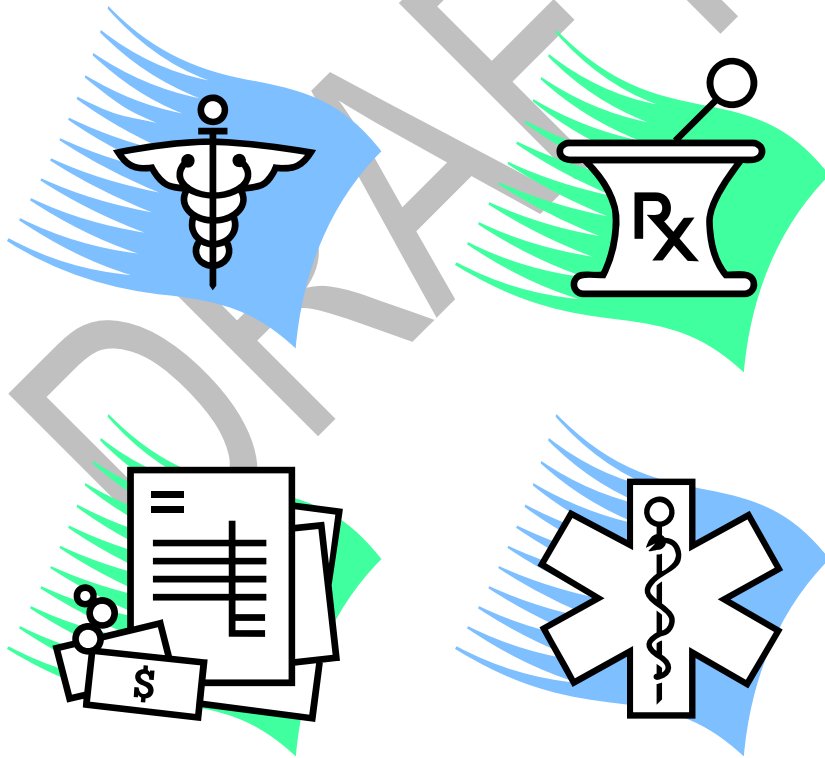


Medicaid

Covered Services



November 2006

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What Services Does Medicaid Cover?

Medicaid covers the cost of most medically necessary health care. A doctor must order the services and a qualified health care professional must provide them. You must have been determined eligible for services for the date the service was provided. Some services may need prior authorization.

This pamphlet describes the general services Medicaid covers. It does not include all possible covered services, nor does it guarantee a service will be covered. Please have your provider confirm with provider services that a particular service is covered. For more covered services information call Health Access Member Services at 1-800-250-8427; contact your health care provider; or visit the AHS informational web site at <http://www.ahs.state.vt.us/AssistVermonters.cfm>.

How Do You Apply?

You don't have to leave home to apply. Just call Member Services at 1-800-250-8427 and ask for an application for Medicaid to be mailed to you. If you're not sure how to fill out the form, call us and we'll talk you through it. Or if you prefer, apply in person at your local ESD District Office. Hospital social workers can often help too.

If you have a hearing disability, call our TTY number: 1-888-834-7898 or call 711.

If you're a senior and need help applying, you may call the Area Office on Aging, 1-800-642-5119.

Abortion

Medicaid will only cover an abortion that is necessary to save the life of the mother; when the pregnancy is the result of an act of rape or incest; or when it is deemed medically necessary by a physician to ensure the beneficiary's emotional or physical well-being.

Acupuncture

Acupuncture and services performed in relation to acupuncture are not covered.

Audiology Services/Hearing Aids

Audiology services are for diagnosis, screening, prevention and correction. Coverage includes:

- Audiologic examination;
- Hearing screening;
- Hearing assessments;
- Tests for hearing loss;
- Analog and Digital hearing aids, plus their repair or replacement;
- Hearing aid batteries (6 per month);
- Fitting/orientation/checking of hearing aids; and
- Ear molds.

