OTHER MEDICAID SERVICES (7400)

Section 7401 Home Health Agency Services.

Home health agencies provide a variety of services including skilled nursing, therapies, aide services and medical social work to beneficiaries in their home. This definition is consistent with the federal definition found at 42 CFR 440.70.

7401.1 Eligibility for Care

Coverage for home health agency service is provided to beneficiaries of any age. Coverage for targeted case management services is limited to at-risk children ages one to five.

7401.2 Covered Services

Home health agency services that have been pre-approved for coverage are limited to:

-- skilled nursing care services;

-- rehabilitative therapy services (as specified in Medicaid Rule 7317.3);

-- home health aide services;

-- medical supplies, equipment and appliances suitable for use in the home; and

-- targeted case management.

7401.3 Conditions for Coverage

Home health care services are covered when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met.

A. General Conditions

For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required. The patient's condition may be either an episode of acute illness or injury or a chronic condition requiring home health care under a physician's order.

Payment for home health services will not be made to any agency or organization that is operated primarily for the care and treatment of a mental disease.

B. Requirement for a Written Plan

Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patient. The plan relates the items and services to the patient's condition as follows:

-- The plan includes the diagnosis and description of the patient's functional limitation resulting from illness, injury or condition.

-- It specifies the type and frequency of needed service, ie. nursing services, drugs and medications, special diet, permitted activities, therapy services, home health aide services, medical supplies and appliances.

-- It provides a long-range forecast of likely changes in the patient's condition.

-- It specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's oral orders.

-- The plan is reviewed by the attending physician, in consultation with professional agency personnel every 62 days, or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature.

-- The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a home health agency in the patient's place of residence.

C. Location Where Service is Provided

The service or item is furnished in the beneficiary's place of residence. A place of residence includes beneficiary's own dwelling; an apartment; a relative's home; a place where patients or elderly people congregate such as senior citizen or adult day center; a community care home; and a hospital or nursing home but the last two only for the purpose of an initial observation, assessment and evaluation visit.

D. Coverage of Initial Visit

An initial visit by a registered nurse or appropriate therapist to observe and evaluate a beneficiary either in the hospital, nursing home or community for the purpose of determining the need for home health services is covered. If physician-ordered treatment is given during the initial visit, the two services may not be charged separately.

E. Requirements Specific to Nursing Care

Nursing care services are covered when the services are related to the care of patients who are experiencing acute or chronic periods of illness and those services are:

-- ordered by and included in the plan of treatment established by the physician for the patient; and

-- required on an intermittent basis; and

-- reasonable and necessary to the treatment of an illness, injury or condition.

F. Requirements Specific to Home Health Aide Services

Services of a home health aide are covered when assigned in accordance with a written plan of treatment established by a physician and supervised by a registered nurse or appropriate therapist. Under appropriate supervision, the home health aide may provide medical assistance, personal care, assistance in the activities of daily living such as helping the patient to bathe, to care for hair or teeth, to exercise and to retrain the patient in necessary self-help skills. In cases where home health aides are assigned to patients requiring specific therapy, the home health aide must be supervised by the appropriate therapist; however, it is not necessary in these cases to require an additional supervisory visit by the nurse to supervise the provision of personal services. During a particular visit, the home health aide may perform household chores (such as changing the bed, light cleaning, washing utensils, assisting in food preparation) that are incidental to the visit. Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 62 days, and more frequently if necessary.

G. Requirements Specific to Medical Supplies

Medical supplies are covered when they are essential for enabling home health agency personnel to effectively carry out the care and treatment that has been ordered for the patient by the physician and used during the visit. These items include catheters, needles, syringes, surgical dressings, and materials used for dressings such as cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, and intravenous fluids and oxygen. Certain supplies are not covered; see 7401.5.

