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Didn't find what you were looking for? Additional Vermont Medicaid rules can be found on the Agency of Human Services website:

- Health Care Administrative Rules (HCAR)
- Health Benefits Eligibility and Enrollment Rules (HBEE)

7101 Medicaid Benefit Delivery (06/01/2018, GCR 17-090)

7101.1 Overview

The following includes steps the department, the eligible Medicaid beneficiary and the medical care provider must take for the provider to receive payment for services given to the beneficiary.

(a) The department must:

(1) Give each Medicaid eligible person an identification document showing that the person has been found eligible for Medicaid; and
(2) Accept and process all provider claims itself or through its administrative agent; and
(3) Notify providers of decisions on claims and pay approved claims.

(b) The beneficiary must:

(1) Tell the provider he or she wants the provider's services charged to Medicaid; and
(2) Advise the provider if he or she has private health insurance coverage in addition to Medicaid; and
(3) Accept liability for any applicable co-payment; and
(4) Show the provider his or her identification document if it has been issued.

(c) The provider must:

(1) Verify that the beneficiary is still eligible for Medicaid on the date the service is provided; and
(2) Bill any other liable third parties prior to billing Medicaid; and
(3) Accept the Medicaid payment rate as payment in full and bill the beneficiary only for any applicable co-payments once Medicaid has been accepted as a source of payment; and
(4) Give a Medicaid covered service; and
(5) File a claim with the department or its agent, including all necessary information about the service and the identifying information from the beneficiary's identification document.

7101.2 Disenrollment of Beneficiaries

(a) In rare instances, it may become necessary to pursue disenrollment of beneficiaries who are intentionally unresponsive to basic managed care expectations. The following may be disenrolled:

(1) Beneficiaries who pose a threat to plan employees or other members.
(2) Beneficiaries who regularly fail to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by the managed health care plan.
(3) Beneficiaries who do not cooperate with treatment and have not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by the plan.

(b) Grounds for disenrollment does not include beneficiaries who have cooperated with the plan in its effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

(c) Plan disenrollment requests must conform to criteria for disenrollment established by the department. Managed health care plans must notify the affected member, or his or her designated

representative, in writing, of a plan-initiated request for disenrollment. Only the department may disenroll a member from a managed health care plan.

(d) Beneficiaries remain in the managed health care plan until the department decides to disenroll the beneficiary. Beneficiaries are notified of this decision in writing and of their right to request a fair hearing before the Human Services Board. Medicaid beneficiaries who are disenrolled, unless enrolled in another managed health care plan or the PCCM program immediately thereafter, will receive services through the traditional fee-for-service system.

7101.3 Primary Care Case Management (PCCM)

The primary care case management (PCCM) program is a managed health care service delivery system that requires a beneficiary to choose a primary care provider (PCP) and to access specified medical care through this provider. The primary care provider (PCP) will provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services.

(a) Definitions

(1) **"Adverse determination"** means a determination by the DVHA that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the DVHA's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.
(2) **"Certification"** means a determination by the DVHA or its designated utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the DVHA's requirements for medical necessity, appropriateness, health care setting, level and intensity of care and effectiveness.
(3) **"Clinical review criteria"** means the written screening procedures, decision abstracts, clinical protocols, practice guidelines and utilization management and review guidelines used by the DVHA to determine the necessity and appropriateness of health care services.
(4) **"Concurrent review"** means utilization review conducted during a beneficiary's hospital stay or course of treatment.
(5) **"DVHA"** means the Department of Vermont Health Access.
(6) **"Health care services"** or **"services"** means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
(7) **"Primary care provider"** means family practitioners, general internists, pediatricians, or doctors of general medicine that shall provide and coordinate medical care for the beneficiary as defined in 7101.3(b).
(8) **"Retrospective review"** means utilization review of medical necessity that is conducted after services have been provided to a beneficiary, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.
(9) **"Second opinion"** means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the proposed service.

(10) **"Urgently-needed care"** or **"urgent care"** means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.

(11) **"Utilization review"** means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

(b) Primary Care Provider (PCP)

Under this system a payment is made to the primary care provider (PCP) each month for case management services provided to each beneficiary enrolled with the PCP. Family practitioners, general internists, pediatricians, or doctors of general medicine, that are enrolled with Vermont Medicaid may become a PCP in the PCCM program. Specialists may become a PCP only under the conditions described below. The PCP selected by a beneficiary shall coordinate needed medical services. PCPs will be responsible for providing beneficiaries with referrals to specialists when in their judgement it is considered medically necessary; for coordinating all ancillary, outpatient and inpatient services; and for preventing the duplication of services.

If a beneficiary has either a life-threatening condition or disease, or a degenerative or disabling condition or disease, that requires specialized medical care over a prolonged period of time, a specialist with expertise in treating the condition or disease may act as the beneficiary's PCP. If a specialist agrees to act as the PCP, the specialist shall provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services. The DVHA Medical Director must review and approve of such arrangements before a specialist may become the PCP. If the request is denied by DVHA, the beneficiary has the right to appeal DVHA's decision and to request a fair hearing.

(c) Change of Primary Care Provider (PCP)

Enrollees may change their primary care provider (PCP) for any reason every 30 days. Primary care provider changes will become effective on the first day of the following month, if all required actions have been completed by the fifteenth of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

If a beneficiary has to change PCP as a result of his or her PCP restricting or terminating participation in the PCCM program, the DVHA will assist the beneficiary in selecting another PCP in order to assure continuity of care.

(d) Procedures for Utilization Review Decisions

(1) The DVHA shall maintain written procedures for making utilization review decisions and for notifying beneficiaries, representatives of beneficiaries, and providers acting on behalf of beneficiaries of its decisions.

(2) For initial and concurrent review determinations, the DVHA shall, within three (3) working days of obtaining all necessary information regarding the admission, procedure or service requiring a review determination, make the determination and notify the treating provider of the determination by telephone. Written confirmation of the determination will be sent to the provider within twenty-four (24) hours of the telephone notification.

(i) In the case of an adverse concurrent review determination, the beneficiary shall not be liable for any services provided before notification to the beneficiary of the adverse determination. Benefits will continue if a fair hearing is requested.
(ii) The DVHA shall establish procedures to expedite initial and concurrent review determinations in cases involving urgently-needed care. In no event shall the DVHA take more than twenty-four (24) hours from the time the service is first requested to make an initial or concurrent review determination for such services.

(3) The DVHA shall conduct retrospective review determinations consistent with federal requirements.

(4) A written notification of an adverse determination shall include the principal reason or reasons for the determination and instructions on how to appeal the determination and how to request additional information. Within 90 days of PCCM program implementation, the DVHA will add to the written notification, the clinical rationale for the determination including an explanation of the clinical review criteria used to make the determination. The DVHA shall make the actual clinical review criteria available to the beneficiary upon request.

(5) The DVHA shall act promptly and in good faith to obtain the information necessary to make utilization review decisions. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(6) The DVHA shall have written procedures to address the failure or inability of a provider or a beneficiary to provide all necessary information for utilization review, which shall include a description of the information required for the review. Copies of the procedures are available to all network providers. In cases where the provider or beneficiary will not release the necessary information, the DVHA may deny certification. In no event shall the DVHA penalize a provider for failing to provide a beneficiary's medical records to the DVHA when the beneficiary has not authorized release of the records and the provider is not otherwise obligated by law or regulation to disclose the records.

(e) Network Adequacy

The DVHA will not require any beneficiary to be assigned to the PCCM program unless covered health care services, including referrals to participating specialty physicians, are accessible to members on a timely basis, as follows. The DVHA will make a good faith effort to attract sufficient numbers and types of providers to ensure that all covered health care services will be provided without unreasonable delay.

(1) Travel times for PCCM beneficiaries, under normal conditions from their residence or place of business, generally should not exceed the following:

(i) Thirty (30) minutes to a network primary care provider;
(ii) Thirty (30) minutes to an outpatient facility for mental health or chemical dependency services;
(iii) Sixty (60) minutes for laboratory, x-ray, pharmacy, general optometry, inpatient psychiatric, MRI and inpatient medical rehabilitation services;
(iv) Ninety (90) minutes for cardiac catheterization laboratory, kidney transplantation, major trauma treatment, neonatal intensive care, and open-heart surgery services; and

(v) Reasonable accessibility for other specialty hospital services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care.

(2) Waiting times for appointments should generally not exceed the following:

(i) Immediate access to emergency care; and
(ii) Twenty-four (24) hours for urgent care; and
(iii) Two (2) weeks for the initial treatment of non-emergency or non-urgent care, with prompt follow-up care as necessary, including referrals for specialty services; and
(iv) Ninety (90) days for preventive care (including routine physical examinations); and
(v) Thirty (30) days for routine laboratory, x-ray, general optometry, and all other routine services.

(3) The DVHA shall develop and implement written standards or guidelines that address the assessment of provider capacity to provide timely access to health care services.

(f) Confidential Information

The DVHA shall take the appropriate steps necessary to ensure that information gathered by it in its quality assurance activities shall be confidential and privileged.