Hearing aids are only available to persons who have specified hearing loss.

There is a limit of one repair per year. Any further repairs need prior authorization.



Ambulance

Ambulance services are only covered when:

- Other methods of transportation would endanger the person's health;
- A physician orders it or the physician at the receiving facility certifies the need for an ambulance; and
- The patient must be transported to and accepted as an inpatient or as an emergency outpatient in the nearest facility to treat the illness or injury.

Chiropractic Services

Services furnished by a licensed chiropractor are covered for people under age 21 only.

Coverage is limited to the manipulation of the spine to correct a subluxation of the spine, and is limited to ten treatments per patient per calendar year.

Dental Services – Beneficiaries under age 21

Services include:

- Prevention, evaluation and diagnosis, including x-rays;
- Periodic cleaning, including topical fluoride applied in a dentist's office (limited to once every six months);
- Periodontal therapy;
- Treatment of injuries;
- Treatment of disease of bone and soft tissue;
- Oral surgery for tooth removal and abscess drainage;
- Endodontics (root canal therapy);
- Restoration of decayed teeth; and
- Replacement of missing teeth, including fixed and removable prosthetics (i.e. crowns, bridges, partial dentures and complete dentures).

Dental Services – Beneficiaries age 21 and older

Services are limited to:

- Prevention, evaluation and diagnosis, including x-rays;
- Periodic cleaning (limited to once every six months);
- Limited periodontal therapy;
- Treatment of injuries;
- Oral surgery for tooth removal and abscess drainage;
- Endodontics (root canal therapy) (limited to three teeth per lifetime); and
- Restoration of decayed teeth.

Coverage of dental services for adults is limited to a maximum dollar amount per person per calendar year. The current maximum dollar amount is \$475 (as of 1/1/06).

Also see Medical and Surgical Services of a Dentist – page 12.

Drugs and Pharmaceutical Items

Pharmaceutical items include drugs, medicine chest supplies, vitamins and related items which are normally obtained through pharmacies.

Items covered must be prescribed by a medical professional who is licensed by the state of Vermont.



Physicians and pharmacists are required to conform to the Generic Drug Bill. It says that only the lowest priced equivalent is considered medically necessary. If the patient does not wish to accept the substitution, Medicaid will **not** pay for the prescription.

Over-the-counter and prescription smoking cessation products have a limit of two courses of treatment per person per calendar year.

Coverage for people enrolled in both Medicare Part D and a Vermont Medicaid program is limited to specific drug classes, and any drugs that Medicaid agrees to cover after Part D plan appeals or systems fail.

Generic pre-natal vitamins are covered for pregnant and lactating women when the physician states that condition on the prescription. Single vitamins or minerals are covered when prescribed for the treatment of a specific disease. High potency multi-vitamins may be covered with prior authorization.

Birth control drugs, supplies and devices are covered when provided on a physician's order. A supply of birth control pills may not exceed 92-days.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program provides comprehensive health services for infants, children, and adolescents. The content of screening services includes the following:

- Health history, including a developmental assessment of physical and mental health;
- Physical exams;
- Immunizations;
- Laboratory tests, including mandatory lead screening;
- Vision screening;
- Hearing screening;
- Dental screening; and
- Health education.

Eyeglasses and Vision Care

Vision care is provided to people of any age. Eyeglasses are provided only for those under age 21.

The following services are covered:

- One complete visual analysis and one interim eye exam within a two year period;
- Diagnostic visits and tests; and
- Other aids to vision when the person is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

The following services are covered for those under age 21:

- Frames and lenses every two years; and
- Contact and special lenses, when medically necessary and with prior approval.

Replacement of eyeglasses (frames or lenses) before two years is limited to when they have been lost, broken beyond repair or scratched, as determined by the provider of the eyeglasses; or when a change in the lens strength exceeds specific guidelines. Eyeglasses (frames and lenses), repairs and replacements must be provided by individuals or businesses who contract with the state for these services.