H. Requirements Specific to Durable Medical Equipment

The rental of durable medical equipment (DME) included on the list of DME items pre-approved for coverage (see 7505.2), that the home health agency owns and is used by a patient as part of the plan of care, is covered when the conditions of coverage, where applicable, as described in 7505.3 are met. Coverage of rental of a specific item of DME may be subject to prior authorization (see 7505.4). The DME coverage limitations described in 7505.5 also apply to DME provided by a home health agency.

I. Requirements Specific to Targeted Case Management Services

Targeted case management services are provided only to children ages one to five who are at-risk for unnecessary and avoidable medical interventions and who do not have another primary case management provider whose responsibility is to provide or coordinate the interventions included in this service. The Vermont Department of Health will review and determine how many targeted case management visits shall be authorized to at-risk children ages one to five.

7401.4 Non-Covered Services

With the exception of services authorized for coverage via 7104, services not included under 7401.2 and services that do not meet criteria specified in 7401.2-7401.4, where applicable, are not covered.

Routine low-cost medical supplies, such as cotton balls and tongue depressors, are deemed to be included in the home visit charges and will not be paid for separately.

7401.5 Qualified Providers

Home health agency providers must be a Medicaid-certified provider and be enrolled with Vermont Medicaid.

7401.6 Reimbursement

Reimbursement for home health agency services is described in the Provider Manual. If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Medicaid reimbursement is requested.

Section 7402 Hospice Services.

Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act.

Hospice services must be rendered by a Medicare certified hospice and be provided in accordance with Medicare regulations.

Recipients of hospice care are required to sign an election of hospice care which waives all other Medicaid coverage except the services of a designated family physician, ambulance service and services unrelated to the terminal illness.

Payment to enrolled hospice providers will be made at the daily rates set by Medicare for each provider. The total number of days of hospice coverage is limited to 210 days. Rates of payment and total reimbursement for hospice care will be made in accordance with Medicare reimbursement and audit principles.

Medicaid will make no payment to the hospice selected by the Medicaid recipient for any services or supplies other than the hospice service.

The hospice may not charge any amount to or collect any amount from the recipient or the recipient's family for a covered hospice service during the period of hospice coverage.

Section 7403 Clinic Services.

Covered clinic services include the following:

Covered physicians' services billed by the clinic on the physician's behalf under an agreement with the physician; and

Services and medical supplies furnished by the clinic incident to covered physicians' services.

7403.1 Mental Health Clinics.

For policies, amount, duration and scope of benefits, and reimbursement rates, see the Department of Mental Health regulations #81-A20. The Department of Mental Health is also responsible for determining provider eligibility as a Community Mental Health Clinic.

7403.2 Indian Health Service Facilities.

Indian Health Service facilities are accepted as providers on the same basis as other qualified providers. The facility need not obtain a license, but must meet all applicable standards for licensure.

7403.3 Rural Health Clinics.

Coverage is limited to rural health clinics which have been certified for participation in Medicare as evidenced by a current agreement signed by the Secretary of HEW.

Reimbursable rural health clinic services are:

Services performed by a physician who is employed by the clinic to provide such services; and

Services and supplies incident to a physician's service if they are of a type commonly furnished in physicians' offices; of a type commonly rendered either without charge or included in the rural health clinic's bill; furnished as an incidental, although integral, part of a physician's service; furnished under the direct, personal supervision of a physician; and, in the case of a service, furnished by a member of the clinic's health care staff. Only drugs and biologicals which cannot be self-administered are included in this benefit (see Section M800 for pharmaceutical items); and

Nurse practitioner and physician assistant services if they are furnished by a qualified professional employed by the clinic; furnished under the medical supervision of a physician; furnished in accordance with medical orders prepared by a physician; of a type the practitioner is legally permitted to perform in the State; and of a type that would be coverable if furnished by a physician; and

Services and supplies incident to a nurse practitioner's or physician assistant's services if they are of a type commonly furnished in physicians' offices; of a type commonly rendered either without charge or included in the clinic's bill; furnished as an incidental, although integral, part of professional services of a nurse practitioner or physician assistant service;

furnished under direct personal supervision of a nurse practitioner or physician assistant; and, in the case of a service, furnished by a member of the clinic's health care staff. Only drugs and biologicals which cannot be self-administered are included in this benefit (see Section M800 for pharmaceutical items).