(g) Disclosure of Information

The DVHA shall supply to each beneficiary upon enrollment and upon major revision thereafter the following information consistent with 42 CFR §438.10(g). The information shall be in handbook form and in twelve-point type, and shall be in plain language. This requirement may be satisfied by giving a copy of the handbook to each household, rather than to each beneficiary. The DVHA shall make available to any beneficiary, upon request, a listing by specialty of the name, telephone number and address of all health care providers and health care facilities enrolled in PCCM and Medicaid (including, in the case of physicians, information as to board certification). This list shall be updated (by addendum or otherwise) at least once every six months, and shall indicate which primary care providers are accepting new patients. In addition, the handbook shall include:

1. Coverage provisions, including covered health care services and items, benefit maximums, benefit limitations, exclusions from coverage (including procedures deemed experimental or investigational by the DVHA), restrictions on referral or treatment options, requirements for prior authorization or utilization review, the use of formularies, and any other limitations on the services covered.

2. A description of the rule 7104 procedure for coverage of prescription drugs from manufacturers that do not participate in the federal rebate program. In addition to the criteria contained in rule 7104, the DVHA shall also consider the following criteria in making rule 7104 determinations for prescription drugs. The currently covered drug:

- has not been effective in treating the patient's medical condition; or
- causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

3. If prior authorization or utilization review is required before obtaining treatment or services, the process a beneficiary must use to obtain that authorization or review, including any time lines that apply.

4. The financial inducements offered to any Medicaid provider or health care facility for the reduction or limitation of health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between the DVHA and a health care provider.

5. The beneficiary's responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a beneficiary's financial responsibility, caps on payments for covered services, and the beneficiary's financial responsibility for non-covered procedures, treatments or services.

6. The beneficiary's financial responsibility for payment when services are provided by a health care provider who is not part of the PCCM network or by any provider after an adverse determination by the DVHA.

7. The criteria used by the DVHA for selecting and credentialing the health care providers it enrolls.

8. The grievance and appeals procedures used to resolve disputes between a beneficiary and the DVHA.

9. A summary of its quality assessment and quality improvement programs.

10. The utilization review procedures of the organization, including the credentials and training of utilization review personnel.

11. The procedure for obtaining emergency services, including any requirements for prior authorization and payment for services rendered outside of Vermont.

12. All necessary mailing addresses and telephone numbers to be used by beneficiaries seeking information or authorization.

13. The process for selecting primary care providers and for obtaining access to other providers in the PCCM network, including any restrictions on the use of network specialists.

14. The procedure for changing primary and specialty care providers within PCCM, including any restrictions on changing providers.

15. How beneficiaries can obtain standing referrals to Medicaid participating specialists, or use specialists or specialized facilities to provide and coordinate their primary and specialty care.

16. The waiting time and travel time standards established in this rule.

17. Whether the health care providers are prohibited from participating in other managed care plans or from performing services for persons who are not members of the PCCM program.

18. Opportunities for beneficiary participation in the development of DVHA policies and in the DVHA's quality assurance and quality improvement activities.

19. The consumer information and services, including the toll-free number for the DVHA Ombudsman.

20. A list of all information available to the beneficiary upon request.

7102 Prior Authorization (04/01/1999, 98-11F)

Prior authorization is a process used by the department to assure the appropriate use of health care services. The goal of prior authorization is to assure that the proposed health service is medically needed; that all appropriate, less-expensive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. The department shall notify each patient and provider of its decision, which is arrived at by applying the criteria set forth in rule 7102.2.

"Health services: as used in these rules include services, items or procedures.

7102.1 Criteria for Prior Authorization (04/01/1999, 98-11F)

The department may require prior authorization of payment for a service when one or more of the following criteria are met.

A. The health service is of questionable medical necessity as determined by the department.

B. The department determines that use of the health service needs monitoring to manage the expenditure of program funds.

C. Less expensive appropriate alternatives to the health service are generally available.

D. The health service is investigational.

E. The health service is newly developed or modified.

F. The department determines that monitoring a health service of a continuing nature is necessary to prevent the continuation of the service when it ceases to be beneficial.

The complete and current list of all services and items including procedure codes that require prior authorization is set out in the Provider Manual. The list is updated periodically. Additions and deletions to the list are also published in advance in the provider advisory newsletter and other communications to providers.

7102.2 Prior Authorization Determination (04/01/1999, 98-11F)

A request for prior authorization of a covered health service will be approved if the health service:

A. is medically necessary (see rule 7103);

B. is appropriate and effective to the medical needs of the beneficiary;

C. is timely, considering the nature and present state of the beneficiary's medical condition;

D. is the least expensive, appropriate health service available;

E. is FDA approved, if it is FDA regulated;

F. is subject to a manufacturer's rebate agreement, if a drug;

G. is not a preliminary procedure or treatment leading to a service that is not covered;

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7102.4 **Date of this Memo** 05/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is there a change in the timeframe for processing prior authorization requests?

ANSWER: Yes. The timeframes now correspond to 42 CFR §438.210. OVHA will continue to issue a notice of decision within three days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 days of receipt of the request, but that time frame may be extended up to another 14 days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.

Also, when a provider indicates, or OVHA determines, that following this timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, OVHA must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than three working days after receipt of the request. This may be extended up to 14 days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.

H. is not the repair of an item uncovered by Medicaid;

I. is not experimental or investigational;

J. is furnished by a provider with appropriate credentials.

The department is responsible for determining questions of coverage and medical necessity under the Vermont Medicaid program. The department may contract with external organizations to help make these determinations; however, the final decision rests with the department.

Supporting information for a prior authorization request must include a completed claim and a completed medical necessity form. Additional information that may be required includes:

- the patients complete medical record;
- the patients plan of care;
- a statement of long-term and short-term treatment goals;
- a response to clinical questions posed by the department;
- a second opinion or an evaluation by another practitioner, at Medicaid expense;
- the practitioners detailed and reasoned opinion in support of medical necessity;
- a statement of the alternatives considered and the provider's reasons for rejecting them; and,
- a statement of the practitioner's evaluation of alternatives suggested by the department and the provider's reasons for rejecting them.

If any of this additional information is required, the department will notify the provider promptly. Once the necessary information has been received, the beneficiary will be sent a notice of decision that may be appealed. See rule 4151.

7102.3 Waiver of Prior Authorization (04/01/1999, 98-11F)

The department shall waive the requirement that a covered service receive prior authorization if, in the department's judgement, the service provided without prior authorization meets one or both of the following circumstances.

- The service was required to treat an emergency medical condition.
- The service was provided prior to the determination of Medicaid eligibility and within the retroactive coverage period.

7102.4 Prior Authorization Process (04/01/1999, 98-11F)

Prior authorization commences with the receipt of a written prior authorization request. The department will issue a notice of decision within three working days of receiving all necessary information. The department will act in good faith to obtain the necessary information promptly so that it can determine, within 30 days, whether the request may be approved. The department will issue a notice of decision within 30 days of receiving the initial prior authorization request, even if all necessary information has not been received.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7105 Date of this Memo 09/01/2013 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes to Medical Service Payments?

ANSWER: Yes. On at least a quarterly basis, the DVHA, instead of its fiscal agent, sends a notice of Medicaid benefits paid to a sample of beneficiaries who received a service during that quarter.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7105.1 **Date of this Memo** 05/01/2012 **Page** 1 of 1
This Memo: [ ] is New [X**] Replaces one dated** 04/01/2008

QUESTION: The rule at 7105.1 (H.) says that we do not cover items and services covered by private health insurances. Do we cover items and services if the other insurance has denied them?

ANSWER: We consider coverage under Medicaid rules if the other insurance denies because the item or service is not included in the coverage contract, is non-covered, or benefits are exhausted.

If the other insurance has denied for a reason other than not included in the coverage contract, non-covered, or benefits exhausted, the beneficiary or provider must first go through all required levels of the insurance plan's appeal process, as well as the external review from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), if eligible and available. If the billed amount is less than $100, BISHCA will not hear the appeal so the final insurance plan appeal is sufficient (mental health appeals do not have the $100 threshold). The beneficiary must meet the timeframes specified by BISHCA for the external appeal.

Medicare beneficiaries or their providers must appeal through the Qualified Independent Contractor level prior to requesting that Medicaid cover the service or item.

If these appeals are all denied, the beneficiary's provider may ask Medicaid to make an independent assessment of coverage and medical necessity and, if approved, cover the item or service. The Medicaid decision will be based on the same documentation submitted for the previous appeals.

For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination.

7105 Medical Service Payments (04/01/2005, 05-09)

The department pays providers for Medicaid Services through a fiscal agent. To receive payment, the provider must send a claim to the fiscal agent subject to the limitations and conditions specified in rules 7105.2-7108.3.

The department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:

- The recipient applied for benefits after February 15, 1973, and was denied; and
- The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal).

Reimbursement is for 100 percent of the out-of-pocket expenditures made by a recipient or a member of his/her Medicaid group or a financially responsible relative who is not a member of the group, for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed). No copayment is due.

Payment cannot otherwise be made direct to a Medicaid recipient, even if he/she has already paid the provider for a covered service. When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the recipient's payment (see also Provider Responsibility).

The fiscal agent sends a notice of Medicaid benefits paid to a sample of recipients who receive a service each month. The recipient must report any disagreement with the notice to the department.

