information about provider requirements can be found in provider enrollment and contractual documents at: https://www.vtmedicaid.com/#/providerEducation.