Payment for rural health clinic services will be made in accordance with rates established for purposes of reimbursement under Medicare as provided in 42 CFR 405.2425.

Section 7405 Laboratory and Radiology Services.

Covered laboratory and radiology services include the following:

-- Microbiological, serological, hematological and pathological examinations; and

-- Diagnostic and therapeutic imaging services; and

-- Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations.

Coverage is extended to independent laboratories and radiological services approved for Medicare participation for services provided under the direction of a physician and certification that the services are medically necessary.

When the place of service is "hospital inpatient", coverage for the technical component is included in the per diem hospital reimbursement. When the place of service is "hospital outpatient", coverage is included in the hospital reimbursement on the outpatient claim form for the technical component. Reimbursement for the professional component will be made only to a physician.

Anatomic pathology services form an exception to the place of service and component coverage. Total procedure codes may be used for anatomic pathology services performed by a laboratory outside the hospital in which the beneficiary is an inpatient or for an independent laboratory performing tests for registered inpatients.

7405.1 Limitations:

Laboratory services for urine drug testing is limited to eight (8) tests per calendar month for beneficiaries age 21 and older. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients.

7405.2 Prior Authorization - Radiology

The following outpatient high-tech imaging services require prior authorization:

-- computed tomography (CT) (previously referred to as CAT scan);

-- computed tomographic angiography (CTA);

-- magnetic resonance imaging (MRI);

-- magnetic resonance angiography (MRA);

-- positron emission tomography (PET); and

-- positron emission tomography-computed tomography (PET/CT).

The following imaging services do not require prior authorization:

-- those provided during an inpatient admission;

-- those provided as part of an emergency room visit;

-- x-rays, including dual x-ray absorptiometry (DXA) images;

-- ultrasounds; or

-- mammograms.

7504.3 [7405.3] Prior Authorization - Laboratory

Exceptions to the limitations in 7504.1 must be prior approved.

Section 7406 Personal Care Services.

Section 7406.1 Definitions

As used in these regulations:

(a) "Activities of Daily Living" (ADL) includes dressing; bathing; grooming; eating; transferring; mobility; and toileting.

(b) "Employer" means the individual or entity who is responsible for the hiring of and ensuring payment to the provider.

(c) "Functional Evaluation Tool" means a standardized assessment tool to assist in the determination of medical necessity for personal care services.

(d) "Instrumental Activities of Daily Living" (IADL) includes personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(e) "Medical Necessity" shall have the same meaning as Section 7103 of this rule.

(f) "Personal care services" means medically necessary services related to ADLs and IADLs that are furnished to an individual who is not an inpatient or resident of a

hospital, nursing facility, intermediate care facility for people with developmental disabilities, or institution for mental disease.

(g) "Personal Care Attendant" means an individual at least 18 years of age having successfully passed required background checks who provides the personal care services to a child. A personal care attendant may not be a biological or adoptive parent, guardian, shared living provider, foster parent, step-parent, domestic/civil union partner of the child's primary caregiver, or a relative serving in the primary caregiver capacity.

7406.2 Eligibility Criteria.

To be eligible for Personal Care Services a child must:

(a) Be under the age of 21;
(b) Have active Medicaid enrollment;
(c) Have a medical condition, disability or cognitive impairment as documented by a physician, psychologist, psychiatrist, physician's assistant, nurse practitioner or other licensed clinician and;
(d) Qualify for medically necessary personal care services based on functional limitations in age-appropriate ability to perform ADLs.