7105.1 General Exclusions (02/01/2003, 02-33)

No payment will be made for certain items and services including the following:

A. Items and services not reasonable and necessary for the treatment or diagnosis of illness or injury, or to improve the functioning of a malformed body member.

B. Items for which neither the beneficiary nor any other person or organization has a legal obligation to pay. This exclusion applies, for example, to X-rays or immunizations provided without charge to the general public by a health organization.

C. Items and services furnished, paid for or authorized by an entity of the Federal Government.

D. Care and services provided in a foreign country, except as provided in Medicare regulation 42 CFR 424 Subpart H, which allows payment for emergency inpatient hospital care and related ambulance and physicians services if the following conditions are met:

- The beneficiary was present in the U. S. when the emergency arose, or was traveling to Alaska by the most direct route without delay, and

- The foreign hospital is closer to, or more accessible from the site of the emergency than the nearest U. S. hospital equipped to deal with and available to treat the individual's illness or injury.

E. Care and services ordered or prescribed by an immediate relative (see F) of the beneficiary.

F. Care and services furnished by an immediate relative of the beneficiary or by a facility, such as a nursing home, of which an immediate relative is owner or principal stockholder. For purposes of this section, "immediate relative" includes spouse; natural parent, child, and sibling; adopted child and parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; grandparent and grandchild.

G. Items and services to the extent that payment has been or can be expected to be made under worker's compensation.

H. Items and services covered by private health insurances.

I. Items and services ordered by an individual not enrolled as a Medicaid provider.

J. Premiums for health insurance plans when the department has not required the beneficiary to enroll or remain enrolled.

K. Preliminary procedures or treatments leading to a service that is not covered by Medicaid.

L. Repair of items not covered by Medicaid.

7105.2 Provider Responsibility (07/01/1991, 91-31)

In order to assure the highest quality medical care and services, Medicaid payments are made only to providers meeting established Medicaid standards. Providers who are certified for participation in Medicare are automatically approved for Medicaid participation, providing no sanction has been imposed as provided in Violations of Provider Responsibility. Comparable standards for providers who do not participate in Medicare are established by State law and appropriate licensing and standard-setting authorities in the respective health and mental health fields. Additional specific requirements by provider type are contained in rules 7201-7608.

Payment for covered services under Medicaid is limited to those services certified as medically necessary in the judgment of a qualified physician for the proper management, control, or treatment of an individual's medical problem and provided under the physician's direction and supervision.

Providers agree to keep necessary records as required by Medicaid regulations and make them available to authorized State and Federal officials upon request.

Medicaid payment rates are established for covered services. For certain services, a recipient copayment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

A provider must accept as payment in full the amounts paid in accordance with the rate schedule established for Medicaid. For example, a physician performing a particular surgical procedure may not request or receive any additional payment from the recipient, or anyone acting on the recipient's behalf, for the same surgical procedure, although in medical expenses spend-down cases, as specified by the Department for Children and Families, Economic Services Division, the recipient may be held responsible for a portion of the amount specified in the fee schedule (see rules 4400-4474.4).

No Medicaid payment will be made for claims received either by the Department or its fiscal agent later than six months following the date the service was provided, except when the delay has been caused by extenuating circumstances and authorization has been granted by the OVHA.

When the recipient has other medical insurance, the benefits available must be applied prior to payment by Medicaid. In instances where other insurance companies have been billed, but not paid, claims may be submitted up to 12 months from the date of service.

In no case will payment be made when more than 24 months have elapsed since the date of service. A provider must, as well, meet other commonly accepted standards of professional practice, including compliance with State and Federal anti-discrimination regulations.

In all joint Medicare-Medicaid cases the provider of services must accept assignment of Medicare payment in order to receive payment from Medicaid of amounts not covered by Medicare.

Claims and claims documentation as required must be submitted in a form acceptable to the OVHA or its designee.

7105.3 No Reassignment of Claims (12/01/1980, 80-62)

No payment for any care furnished to a recipient will be made to anyone other than the provider except that payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order (see also appeal process exception - rule 7105).

With respect to physicians, dentists, or other individual practitioners payment may be made:

To the employer, if the practitioner is required as a condition of his employment to turn over his fees to his employer; or

To the facility in which the care or service was provided, if there is a contractual arrangement between the practitioner and that facility whereby the facility submits the claims for reimbursement; or

To a foundation, plan, health maintenance or similar organization, which furnishes health care through an organized health care delivery system if there is a contractual arrangement between the organization and the person furnishing the service under which the organization bills or receives payments for such person's services.

Payment will not be made to or through a factor, making claim by virtue of a power of attorney, sale, assignment or other transfer given by the provider to the factor. In this context a "factor" is an organization, collection agency, service bureau, or an individual that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for advancing money to a provider for his accounts receivable.

7106 Violations of Provider Responsibility (04/01/1999, 98-11F)

Information from any source indicating that a provider is violating any of the policies set forth above shall be transmitted to the department. The following describes the administrative actions and sanctions that the department may take with regard to any provider participating in the Vermont Medicaid program. Taking these actions, however, does not preclude subsequent or simultaneous civil or criminal court action.

7106.1 Definitions (04/01/1999, 98-11F)

"Provider" means any individual, firm, corporation, association or institution that is currently approved to provide medical assistance to a beneficiary pursuant to the Vermont Medicaid Program.

"Person" means any natural person, company, firm, association, corporation or other legal entity.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Administrative Agent" means an organization that processes and pays provider claims on behalf of the department.

"Review Methods" means the methods by which the department or its administrative agent determines whether payment errors have been made.

"Exclusion from participation" means termination of a provider's participation in the Vermont Medicaid Program, with the probability that it is permanent.

"Suspension from participation" means temporary expulsion from participation in the Vermont Medicaid Program for a specified period of time or until specified conditions are met.

"Deferment of payments" means the withholding of payments due a provider pending resolution of a specified problem. It may be taken or continued as a sanction or imposed as an administrative precaution upon discovery of a provider discrepancy.

"Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on deferred, pending, or future bills for purposes of recovering over-payments previously made to the provider.

"Closed-end Medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

"Open-end Medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

7106.2 Grounds for Sanctioning Providers (04/01/1999, 98-11F)

Sanctions may be imposed by the department against a provider for one or more of the following reasons.

A. Presenting or causing to be presented for payment any false or fraudulent claim for care or services.

B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

D. Submitting a false or fraudulent application to obtain provider status.

E. Failing to disclose or make available to the department or its authorized agent records of services provided to Medicaid beneficiaries and records of payments received for those services.

F. Failing to provide and maintain services to Medicaid beneficiaries within accepted medical community standards as adjudged by a body of peers.

G. Failing to comply with the terms of the provider certification agreement that are printed on the Medicaid claim form.

H. Over-utilizing the Medicaid program by inducing, furnishing or otherwise causing a beneficiary to receive care and services not required by the beneficiary.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Conviction of a criminal offense related to the practice of medicine resulting in death or injury to one or more patients.

K. Failing to meet and maintain substantial compliance with all State and Federal regulations and statutes, applicable to the provider's profession, business or enterprise.

L. Termination or suspension from participation in Medicare.

M. Suspension or termination from participation in other State or Federal programs such as Maternal and Child Health, etc.

N. Documented practice of billing or collecting from the beneficiary an amount in addition to that received from Medicaid for that care or service.

O. Failing to correct deficient provider operations after receiving written notice of these deficiencies from the department, other responsible State agencies, or their designees.

P. Formal reprimand or censure by an association of the provider's peers for unethical practices.

Q. Failure to change or modify delivery patterns for care and services within a reasonable period from receipt of a request to do so by a peer review committee whose composition includes representation of the provider's peers.

R. Presenting or causing to be presented for payment a disproportionate number of claims which are rejected or denied due to submission errors made by the provider or his or her agent. In this context disproportionate is determined in relation to providers of similar services.

S. Being convicted under any law relating to the Medicaid program or under any law of general applicability for acts arising out of the Medicaid program.

7106.3 Sanctions (04/01/1999, 98-11F)

One or more of the following sanctions may be invoked against providers based upon the grounds specified in rule 7106.2:

- exclusion from participation in the Medicaid program;
- suspension from participation in the Medicaid program;
- deferment or offsetting of payments to a provider;
- transfer to a closed-end provider agreement not to exceed 12 months;
- mandatory attendance at provider information sessions;
- required prior authorization of service;
- 100 percent review of the provider's claims prior to payment; or
- recovery of overpayment by offset or civil action, including recovery of reasonable interest and costs.

7106.4 Imposition and Extent of Sanctions (04/01/1999, 98-11F)

When the staff of the department determines that grounds exist and a provider sanction is being considered the department will advise the provider in writing, of the discrepancy noted. The contact with the provider will set forth in the case of mandatory sanctions (rule 7106.4.3), the extent and reason for the sanction, or in cases of discretionary sanctions:

- the nature of the discrepancy or inconsistency;
- the dollar value, if any, of such discrepancy or inconsistency;
- the method of computing such dollar values;
- that one or more sanctions may be taken;
- that the provider may, within 20 days from receipt of written notice, request a meeting with the Director of the OVHA to negotiate an amicable settlement of the discrepancy or request a commissioner's conference to be heard in the matter;
- that the provider may bring evidence, witnesses and representation of choice to either the meeting or conference as desired, or may submit a written statement to the Director or Commissioner for consideration in the decision to impose sanction; and
- that if a meeting or conference is not requested within the 20-day period, the decision regarding imposition of sanctions will be made based upon information at hand.