Family Planning

Family planning services are for prevention or delay of pregnancy. These include exams, counseling, testing and prescription drugs. Covered services also include medically oriented services that are furnished by physicians, registered nurses (RN), licensed practical nurses (LPN), aides, counselors and technicians employed by Planned Parenthood of Vermont.

Fertility Services

Fertility services and procedures done to increase fertility are not covered.

Home Health Care

Home Health Care services are provided by a home health care agency through a written plan signed by a physician.

Services include:

- Skilled nursing care;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Home health aides;
- Medical supplies, equipment and appliances suitable for use in the home; and



Hospice

Coverage for Hospice services are provided to terminally ill beneficiaries. The total number of days of hospice coverage is limited to 210 days. Services must be received from a Medicare certified hospice provider and be consistent with Medicare rules.

Hospital Services

Inpatient Services

Medicaid covers general hospital services when the person is admitted.

These services include:

- A semi-private room (2-4 beds);
- Nursing services;
- X-Ray;
- Blood transfusions;
- Drugs;
- Rehabilitation services (physical therapy, occupational therapy, speech therapy);
- Diagnostic tests;
- Psychiatric care; and
- Care of a newborn child.

The following inpatient services are excluded:

- Private room at patient's request for his or her personal comfort;
- Personal comfort items such as telephone, radio or television in the hospital room; and
- Private duty nursing.

Outpatient Services

Medicaid covers services and items in a hospital for patients who are not admitted.

These services include:

- Treatment for an accidental injury;
- Minor Surgery;
- Tests such as x-rays, blood tests, urinalysis, etc.;
- Diabetic counseling (limits apply);
- Rehabilitative therapies (physical therapy, occupational therapy, speech therapy, inhalation therapy); **(NOTE: These services must be ordered by a physician and after the first four months require prior authorization to be continued)**

- Emergency room care – only for treatment of emergency medical conditions (A sudden and unexpected start of an illness or accident that if left untreated, would result in: a serious threat to physical or mental health, serious harm to bodily functions, or serious failure of any bodily organ or part).

Independent Psychologists

An independent psychologist is licensed in Vermont and has a practice not in an institution, agency, or physician's office. Diagnostic testing and psychotherapy services are covered.

Laboratory and Radiology Services

Covered laboratory and radiology services include:

- Blood tests; and
- X-rays, including computerized axial tomography (CAT scans); and
- Electroencephalograms (EEG), electrocardiograms (EKG), respiratory and cardiac tests.



Long-Term Care

Choices for Care Long-Term Care Waiver - This program provides long-term care services to elderly or physically disabled Vermont adults who are found eligible by the Department of Disabilities, Aging and Independent Living (DAIL) to provide equal access to either nursing facility care or home and community-based services.

Beneficiaries may receive covered services in:

- Nursing Facilities (NF);
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR);
- Psychiatric Facilities/Institutions for Mental Disease;
- Rehabilitation Centers; or
- At home.

Massage Therapy

Massage therapy and services performed in relation to massage therapy are not covered.

Medical and Surgical Services of a Dentist

Medical and surgical services of a dentist are furnished by a doctor of dental medicine (D.D.M.) or dental surgery (D.D.S.). Services are covered:

1. if furnished by a physician, they would be considered physician services; and
2. if under Vermont law, they may be furnished by either a physician or a doctor of dental medicine or dental surgery.

Services are limited to:

- Biopsies;
- Repair of lacerations (tears in skin);
- Removal of a cyst or tumor;
- Reconstructive surgery;
- Fixing a fracture;
- Repair of temporomandibular joint (TMJ) dysfunction, including surgical treatment;
- Problem-focused limited oral evaluation;
- Problem-focused limited re-evaluation;
- Incision and drainage of an abscess; and
- Emergency treatment of dental pain – minor procedures.