7406.3 Covered Services.

A. Covered personal care services must be medically necessary and shall include:

1. Assistance with ADLs; such as bathing, dressing, grooming, bladder, or bowel requirements;
2. Assistance with eating, or drinking and diet activities;
3. Assistance in monitoring vital signs;
4. Routine skin care;
5. Assistance with positioning, lifting, transferring, ambulation and exercise;
6. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the assistance with ADLs;
7. Assistance with home management IADLs that are linked to ADLs, and are essential to the beneficiary's care at home;
8. Assistance with medication management;
9. Assistance with adaptive or assistive devices when linked to the ADLs;
10. Assistance with the use of durable medical equipment when linked to the ADLs;
11. Accompanying the recipient to clinics, physician office visits, or other trips which are medically necessary.

B. Services shall be individualized and shall be provided exclusively to the authorized individual.

C. Payment for services shall not exceed the amount awarded.

D. Prior authorization shall be required prior to the provision of personal care services.

E. Services must be provided in the most cost effective manner possible.

7406.4 Personal Care Attendant.

A. A personal care attendant may be employed:
   i. By home health agencies, nursing service agencies, or other agencies designated to furnish this service; or
   ii. Directly by the recipient, family, guardian, or guardian's designee (known as self/family/surrogate directed services). In the case of self, family, or surrogate direction, the employer must use the state-sanctioned fiscal employer agent for payroll and administrative services.

B. Personal care attendants may be paid within the awarded amount:
   i. The current Medicaid rate on file. The current Medicaid rate is published on the website of the Department of Vermont Health Access and may be found at http://dvha.vermont.gov/ and is hereby incorporated by reference; or
   ii. A flexible wage. The flexible wage shall not be lower than the current Medicaid rate on file, but may be reasonably higher.
   iii. The recipient, if an adult between the ages of 18 and 21, or his or her guardian, or the parent or guardian of a minor child, may select the personal care attendant's reasonable rate of pay. Different rates of pay may be paid to different personal care attendants providing services to the same child.

C. Personal Care Attendant Wages and Payroll Taxes –The employer is responsible for paying the appropriate payroll taxes out of the awarded amount.

D. A personal care attendant may provide personal care services to only one recipient at a time.

7406.5 Determination of Personal Care Services

A. The State shall from time to time adopt and designate for use a functional evaluation tool.

B. The functional evaluation tool shall assist in measuring the level of assistance a recipient requires in activities of daily living and such instrumental activities of daily living linked to the recipient's ADLs.

C. Reevaluations will occur in accordance with the following:
   i. Annually through age 5;
   ii. Changing to every 3 years if the child has two consecutive years of the same evaluation outcome; or
   iii. When there is a change in the child's ability to perform ADLs and IADLs.

Section 7407 Ambulance Services.

In order for ambulance services provided to eligible Medicaid recipients to be covered, the following conditions must be met:

The vehicle and personnel must be certified for participation in Medicare; and

Other methods of transportation must be medically contra-indicated. No payment will be

made when some means of transportation other than an ambulance could have been used without endangering the individual's health; and

The ambulance service must be ordered by a physician or certified as to necessity by a physician at the receiving facility; and

The patient must be transported to and accepted as an inpatient or as an emergency outpatient in an institution (i.e., a hospital or skilled nursing facility) whose locality (i.e., the service area surrounding the institution from which individuals normally come or are expected to come) encompasses the place where the transportation began and which would be expected to have the appropriate facilities for the treatment of the injury or illness involved. Coverage is also provided for transporting of an inpatient of a hospital or skilled nursing facility to his home.

Prior authorization from the State Medicaid Division Office in Waterbury is required to qualify for reimbursement for transportation to an out-of-state hospital. An out-of-state hospital is any hospital located outside the borders of Vermont except those listed in M500.

Non-Covered Services

Ambulance services provided to a hospital inpatient for the purpose of transporting the patient to and from another facility for outpatient services not available at the hospital where the patient was admitted are not covered.