Simultaneous with taking action to advise the provider as above, the department may defer payments on pending and future claims pending resolution of the discrepancy and shall so advise the provider if this action has been taken.

If a mutually agreeable settlement is negotiated with the Director of the OVHA, formal sanction action is discontinued at this point. If not, at any point in the negotiation, at the discretion of either party, a commissioner's conference may be requested to resolve the issue.

If the provider prefers to bypass negotiation with the director and, within 20 days from receipt of written notice, does request a commissioner's conference in the matter at dispute, or negotiations are unsuccessful and a conference is requested, a date shall be set, with notice sent to all parties, and the conference conducted within 20 days from the date of request. The purpose of the conference shall be to assure that the commissioner has all pertinent information at hand prior to making a decision regarding imposition of sanctions. The provider may utilize any records, witnesses, or other information which will be helpful in achieving this purpose and may utilize legal or other representation in the presentation. The conference will be recorded and pertinent records retained by the department at least until the end of the appeal period, and if subsequent imposition of sanction is appealed, shall be made available to all parties as potential evidence in the conduct of the appeal hearing. If, after written notice as provided above, there has been no request from the provider for either a director's meeting or commissioner's conference at the end of 10 days, this shall be noted and the commissioner shall proceed, on the basis of information at hand, to imposition of sanctions as outlined in following sections.

7106.4.1 Imposition of Sanctions

The decision as to discretionary sanctions to be imposed shall be made by the commissioner.

The following factors shall be considered in determining discretionary sanctions to be imposed:

- seriousness of the offense,
- extent of the violations,
- history of prior violations,
- prior imposition of sanctions,
- prior provision of provider information and training,
- provider willingness to adhere to program rules,
- agreement to make restitution,
- actions taken or recommended by peer groups or Licensing Boards, and
- whether a lessor sanction will be sufficient remedy.

The following mandatory sanctions shall be applied by the commissioner effective as of the date of action requiring the sanction.

- When a provider has been suspended or terminated from the Medicare program, imposition of the same sanction as that imposed by Medicare is mandatory upon the commissioner by federal regulation. The only appeal is to the Medicare sanctioning authority.
- When a provider has been convicted of a violation under 33 VSA Chapter 26, Subchapter 5 or under any Vermont statute of general applicability, and said conviction arises from or is directly related to the Medicaid program (33 VSA Ch 36), that provider will be suspended from further participation in the Medicaid program for a period of four years unless such suspension is specifically waived or reduced by the Secretary of Human Services.
- When a provider has failed to retain licensure, certification or registration which is required by state or federal law for participation in the Medicaid program, suspension from participation shall be imposed.

7106.4.2 Scope of Sanctions

A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of such person.

Suspension or exclusion from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claim submitted by any clinic, group, corporation or other association to the department or its fiscal agent for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the effective date of the suspension or exclusion.

No clinic, group, corporation or other organization which is a provider of services shall submit claims for payment to the department or its administrative agent for any services or supplies provided by a person within such organization who has been suspended or excluded from participation in the Medicaid program except for those services and supplies provided prior to the effective date of the suspension or termination.

When any provision of rule 7106.2, above is violated by a provider of services which is a clinic, group, corporation or other organization, the department may suspend or terminate such organization or any individual within said organization who is responsible for such violation.

7106.4.3 Notice of Sanctions

When a provider has been sanctioned, the commissioner or the commissioner's designee shall notify the provider in writing of the sanction imposed. The letter will also notify the provider of his right of appeal. The provider shall also be notified when a decision is made to take no sanctions.

When a provider has been sanctioned, the commissioner shall notify as appropriate, the applicable professional society, Board of Registration or Licensure, and federal or state agencies of the findings made and the sanctions imposed.

When a provider's participation in the Medicaid program has been suspended or terminated, the commissioner may notify the beneficiaries for whom the provider has submitted claims for services, that such provider has been suspended or terminated.

7106.5 Provider Information Program (04/01/1999, 98-11F)

When the sanction of mandatory attendance at provider information programs is a condition of continued participation, the department will notify the provider of time, date and place. These sessions may be scheduled as group sessions or as individual sessions at the discretion of the department and may include voluntary attendees as well as those required to attend under sanction.

Provider Information Programs may include instructions relating to:

- claim form completion,
- use and format of provider manuals,
- use of appropriate procedure codes,
- key provisions of the Medicaid program,
- reimbursement rates and billing charges, and

- how to inquire about coding or billing problems.

7106.6 Right of Appeal (04/01/1999, 98-11F)

The rights of appeal from mandatory sanctions are limited to the appeal rights inherent in the originating authority; i.e., the Medicare sanctioning authority, the courts, or licensing authority as appropriate to the cause for sanction.

A provider may appeal a discretionary sanction within 10 days after notice of such sanction by requesting a hearing of the Secretary of the Agency of Human Services. Unless a timely request for hearing is received by the Secretary, the sanctions shall be considered final and binding. The sanctions imposed shall be suspended pending the outcome of the hearing; however, if payment on pending and future claims has been deferred pending resolution of the discrepancy, such deferment shall be continued.

A hearing on the appeal shall be conducted within 30 days of the request, by the Secretary or a hearing officer appointed by the Secretary, under the same rules of conduct as in current use for hearings before the Human Services Board.

7106.7 Withholding Payments (04/01/1999, 98-11F)

In accordance with 42 C. F. R. 455.23, the department may withhold payment, in whole or in part, to a provider upon receipt of reliable evidence that; grounds for sanctioning a provider may exist as set forth in rule 7106.2. The Medicaid Fraud and Residential Abuse Unit (MFRAU) of the attorney general's office will review the evidence and determine whether there are reasonable grounds to believe that fraud or willful misrepresentation has occurred. If the MFRAU determines that reasonable grounds exist then the department may withhold payments without first notifying the provider of its intention to withhold such payments.

The department shall send notice of its decision to withhold program payments within five days of taking such action. The notice must set forth the general allegations that form the basis of the withholding action. The notice shall also:

- state that payments are being withheld in accordance with this provision;
- state that the withholding is for a temporary period as stated in this section, and cite the circumstances under which withholding will be terminated;
- specify which Medicaid claims are affected by the withholding action; and
- inform the provider of the right to submit to the commissioner written evidence contradicting the allegations which formed the basis for the withholding action.

Within ten days, the commissioner shall review the evidence submitted by the provider and determine whether the withholding of payments by the department under this section is warranted.

All withholding of payment actions under this section will be temporary and will not continue after:

- the department and the Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office determine that there is insufficient evidence of fraud or willful misrepresentation by the provider; or

- legal proceedings related to the providers alleged fraud or willful misrepresentation are completed.

The procedures relating to sanctions under the Medicaid program as delineated in rules 7106.4–7106.6 shall not apply during the period of any withholding action under this section.

7107 Utilization Control (12/01/1980, 80-62)

The Department in accordance with 1902 (a) (30) of the Social Security Act, has implemented a statewide utilization control program to safeguard against unnecessary or inappropriate utilization of services available under Medicaid. Excessive or inappropriate use of service is identified through the utilization review process and characterized as recipient abuse, provider abuse, or a combination thereof. Reports of suspected abuse generated by Department staff, the medical community or the general public should be referred to the OVHA.

7107.1 Beneficiary Abuse (12/01/1980, 80-62)

When recipient abuse is identified, the recipient's access to care will be limited through a requirement for prior authorization, restriction to selected providers, or other appropriate action. Instances of recipient abuse include, but are not limited to:

Obtaining an inordinate supply of a prescription drug, especially those which are potentially addictive; or

Consistently requesting care at a hospital emergency facility for non-emergency ailments; or

Obtaining concurrent service from two or more practitioners for the same condition without medical referral, on an ongoing basis or for purpose of obtaining prescriptions necessary for the implementation of (i) above. This is not to preclude reasonable access to a "second opinion" of a diagnostic nature or taking action on such opinion.

7107.2 Provider Abuse (12/01/1980, 80-62)

When provider abuse is identified it may result in denial of payment, taking administrative action as provided in rule 7106, or the initiation of civil or criminal fraud action. Examples of provider abuse include, but are not limited to:

Inducing, furnishing or otherwise causing a recipient to receive service not required for the recipient's care; or

Submission of incorrect claims; or

Excessive prescribing or dispensing of drugs, especially those which are potentially addictive or which are essentially irrelevant to the patient's care other than for their placebo effect.

7108 Third Party Liability (02/01/2003, 02-33)

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the beneficiary for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid; it then becomes an issue of recovery (see rule 7108.2). Medicaid beneficiaries are required to follow all rules of their third party insurance. Medicaid will not pay claims that have been denied by the third party insurer for failure to follow their rules. Some examples of third party medical resources are:

- Medicare;
- Health insurance, including health and accident but not that portion specifically designated for "income protection" which has been considered in determining beneficiary eligibility to participate in the Medicaid program;
- Medical coverage included in conjunction with other benefit or compensation programs such as military and veteran programs, and worker's compensation; and
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

7108.1 Health Insurance Premiums (02/01/2003, 02-33)

The commissioner may elect at any time to require an applicant or beneficiary to enroll, or remain enrolled, in a private health insurance plan, provided that such enrollment meets the conditions specified in this section and in rule 4138.4 and, in the commissioners judgment, is likely to be cost-effective and in the department's best interest. If enrollment is required, the department will pay the individual's share of the health insurance premium.