Mental Health Services

Mental Health Services are offered by a variety of professionals, including psychiatrists and psychologists. If you need help finding someone to help you, contact your local community mental health center or call Member Services at 1-800-250-8427.

Nurse Practitioners

Medicaid covers nurse practitioners in either independent practice or affiliated with a physician when they are certified as:

- Nurse-Midwife;
- Family Nurse Practitioner; or
- Pediatric Nurse Practitioner.

Orthodontic Treatment

Medicaid covers medically necessary orthodontic treatment for persons under age 21 to correct a severe malocclusion (the teeth are not lined up correctly). To be considered medically necessary, the person must have one major or two minor malocclusions.



Personal Care Services

Coverage for personal care services is available only to Medicaid/Dr. Dynasaur beneficiaries under age 21. Personal care services supplement care provided by a beneficiary's family or primary caregiver, not replace it.

Covered personal care services include:

- Help with bathing, dressing and grooming;
- Help with bladder or bowel requirements;
- Help with eating, drinking and diet, to include the preparation of meals if necessary;
- Routine skin care;
- Help with positioning, lifting, transferring, ambulation and exercise.

Personal care attendants must be employed by home health agencies, nursing service agencies or other agencies approved to furnish these services.

Physician Services

Medicaid covers medical and surgical services provided in the home, office, hospital or nursing home. Covered services include:

- Routine check-ups and office visits;
- Diagnostic tests; and
- Immunizations.

Podiatry

Podiatry services are limited to non-routine foot care; such as

- Surgical removal of ingrown toenails;
- Treatment of foot wounds from infection or diabetic ulcers; and
- Similar Medicare covered services.



The fact that an individual is unable, due to physical disability, to perform routine foot care services for him/her self does not change the character of the services and make them "non-routine".

Psychiatric Services

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".

Sterilization Procedures

Sterilization for both males and females is covered within specified guidelines (contact your physician).

Operations or procedures done to reverse or attempt to reverse the effects of any sterilization procedure are not covered.

Substance Abuse Services

In partnership with other public and private organizations, the Division of Alcohol and Drug Abuse Programs (ADAP) of the Department of Health supports a system that provides:

- Education
- Prevention
- Intervention
- Treatment
- Recovery
- Research services

More detailed information can be found on the web at: <http://healthvermont.gov/adap/adap.aspx> or by calling: 802-863-7200 or 1-800-464-4343 [TTY/TDD: Dial 711 first].

Supplies and Equipment

Medical supplies and non-durable items are for the care of a specific illness, injury or disability. Medical supplies and equipment must be prescribed by a physician who is enrolled in Vermont Medicaid. Coverage of medical supplies is provided to beneficiaries of any age.

Some of the general categories of medical supplies pre-approved for coverage are limited to:

- Adhesive tape and removers;
- Antiseptics;
- Briefs, diapers and underpads;
- Catheters and catheter supplies;
- Diabetic diagnostics and daily care supplies;
- Eye care, gauze pads and rolls;
- Gloves;
- Low protein modified food products for the treatment of an inherited metabolic disease;
- Ostomy care supplies (including adhesives, irrigation supplies and bags); and
- Respiratory/tracheotomy care supplies.

Other medical supplies are covered through the prior authorization process. Some supplies may have quantity limits.

Durable Medical Equipment (DME) is defined as equipment that will stop, help or slow a medical condition and is:

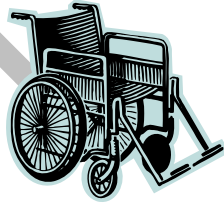
- Primarily and customarily used to serve a medical purpose;
- Lasting and able to withstand repeated use;
- Generally not useful to a person in the absence of illness, injury or disability; and
- Suitable for use in the home.