7407.1 Reimbursement.

Payment for ambulance services will be at the lower of:

The actual charge made for the base rate for the trip and each loaded mile; or

the Medicaid reimbursement rate on file.

The provider must accept Medicaid payment as payment in full. Supplementation from any source is prohibited.

Section 7408 Transportation.

Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.

The following limitations on coverage shall apply:

1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)

2. Transportation is not otherwise available to the Medicaid recipient.

3. Transportation is to and from necessary medical services.

4. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.

5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.

6. Reimbursement for the service is limited to enrolled transportation providers.

7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.

8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

Section 7409 Planned Parenthood of Vermont.

Covered family planning services include medically oriented services furnished by Planned Parenthood of Vermont, Incorporated (PPV). "Medically oriented" services are those furnished

Directly by physicians, registered nurses and licensed practical nurses employed by PPV; and

By auxiliary personnel such as aides, counsellors and technicians but only when there is direct supervision by the physician.

Direct supervision requires that the physician be on the premises during the time services of auxiliary personnel are rendered.

Family planning services furnished by PPV will be reimbursed at the negotiated rates.

These are all-inclusive rates and no additional payment will be made for tests, drugs, supplies or contraceptive devices.

All payments made to PPV will be deemed to qualify as family planning services and subject to the increased Federal financial participation contained in Section 1903(a)(5) of the Social Security Act. Similarly family planning services and supplies provided by other participating physicians, pharmacies and hospitals will qualify for the increased Federal match.

Section 7410 Early and Periodic Screening, Diagnosis and Treatment (EPDST).

Section 403(g) of the Social Security Act and 45 CFR 249.10 (b)(4)(iii) require the state agency for Medicaid to develop a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) in three basic areas:

Informing all ANFC families of the availability of child health screening services; and

Providing or arranging for the provision of such screening services in all cases where they are requested; and

Arranging for further diagnosis and corrective treatment, the need for which is disclosed by screening services.

7410.1 Informing.

ANFC families are informed of EPSDT services by means of the following:

District Office staff explanation of EPSDT to each family during initial determination and each redetermination of eligibility; and

A mailing piece outlining EPSDT enclosed with all ANFC checks at least once during each calendar year; and

Informational brochures about EPSDT are displayed at each District Office and distributed throughout the State for use in hospitals, physicians' offices, day care centers, and other appropriate locations; and

Outreach activities to enlist participation of Medicaid eligibles in EPSDT performed by staff employed by the Department of Health under a special agreement with DSW.

7410.2 Screening and Outreach.

Under the terms of the special agreement, the Department of Health makes available the complete EPSDT screening package through its Well-Child Conferences. In addition, DSW reimburses physicians, clinics, and other appropriate providers directly through its fiscal agent for screening services they may furnish to EPSDT eligibles.

7410.3 Corrective Treatment.

The family receives information about the health care resources available in the community that furnish further diagnostic and treatment services. Department of Health staff offers assistance, when requested, in securing services from these providers. At suitable intervals, followup contacts are made with the family to encourage them to pursue treatment plans to completion.

7410.4 Rates of Payment.

The Department of Health is reimbursed pursuant to the agreement. Other providers furnishing EPSDT services are reimbursed in accordance with the appropriate section of these regulations; e.g., physicians are reimbursed as per Section M600.

Section 7411 Private Non-medical Institutions.

A Private Non-Medical Institution (PNMI) is a facility that provides medical care to its residents. The facility is enrolled as a Medicaid provider and receives Medicaid reimbursement for the actual medical services that are provided to Medicaid beneficiaries residing in the facility. This definition of a PNMI is consistent with federal regulations at 42 CFR § 434.2.

7411.1 Residential Child Care Facilities.

Vermont Medicaid reimburses for medical services provided to beneficiaries who are residents of private non-medical institutions for child care services.