Once an individual has met this requirement by enrolling or remaining enrolled in a health insurance plan, Medicaid will cover the full array of Medicaid services and items, provided that the rules of their health insurance plan have been followed.

7108.2 Adjustment or Recovery (02/01/2003, 02-33)

The department may take action either before or after Medicaid payment of a claim to assure appropriate disbursement of Medicaid funds when payment turns out to be inappropriate due to subsequently discovered resources, fraud, error, or the development of third party-liability. Taking administrative action and accepting partial or full reimbursement shall not preclude either simultaneous or subsequent action in civil or criminal court as appropriate.

The department may:

A. negotiate adjustment or recovery on a voluntary basis with recipient, provider, or an obligated third party;

B. accept adjustment or recovery in conjunction with the imposition of provider sanctions (see rule 7106.4);

C. file a lien against any third party to recover Medicaid expenditures from any settlement, judgment, or other income that may be awarded through negligence liability action;

D. enter direct civil action to effect adjustment or recovery when other efforts fail; or

E. investigate and prepare for referral to the appropriate criminal prosecutor any case presumed subject to adjustment or recovery by way of such action.

Providers may be required to enter a claim against any subsequently discovered health insurance resources previously unknown or overlooked and submit an adjusted Medicaid claim upon collection, with reimbursement as appropriate.

7108.3 Estate Recovery (02/01/2003, 02-33)

The department shall seek adjustment or recovery from the estates of individuals who died on or after January 1, 1994 provided that the individuals were 55 years of age or older when they received long-term care services paid for by the Medicaid program for nursing facility services, home-and-community-based waiver services, and related hospital and prescription drug services. Related hospital and prescription drug services are those paid for by the Medicaid program during a period of time when the individual is living in a nursing facility or enrolled in a home-and-community-based waiver program. Adjustment or recovery shall include amounts in personal needs accounts.

The department will file a claim with the probate court as a creditor of the estate to recover its expenditures for long-term care services only after the death of an individual's surviving spouse, if any, and when the individual has no surviving child who is under age 21, or blind, or permanently and totally disabled as defined by the Social Security Administration.

7108.3.1 Exemptions from Estate Recovery

The department exempts the following assets from estate adjustment or recovery when an heir requests an exemption in writing no later than four months after the publication of notice to creditors of the estate.

A. Homes in trust prior to December 1, 1997:

The department normally recovers for long-term care Medicaid costs incurred after January 1, 1994. Individuals with homes in revocable trusts who received Medicaid payment of long-term care services before December 1, 1997, however, are exempt from recovery until after May 1, 1998, or, if later, the effective date of the first Medicaid eligibility review completed after December 1, 1997.

B. When loss of assets would present an undue hardship:

The department will not seek adjustment or recovery from assets when that adjustment or recovery would present an undue hardship to the decedents family members, as specified below and in rule 7108.3.

1. Income-producing assets

Undue hardship exists when adjustment or recovery from an income-producing asset can be made only if the asset, alone or in combination with other related assets, is sold and either or both of the following conditions are met:

a. The assets sold are the sole source of income for the decedents spouse, parents, children, or siblings.

b. As a result of the sale, the decedents spouse, parents, children, or siblings would qualify for public assistance (Reach Up benefits, SSI/AABD, general or emergency assistance, or TANF or TANF/MOE benefits from another state).

C. Estates with personal property valued at less than $2,000:

The department will not seek recovery where the estate inventory filed with the probate court consists only of personal property that does not exceed $2,000 in value, such as home furnishings, apparel, personal effects, and household goods.

The department will not seek to recover assets for which the department has imposed a penalty period of ineligibility for Medicaid coverage of long-term care services related to the transfer of those assets.

7108.3.2 Hardship Exemptions for Homesteads

At any time before closure of the probate estate, an heir may assert that adjustment or recovery against the homestead would be an undue hardship and that the homestead should be exempt from adjustment or recovery for the costs of Medicaid long-term care services. The department shall exempt a decedents home from estate adjustment or recovery based on undue hardship when one or more of the following three conditions have been established to the departments satisfaction.

A. A sibling has been living in the home continuously for at least one year immediately before the date the decedent began receiving long-term care services.

B. A son or daughter has been living in the home continuously for at least two years immediately prior to the date the decedent began receiving long-term care services and provided care that allowed the decedent to remain at home.

C. Conditions (1), (2), and (3) below have been met.

1. The fair market value of the homestead is less than $250,000. If the fair market value of the homestead exceeds this amount, the first $250,000 in fair market value shall be exempt from estate recovery and any equity value in excess of $250,000 shall be subject to the provisions of rule 7108.3.

2. A sibling or lineal heir of the deceased Medicaid beneficiary will inherit the homestead. A lineal heir is a direct descendant, such as a child or grandchild.

3. The heir meets one or both of conditions (a) and (b) below.

a. The heir has gross family income below 300 percent of the federal poverty level. No income exclusions or deductions are allowed. The income of the persons presented in the following table is included in the heirs gross family income, provided that they are living in the heirs household.

Heir's Household

Type of Heir	Family Members, If Living in the Heirs Household
Adult 18 years or older; or person younger than 18 and emancipated	Heir Heirs spouse or civil union partner Heirs biological or adoptive child or stepchild
Person younger than 18 and not emancipated	Heir Heirs parent Heirs stepparent Heirs biological or adoptive sibling, stepsibling, or half sibling, if younger than 18 and not emancipated

b. The heir demonstrates that significant services or financial support provided to the deceased person by heirs meeting condition (2) or the spouses of such heirs enabled the person to avoid long-term care or delay it at least six months. It is not necessary for the deceased person to have been a Medicaid beneficiary when the services or financial support were provided. Services may have been provided in combination with services provided by governmental or other private entities.

To meet condition (b), the services or financial support must fall into one or both of the following two categories:

i. Medical or remedial care or support services that were:

- medically necessary;
- provided directly by the heir or the heir's spouse without compensation, or purchased with the heir's funds; and
- provided while the deceased person required medical care and services consistent with the level of care standard for level III residential care homes at a frequency averaging no fewer than three times per week or, if provided less frequently, constituting the equivalent expenditure of time or money.

The department shall not verify the level of care unless it has a reasonable basis for questioning that the level III standard was met.

ii. Other services or financial support at least as significant as the care or services described in category (i).

When there are two or more heirs, the full value of the homestead is exempt from Medicaid estate adjustment or recovery only if each heir meets conditions (1), (2), and (3) above. When one or more heirs do not meet conditions (1), (2), and (3), the percentage of the value of the homestead corresponding to their share is subject to Medicaid estate adjustment or recovery.

7108.3.3 Adjusting Claims Against Homesteads

An estate includes all real and personal property and other assets listed on an inventory filed in the probate court. The probate court oversees the distribution of assets to heirs and the payment of the decedent's outstanding debts, which requires creditors to submit proof of their claims to the court.

The probate court judge compares the total value of claims filed by creditors to the total value of available assets in the estate. The court determines which assets are available to pay debts.

When any heir meets the department's undue hardship criteria as specified in rule 7108.3, some or all of these available assets may be exempt from adjustment or recovery by the department under these rules. Nonexempt assets are those subject to the department's claim because an heir has not met the undue hardship criteria. Creditors other than the department are not subject to these exemptions.

When the total available assets are insufficient to pay all claims, the probate court prioritizes the debts and prorates each claim according to law. Each creditor collects the resulting percentage of its claim.

If there are sufficient nonexempt assets to allow the department to collect its full percentage, it does so. If the nonexempt assets allow the department to collect only a partial amount of its share after the court's proration, it collects that amount. The department shall maintain its original claim so it can be prorated along with all other creditors claims according to law. The department notifies the court of its decision on the homestead exemption. If the department grants a homestead exemption, it shall inform the court of the maximum payment it will accept against its claim. The department determines the maximum payment it will accept by subtracting the amount of the exemption from the amount of the department's claim.

7108.3.4 Retroactive Homestead Exemptions

The undue hardship exemption applicable to homesteads shall be effective for any probate estate opened after June 30, 1999. Heirs seeking the exemption from July 1, 1999, through the effective date of this policy must submit their claim to the department's Coordination of Benefits unit in the Office of Vermont Health Access within 60 days following receipt of proper notice from the department. In the sole discretion of the commissioner, the department may make exceptions to the 60-day rule when an heir establishes undue hardship due to lack of notice, a medical need, or natural disaster. Heirs seeking an exemption from the 60-day submission requirement must sign an affidavit describing the condition that prevented them from complying with the 60-day submission requirement and submit the affidavit along with supporting documentation to the commissioner.

7108.3.5 Long-Term Care Insurance Partnership Exemption

The department will exempt assets or resources pursuant to rule 4242.2 in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy whether or not an heir requests an exemption.

7109 Health Care Trust Fund (10/01/1995, 95-28)

In accordance with 33 VSA §1956, a Health Care Trust Fund is established in which proceeds from health care provider taxes shall be deposited. The proceeds of other taxes designated by law and donations may also be deposited in the fund.

Health care provider taxes shall be assessed upon hospitals, nursing homes and intermediate care facilities for the mentally retarded (ICF/MRs) licensed in Vermont, pursuant to 33 VSA §1953, §1954, and §1955, in an amount established by statute.

For each fiscal year in which health care provider taxes are due, the Office of Vermont Health Access (OVHA) shall notify each provider of the amount of its assessment. The notification shall include the appeals provisions set forth in 33 VSA §1958 and shall establish an assessment payment schedule for each provider.

Payment in full of each installment must be sent to the OVHA post marked no later than the date specified for each payment by the Director in the assessment notification. Late payments will be subject to a late fee assessment of eight percent or $1,000, whichever is less. The filing of a request for reconsideration, pursuant to 33 VSA §1958, does not relieve a provider from its obligation to make timely payments.

For hospital fiscal years ending after June 30, 1993, hospitals are required to identify gross inpatient revenues as a separate footnote in their audited financial statement.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7301.1 Date of this Memo 1/01/2014 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes in Medicaid coverage of smoking cessation counseling?

ANSWER: Yes. Effective January 1, 2014, the DVHA will cover face-to-face counseling for smoking cessation for all Vermont Medicaid beneficiaries. The maximum number of allowed visits per calendar year and qualified providers who can bill for counseling remains unchanged.

7301 Physicians and Other Licensed Practitioners (07/26/2012, 12-01)

Coverage of physician and other licensed practitioner services are limited to:

Vermont physicians and other specified practitioners licensed by the appropriate licensing agency of the State; or

Out-of-State physicians and other licensed practitioners affiliated with the hospitals included in the Green Mountain Care Network.

All other out-of-state physicians and other licensed practitioners are considered out-of-network and non-emergent, non-urgent office visits are covered only if the service receives prior authorization. Emergent and urgent care is defined in Medicaid Rule 7101.3.

For certain services, a recipient co-payment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

7301.1 Physician Services (07/26/2012, 12-01)

Covered physician services are those provided by a Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine(D.O.), or Naturopathic Doctor (N.D.) when medically necessary and performed within the scope of their licenses.

Routine physical exams, diagnostic services, immunizations, and certain injectable drugs are covered.

Medical and surgical services provided in the home, office, hospital or nursing home are covered with limitations described in rule 7301.1.1.

Supplies used in connection with a physician's treatment are included in the service; some examples of these supplies are tongue depressors, dextrosticks, bandages, antiseptics and other consumable items.

Coverage of face-to-face counseling for smoking cessation for pregnant Vermont Medicaid beneficiaries is limited to 16 visits per calendar year. Services can be provided by physicians, nurse practitioners, licensed nurses, nurse midwives, and physician's assistants. "Qualified" Tobacco Cessation Counselors are also allowed (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

7301.1.1 Physician Visits

Coverage for physician visits is limited in the following manner:

Office visits - up to five visits per month;

Home visits - up to five visits per month;

Nursing facility visits - up to one visit per week;

Hospital visits - up to one visit per day for acute care, limited to the direct services of a physician, a physician's assistant, or nurse-midwife.

Visits in excess of those listed above may be covered if there is a significant change in the health status of the patient that requires more frequent visits; prior authorization is required for visits in excess of the limits listed above.

Coverage for surgery services includes postoperative care limited to evaluation and management services compliant with Medicare global-day recommendations.

7301.1.2 Nurse Practitioners

Coverage is limited to enrolled nurse practitioners in either independent practice or affiliated with a physician when certified as: 1) a Nurse-Midwife or 2) a Family Nurse Practitioner or 3) a Pediatric Nurse Practitioner and is limited to Medicaid covered services contained in protocols reviewed and accepted by the Vermont State Board of Nursing and the Vermont State Board of Medical Practice.

7301.2 Psychiatric Services (07/26/2012, 12-01)

Psychiatric services are covered as physician's services for treatment of mental, psychoneurotic, or personality disorders, as defined in the American Psychiatric Association's "Diagnostic and Statistical Manual - Mental Disorders."

7301.2.1 Psychologists Practicing Independently

Diagnostic tests performed by a qualified Vermont psychologist practicing independently of an institution, agency, or physician's office are covered. A "qualified" psychologist is one practicing in the state who has been approved for participation in Medicare by the Part B Carrier or who is licensed in accordance with 26 V. S. A. Chapter 55.

Psychological evaluation includes interviewing, testing, scoring, evaluation and a written report. Group therapy is limited to no more than three sessions per week. Reimbursement is limited to one session per day per group and no more than 10 patients in a group.

7301.2.2 Non-Covered Services

Psychotherapy or diagnostic tests provided by a psychologist practicing independently to an inpatient or outpatient of general hospital or mental hospital or in a community mental health clinic are not covered.

7301.3 Reimbursement (07/26/2012, 12-01)

Reimbursement for physicians and other licensed practitioners is described in the Provider Manual.

7317 Rehabilitative Therapy Services (02/26/2011, 10-13)

Rehabilitative Therapy services include diagnostic evaluations and therapeutic interventions that are designed to improve, develop, correct, prevent the worsening of, or rehabilitate functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Rehabilitative Therapies include Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) (also called Speech/Language Therapy or Speech Language Pathology). 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.

Rehabilitative Therapy services must be:

- directly related to an active treatment regimen designed by the physician; and
- of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required; and
- reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition.

NOTE

Not all services listed in the State Practice Acts are medical in nature. Medicaid only covers medically necessary rehabilitative therapy services. Medical necessity is defined in Rule 7103.

7317.1 Limitations (05/01/2012, 11-19)

Quantity limits on services are on a per beneficiary basis, regardless of program or coverage source. Changing programs and/or eligibility during a calendar year does not reset the number of available visits.

These service limitations and prior authorization requirements are not applicable when Medicare is the primary payer.

A. Rehabilitative Therapy Services for Beneficiaries Age 21 and Older

Thirty (30) therapy visits per calendar year are covered and include any combination of physical therapy, occupational therapy and speech/language therapy.

Prior authorization beyond 30 therapy visits in a calendar year will only be granted to beneficiaries with the following diagnoses, and only if the beneficiary meets the criteria found in Rule 7317:

- Spinal Cord Injury
- Traumatic Brain Injury
- Stroke
- Amputation
- Severe Burn

B. Rehabilitative Therapy Services for Beneficiaries Under Age 21

Eight (8) therapy visits from the start of care date per diagnosis/condition for each type (physical therapy, occupational therapy, and speech/language therapy) are covered based on a physician's order. Provision of therapy services beyond the initial 8 visits is subject to prior authorization review as specified below (Rule 7317.2).

7317.2 Prior Authorization Requirements: (02/26/2011, 10-13)

Prior authorization is defined in Rules 7102-7102.4.

To receive prior authorization for additional services a physician must submit a written request to the department with pertinent clinical data showing the need for continued treatment, projected goals and estimated length of time.

7317.3 Rehabilitative Therapy Services: Home Health (02/26/2011, 10-13)

Rehabilitative 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.

Prior Authorization Requirements:

In making its prior authorization decision, the DVHA will obtain and take into consideration a qualified therapist's assessment when determining whether the service may be reasonably provided by the patient's support person(s). In addition, when the department has determined that therapy services may be reasonably provided by the patient's support person(s) and the patient otherwise meets the criteria for authorization of therapy services beyond the initial four-month period, professional oversight of the support person's provision of these services is covered, provided such oversight is medically necessary.

Prior authorization for rehabilitative therapy services beyond one year will be granted only:

- if the service may not be reasonable provided by the patient's support person(s), or
- if the patient undergoes another acute care episode or injury, or
- if th epatient experiences increased loss of function, or
- if deterioration of the patient's condition requiring therapy is imminent and predictable.

7403 Clinic Services (10/02/1984, 84-46)

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 (10/02/1984, 84-46)

For policies, amount, duration and scope of benefits, and reimbursement rates, see the Department of Mental Health regulations #8l-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 (10/02/1984, 84-46)

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 (12/01/1980, 80-62)

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 HHS.

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 rule 7501 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 rule 7501 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.

7405 Laboratory and Radiology Services (02/26/2011, 10-13)

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: (02/26/2011, 10-13)

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: (02/26/2011, 10-13)

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.

7405.3 Prior Authorization — Laboratory: (02/26/2011, 10-13)

Exceptions to the limitations in Rule 7504.1 must be prior approved.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7406 Date of this Memo 02/01/2003 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: What is Participant-Directed Attendant Care (PDAC), and where can I find those regulations?

ANSWER: Participant-Directed Attendant Care is a Medicaid-covered service, which provides physical assistance with activities of daily living and instrumental activities of daily living.

Participant directed attendant care is covered when the individual requires physical assistance with a minimum of two activities of daily living due to a chronic physical condition, and has the personal capacity to obtain and direct attendant care services (including serving as an employer to hire, train, schedule, supervise, and fire attendants.)

At least annually, the need for Participant-Directed Attendant Care will be reviewed and authorized by the Department of Aging and Independent Living.