These facilities are residential child care facilities that are maintained and operated for the provision of child care services, as defined in 33 VSA 306, and are licensed by the Department of Social and Rehabilitation Services under the "Licensing Regulations for Residential Child Care Facilities".

Services may be provided by physicians, psychologists, R.N.s, L.P.N.s, speech therapists, occupational therapists, physical therapists, licensed substance abuse counselors, Masters degree social workers, and other qualified staff carrying out a plan of care. Such plans of care, or initial assessments of the need for services, must be prescribed by a physician, psychologist, or other licensed practitioner of the healing arts within the scope of his/her practice under State law.

7411.2 Prior Authorization.

All admissions to private non-medical institutions for which Medicaid reimbursement is anticipated must be prior authorized by the placing agency, i.e., the Department of Social and Rehabilitation Services, the Department of Developmental and Mental Health Services, or the Department of Education or Local Education Agency.

7411.3 Reimbursement.

Reimbursement for these services is made at per diem rates based on a cost-based prospective rate setting system as described in the Private Non-Medical Institution section of the Medicaid Practices and Procedures Manual. Such rates include the following three components:

1. treatment,

2. room, board, and supervision

3. education.

No Medicaid reimbursement is made for the room and board or educational components of the rates.

7411.4 Assistive Community Care Facilities.

Vermont Medicaid reimburses for medical services provided to beneficiaries who are residents of private non-medical institutions providing assistive community care services.

These PMNI facilities must be licensed by the Department of Aging and Disabilities as level III residential care homes and must be in good standing with the licensing agency in order to become a certified Medicaid provider.

The medical services provided in an Assistive Community Care facility include:

Case Management: Case management assists residents in gaining access to needed medical, social, and other services in order to promote the resident's independence in the facility. In addition case management includes coordinating referrals required to link the resident and family to services specified in the resident's plan of care, and consultation to providers and support person(s).

Assistance with the Performance of Activities of Daily Living: Assistance with the performance of activities of daily living includes help with meals, dressing, movement, bathing, grooming, or other personal needs.

Medication Assistance, Monitoring and Administration: Medication assistance, monitoring and administration include those activities defined and described in the Vermont Residential Care Home Licensing Regulations adopted 10/7/93 at 2.2b, 2.2.a, and 5.9 (see pages 3, and 25 - 31).

24-hour On-site Assistive Therapy: Assistive therapy includes activities, techniques or methods designed to improve cognitive skills or modify behavior. Assistive therapy is furnished in consultation with a licensed professional, such as a registered or practical nurse, physician, psychologist, mental health counselor, clinical social worker, qualified mental retardation professional (QMRP), or special educator.

Restorative Nursing: Restorative nursing includes services that promote and maintain function. Restorative nursing services are specified in the resident's service plan and may be provided in a group setting.

Nursing Assessment: Nursing assessment includes completion of an initial and periodic reassessment of the resident, and other skilled professional nursing activities that include evaluation and monitoring of resident health conditions and care planning interventions to

meet a resident's needs at the times specified by the Vermont Residential Care Home Licensing Regulations for Level III residential care homes.

Health Monitoring: Health monitoring includes resident observation and appropriate reporting or follow-up action by residential care home staff, in accordance with the Residential Care Home Licensing Regulations adopted 10/7/1993.

Routine Nursing Tasks: Routine nursing tasks are performed by trained personal care or nursing staff with overview from a licensed registered nurse in accordance with the Vermont Residential Care Home Licensing Regulations adopted 10/7/1993 and the Vermont Nurse Practice Act. Assistive Community Care Services reimbursement is not designed to compensate for care which requires a variance under the Vermont Residential Care Home Licensing Regulations adopted 10/7/1993, or which cannot be performed while meeting the needs of the total resident population of a home.

7411.5 Reimbursement.

Reimbursement for assistive community care services is made at a single per diem rate for all residential care homes enrolled in Medicaid to provide this service. This reimbursement does not cover room and board services provided to Medicaid beneficiaries.