Attendant Services Program Regulations are published by the Department of Aging and Independent Living (DAIL), and are available upon request by calling DAIL at 802 241-2400.

7406 Personal Care Services (10/29/2013, 13P016)

7406.1 Definitions (10/29/2013, 13P016)

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.

7406.3 Eligibility Criteria (10/29/2013, 13P016)

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.

7406.4 Covered Services (10/29/2013, 13P016)

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.

7406.5 Personal Care Attendants (10/29/2013, 13P016)

A. A personal care attendant may be employed

1. By home health agencies, nursing service agencies, or other agencies designated to furnish this service; or
2. 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:

1. 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
2. A flexible wage. The flexible wage shall not be lower than the current Medicaid rate on file, but may be reasonably higher.
3. 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.

7406.6 Determination of Personal Care Services (10/29/2013, 13P016)

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:

1. Annually through age 5;

2. Changing to every 3 years if the child has two consecutive years of the same evaluation outcome; or

3. When there is a change in the child's ability to perform ADLs and IADLs.

7411 Private Non-Medical Institutions (07/01/1999, 99-12)

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 (07/01/1999, 99-12)

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 for Children and Families 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 (07/01/1999, 99-12)

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 for Children and Families, the Department Mental Health, the Department of Disabilities, Aging and Independent Living, or the Department of Education or Local Education Agency.

7411.3 Reimbursement (07/01/1999, 99-12)

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:

A. treatment,

B. room, board, and supervision

C. education.

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

7411.4 Assistive Community Care Facilities (07/01/1999, 99-12)

These PMNI facilities must be licensed by the Department of Disabilities, Aging and Independent Living 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 residents independence in the facility. In addition case management includes coordinating referrals required to link the resident and family to services specified in the residents 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 residents service plan and may be provided in a group setting.

Nursing Assessment: Nursing assessment includes completion of an initial and periodic re-assessment 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 residents 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 (07/01/1999, 99-12)

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.

7601 Long-Term Care Services (02/06/10, 09-07)

These regulations apply to all long-term care services for Medicaid beneficiaries of any age. For beneficiaries age 18 or over, regulations promulgated by the Department of Disabilities, Aging and Independent Living (DAIL) "Choices for Care 1115 Long-Term Care Medicaid Waiver" program (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) shall be controlling if they conflict with the provisions in this chapter (7601–7606).

The Medicaid Program (Title XIX) includes long-term care services provided to eligible beneficiaries in the following settings.

A. Nursing Facilities (NF's)

A Nursing Facility provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24–hour a day basis to assist beneficiaries to reach their optimal level of functioning.

All nursing facilities, pursuant to Section 1910(2) of the Social Security Act, have been certified for participation in Medicare, or if not participating in Medicare, have been continuously certified since July 1, 1980 for participation as a nursing facility as evidenced by a valid certification agreement on file with the Office of Vermont Health Access.

An out-of-state nursing facility must be participating in that state's Medicaid program as well as enrolled as a Vermont Medicaid provider. An in-state nursing facility (or distinct part of a facility) must be licensed by DAIL and enrolled as a Vermont Medicaid provider, in order to be reimbursed.

(1) Rehabilitation Center Services

Coverage of rehabilitation center services is limited to Medicare-certified nursing facilities, licensed by, and approved for participation by the state in which the facility is located and enrolled as a Vermont Medicaid provider. These services include intensive sensory stimulation; intensive physical, speech and occupational therapy; adjustment counseling; training in the use of prosthetics, orthotics and durable medical equipment; and other medical services needed to improve the patient's daily living skills and/or to facilitate recuperation from disease, injury or medical event. Care must be supervised by physician specialists. The purpose of rehabilitation center services is to restore a beneficiary's functional abilities to the highest practical level of physical and/or mental self-sufficiency which will prepare the beneficiary for discharge. The discharge plan will provide for the active participation and training of family members, if appropriate.

Coverage is limited to one year unless an extension beyond one year is granted by DAIL when documented medical evidence shows that the beneficiary is continuing to demonstrate significant physical and/or mental progress and can reasonably be expected to be discharged to the setting for care established in the discharge plan. Under no condition will authorization be made beyond two years.

B. Intermediate Care Facilities for the Mentally Retarded (ICF/MR's)

A public or private institution (or distinct part thereof) certified for CMS participation by DAIL's Division of Licensing and Protection, for the provision of Intermediate Care Facility services for the Mentally Retarded (ICF/MR) as evidenced by a valid certification agreement on file with the Office of Vermont Health Access executed under 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and G. An ICF/MR provides, directly or by contract, health-related care and services to individuals with mental retardation.

C. Home and Community-Based Services

Long-Term Care Services

Home and Community-Based Services include long-term care services provided in a home setting or an enhanced residential care setting. An individualized written service plan shall be developed for each participant. Services may include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, Adult Day Service, Respite, Companion Service, Personal Emergency Response System, Home Modification/Assistive Devices, and other such services as DAIL may include (Choices for Care Regulations).

7602 Supplementation Prohibition (02/06/10, 09-07)

Federal regulations require all Medicaid providers of long-term care services to accept the Medicaid payment as payment in full. For example, if a facility elects to serve Medicaid beneficiaries and the facility's customary charge for a semi-private room is $250.00, but the Medicaid payment is $200.00 per day, the Medicaid payment must be accepted as payment in full. The facility cannot collect any supplemental amount for the semi-private room from the beneficiary or anyone else acting on behalf of the beneficiary. If the beneficiary, or anyone acting on behalf of the beneficiary, wishes to have a private room, the facility cannot charge more than the difference between the charges for a semi-private and a private room. In no case can the total payments for a private room exceed the charge for a private room.

Federal regulations also describe specific items and services for which a facility may charge residents extra. Beyond these items and services, supplementation by the beneficiary, family, friends or any other source is prohibited.

Federal regulations also require that Medicaid beneficiaries be informed, in writing, by the facility, at the time of admission to the nursing facility or when they become eligible for Medicaid, of the items and services that the facility offers and for which the beneficiary may be charged, as well as the amount of charges for those services. The Division of Licensing and Protection within the DAIL is responsible for enforcing this regulation.

7603 Services Covered in a Nursing Facility (02/06/10, 09-07)

The following covered services are included in the per diem rates for nursing facilities.

A. Room and board;

B. Required nursing services (except private duty nurses);

C. Therapy services (physical, occupational, inhalation, recreational, etc.) furnished on the premises by staff employed by the facility;

D. Modification of diet (i.e., salt-free, low-fat, diabetic and other special diets and including sugar substitutes and food supplements).

E. Other special care services including, but not limited to: handfeeding, incontinence care, total care, full-time care, etc.;

F. Washing personal clothing and provision of clean bedding;

G. Bathroom supplies including toothbrush, comb, soap, shampoo, tissue, rubbing alcohol, toothpaste, lotions, talcums and similar preparations used in daily care;

H. Bedding, sheets, disposable pads, etc.;

I. All prescribed over-the-counter drugs;

J. Sterile water, saline solution, etc.;

K. All medical supply items ordered by the physician; and

L. Use of durable medical equipment with whatever frequency is medically indicated.

7603.1 Drugs in a Long-Term Care Facilities (02/06/10, 09-07)

For those Medicaid beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B and enrolled in a Medicare prescription drug plan, this section applies only to drugs not included in a Medicare-covered prescription drug class.

Drugs prescribed by the attending physician for a beneficiary in a nursing facility or an ICF/MR are covered in the same manner as for a beneficiary living in the community. Covered drugs are those available only with a prescription, obtained from a participating pharmacy, and billed directly by that pharmacy to the Medicaid fiscal agent; the pharmacy cannot bill the nursing facility and the facility then re-bill Medicaid. An exception is made for a Medicare-participating nursing facility which must collect first from Part A for covered drugs supplied as an ancillary service during the period a beneficiary is receiving nursing facility benefits under Medicare Part A.

All prescribed over-the-counter drugs for their residents are to be furnished by each nursing facility or ICF/MR. The facility will obtain these drugs from a pharmacy or drug wholesaler and enter the charges incurred in the cost report submitted for purposes of calculating the per diem rate. The facility shall not make a charge either to the program or to the beneficiary for prescribed over-the-counter drugs.

A pharmacy may, however, receive payment directly from a nursing facility or ICF/MR for reasonable costs incurred for unit dose or other systems, consulting services, or other costs incurred by the pharmacy in complying with Medicaid Rule 7501.7 and the facility shall include this cost in its cost report.

7603.2 Personal Comfort Items (02/06/10, 09-07)

Radio, television, telephone, air conditioners, beauty and barber services, and similar personal comfort items are excluded from coverage under Medicaid. The beneficiary may be charged for any personal comfort item when the beneficiary has requested it and has been advised that he or she will be charged.

The facility may also charge the beneficiary for store items secured on the beneficiary's behalf such as magazines, newspapers, candy, tobacco, dry cleaning, denture cream, hairbrush, and deodorant.

7603.3 Ancillary Services in a Nursing Facility (02/06/10, 09-07)

A nursing facility participating in Medicare must bill under Medicare Part B for the following services provided to beneficiaries when that beneficiary has exhausted his or her extended care coverage under Medicare Part A. For beneficiaries not covered by Medicare, billing Medicaid for these ancillary services is allowed.

A. diagnostic X-ray, diagnostic laboratory and other diagnostic tests;

B. X-ray, radium and radioactive isotope therapy;

C. surgical dressings, splints, cast and other devices used to reduce fractures;

D. prosthetic devices;

E. leg, arm, back and neck braces;

F. "outpatient" physical therapy and speech therapy services. Payment for outpatient physical therapy and speech therapy services requires certification by a physician that:

(1) Therapy services are or were required on an outpatient basis; and

(2) A plan for furnishing the therapy services is or was established and reviewed periodically by the physician; and

(3) The services are or were furnished while the patient was under care of a physician.

Therapy services furnished by a provider’s employees to its residents may not be billed as outpatient services.

A nursing facility participating in Medicare may provide, under arrangements with another provider, certain covered outpatient services to its residents. Under the arrangements the nursing facility must exercise professional responsibility over the arranged-for services. The services would be treated just as though they were furnished directly by the nursing facility.

7604 Duration of Coverage (02/06/10, 09-07)

Payment on behalf of an eligible beneficiary, for the period(s) the beneficiary is determined to be in need of institutional care, will begin on admission to the facility or the first day of Medicaid eligibility, whichever is later. Payment will end on the day before the day of discharge or death, the last day the beneficiary is determined to need institutional care or the last day of eligibility, whichever is earliest.

Payment will end for any absence from a facility for an inpatient stay in another medical facility (i.e., hospital, psychiatric hospital, another nursing facility except as provided below (7604.1.B).

7604.1 Leave of Absence from a Nursing Facility (02/06/10, 09-07)

A. Home Visit

Payment to a nursing facility on behalf of an eligible Medicaid beneficiary is continued during an absence for the purpose of a "home visit" (not including hospital stays) for up to 24 home visit days in a calendar year. A home visit is defined as a visit that includes an overnight stay. Such absences must be included in the beneficiary's plan of care.

B. Hospitalization

Pursuant to the Nursing Home Residents' Bill of Rights (33 VSA §§ 7301–7306), a Medicaid beneficiary has the right to retain his or her bed in a nursing facility while absent from the facility due to hospitalization provided such absence does not exceed ten (10) successive days.

Medicaid payment will be made to a nursing facility that is not a swing bed facility for up to a maximum of six (6) successive days when the bed of a beneficiary is retained because the beneficiary is admitted as an inpatient to a hospital subject to the following conditions:

(1) the nursing facility would otherwise be at its maximum licensed occupancy if the operator were not obligated to hold the bed open,

(2) the beneficiary continues to meet Medicaid eligibility criteria,

(3) the beneficiary has been an inpatient resident of the nursing facility and was admitted directly to the hospital.

(4) the nursing facility has a valid provider agreement in effect on the dates of service for which payment is made,

(5) the beneficiary's attending physician attests that the beneficiary is expected to be readmitted to the nursing facility from the hospital in ten (10) days or less, or, upon notice supplied by the hospital discharge planning unit to the nursing facility that the beneficiary will be discharged with an absence which shall not exceed ten successive days, and

(6) documentation as required above (#3) above is provided to OVHA, and is on file at the nursing facility.

Payment for the days the bed is retained for the beneficiary will be made at the certified Medicaid per diem rates established for the nursing facility reduced by the amount, if any, of the beneficiary's share.

No payment will be made when a physician or hospital discharge planning unit makes a determination that the beneficiary will be hospitalized for more than ten (10) successive days, will never return to the nursing facility, or the beneficiary or legal representative agree to waive the right to have his or her bed retained.

When a redetermination about the length of stay is made because of a change in the beneficiary's medical condition, payment will be made in accordance with the redetermination.

Each day reimbursed under this regulation is counted as a patient day for cost reporting purposes and must be reported separately from home visit days.

7604.2 Leave of Absence from an ICF/MR (02/06/10, 09-07)

Payments to an ICF/MR on behalf of an eligible beneficiary is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the beneficiary's current service agreement. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per year shall be obtained in advance from DAIL.

Medicaid payment shall be made to an ICF/MR for an eligible beneficiary during a leave of absence, subject to the following conditions:

A. Any day for which the facility is paid to hold a bed open must be counted as a patient day and the revenue must be accounted for as a patient revenue.

B. The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.

C. The facility shall hold the bed vacant during leave.

D. The beneficiary's return from leave shall not be followed by discharge within 24 hours.

E. The facility shall identify the inclusive dates of leave in the manner designated by DAIL.

F. Leave shall be terminated on the day of death.

7605 Authorization for Long-Term Care (02/06/10, 09-07)

A. Nursing Facilities

After DAIL has determined clinical eligibility for long-term care, the Department for Children and Families — Economic Services Division (ESD) determines financial eligibility for long-term care. ESD then furnishes written authorization to long-term care service providers of financial eligibility for long-term care. Eligibility for long-term care is based on financial eligibility, admission-discharge status, and clinical eligibility as determined by DAIL. Updated or revised authorizations are issued whenever one of these factors changes. The determination by DAIL shall control notwithstanding any statements by a physician or other health care professional to the contrary. Where applicable, such statements shall be reviewed by DAIL in making its determination.

Authorization for payment will be made on behalf of an eligible beneficiary based on a determination of financial eligibility (Medicaid Rules 4100–4400), and clinical eligibility made by DAIL (Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations, Section IV.B).

No Medicaid payment will be made for services provided by any out-of-state nursing facilities, other than those mentioned below, unless the facility has been enrolled by the OVHA, and the admission authorized by DAIL.

Some out-of-state nursing facilities are regarded the same as any participating Vermont facility. No prior authorization is needed. The current list of approved facilities can be found on the DAIL web site (http://www.dlp.vermont.gov/other/pre-approved-out-of-state-facilities) or can be requested from the DAIL.

Information regarding nursing facility care in a hospital (swing beds) is located in Medicaid Rule 7606.

(1) Level of Care

DAIL has review authority for all nursing facilities. The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. DAIL shall consider:

The need for a beneficiary's admission to the facility.

The need for continued stay.

The level of care required.

The appropriateness and quality of care received.

(2) Pre-Admission Screening and Resident Review (PASARR)

Pre-admission Screening and Resident Review shall be completed for certain individuals who have been or will be admitted to a nursing facility, as required by federal regulations at 42 CFR §483(c). PASARR shall determine if a person with a diagnosis of mental illness, mental retardation or a related condition requires the care provided in another type of facility, home and community-based care, or specialized services while residing in a nursing facility. The Department of Mental Health shall be responsible for PASARR for those individuals suspected of having a mental illness, or with a diagnosis of mental illness. DAIL shall be responsible for PASARR for those individuals suspected of having mental retardation or a related condition, or with a diagnosis of mental retardation or a related condition.

(3) Post-Admission Review

Clinical eligibility for any Medicaid beneficiary or applicant residing in or admitted to a nursing facility shall be determined by DAIL within ten (10) days of notification of admission or notification of application. If the beneficiary is found medically ineligible, he/she will be notified by the DAIL.

(4) Children in Long-Term Care Facilities

Least restrictive alternate living situations shall be utilized for children under age 18. When necessary, children may be served by nursing facilities in Vermont. All out-of-state nursing facilities are covered only after obtaining prior approval from DAIL. Payment for out-of-state nursing facilities for children will be covered only if there is no less restrictive placement in Vermont, only if deemed necessary by DAIL, and only if the facility is enrolled as a Vermont Medicaid provider.

B. ICF/MRs

Decisions regarding initial admission and continued stay in an ICF/MR shall be made DAIL in accordance with appropriate state and federal regulations.

7606 Nursing Facility Care in Hospitals — Swing Beds (02/06/10, 09-07)

Payment may be made on behalf of a Medicaid beneficiary who remains residing in a hospital upon determination by the Department of Disabilities, Aging, and Independent Living (DAIL) that he/she no longer needs hospital care but has been found in need of nursing facility level of care (swing bed). Such payment will be made only if the following conditions are met:

A. The beneficiary is eligible for Medicaid during the period for which reimbursement is requested.

B. The beneficiary is determined by the appropriate Utilization Review authority to be in need of nursing facility care for this period.

C. The beneficiary has a qualifying inpatient hospital stay in the hospital seeking nursing facility payment under these provisions.

D. The hospital's documentation shows a concerted and continuous effort to secure appropriate alternative placement for the beneficiary. No payment will be made in instances in which the Office of Vermont Health Access establishes that discharge planning efforts have been inadequate; where payment has already been made, recovery will be sought.

E. The beneficiary or anyone acting on his or her behalf has not declined an available bed in an appropriate participating long-term care facility in the area.

The per diem rate is all inclusive and includes the covered services as specified in Medicaid Rule 7603. For beneficiaries covered by Medicare, billing for ancillary services covered by either Part A or Part B is allowed. For beneficiaries not covered by Medicare, billing to Medicaid for ancillary services listed in Medicaid Rule 7603.3 is allowed.

Out-of-state pre-approved hospitals with swing bed status are regarded the same as any participating Vermont facility. The current list of approved facilities can be found on the DAIL web site (http://www.dlp.vermont.gov/other/pre-approved-out-of-state-facilities) or can be requested from the DAIL.

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