General categories include:

- Alternating pressure pumps and mattresses;
- Apnea monitors and related supplies and services;
- Bathtub chairs and seats, including shower chairs and transfer benches;
- Hospital beds and bed accessories for severe medical conditions;
- Blood glucose monitors
- Blood pressure cuffs/machines (including stethoscopes) when prescribed for patients who require frequent monitoring for a specific disease and when used as an alternative to home health nursing visits;
- Rental of electric breast pumps and supplies for mothers of premature or critically ill newborns;
- Canes, crutches, walkers;
- Commodes (including bed pans, urinal pans and raised toilet seats) when the person is unable to access typical bathroom facilities;
- Continuous passive motion devices (CPM) for homebound individuals who have received total knee replacements;
- Diabetic equipment and supplies;
- Digital electronic pacemaker monitor;
- External infusion pumps;
- Lifts (hydraulic or electric, including one sling), if safe transfer between bed and a chair, wheelchair or

commode requires the assistance of more than one person;

- Oxygen systems;
- Portable sitz baths;
- Protective helmets when the person is prone to falling (i.e. seizures, ataxia);
- Repair of durable medical equipment including parts and labor;
- Seat lift chairs when the person is unable to achieve a standing position without assistance;
- Suction equipment;
- TENS/EMS units (muscle or nerve stimulator);
- Traction equipment;
- Vaporizers; and
- Wheelchairs (initial purchase of a standard manual wheelchair with a sling seat – all others require prior authorization).



Other equipment is covered through the prior authorization process.

Augmentative communication devices or systems are covered when they are necessary to assist a person with a severe communication impairment. These devices need prior authorization.

Prosthetic devices are covered for beneficiaries of any age. A prosthetic device is a replacement, corrective or supportive device to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malformation; or
- Support a weak or deformed portion of the body.

Some of the general categories of medical equipment

NOT covered are:

- Car seats (special car seating systems for children with serious health conditions may be approved with prior authorization);
- Craftomatic beds, oscillating/lounge beds, bed boards, ordinary mattresses, beds larger than single occupancy, tables and other bed accessories;
- Elevators and stair lifts;
- Exercise balls, weights, mats, and other equipment;
- Equipment prescribed for educational or vocational purposes;
- Equipment that is primarily hygienic in nature such as hand-held shower units;
- Equipment that basically serves comfort or convenience functions for the beneficiary/caregiver;
- Equipment used for environmental control or to enhance the environmental setting (i.e. air filters, air conditioners, room/central humidifiers, vacuums, electric air cleaners, etc.);
- Home modification, including access ramps;
- Items used for cosmetic purposes such as wigs;
- Mobile geriatric chairs;
- Orthopedic shoes when prescribed for flat feet;
- Orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need;
- Repair of rental equipment or equipment covered under warranty;
- Two-wheeled motorized vehicles; and
- Whirlpool pumps.



Surgical Services

Medicaid covers surgery, including postoperative care for 30 days, except for:

- **Cosmetic Surgery:** Cosmetic surgery and the related costs are not covered. "Cosmetic Surgery" includes any procedure to improve appearance (including removal of tattoos), except when needed for the prompt repair of an accidental injury or to help the function of a malformed body part.
- **Experimental Surgery:** Experimental surgery and the related costs are not covered. "Experimental Surgery" includes any surgical procedure not proven clinically effective by literature and experts in the field.
- **Hysterectomy:** A hysterectomy is not covered when the sole purpose of the surgery is to make the woman unable to have children.

Therapy: Occupational, Physical and Speech

Therapy services must be provided through an approved plan of care ordered by a physician.

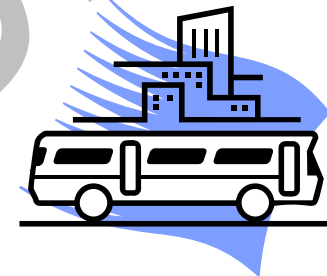
Physical, occupational, and speech therapy services are covered for up to four months based on a physician's order. Services beyond this initial four-month period require prior authorization. Therapy services must be:

- 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 for the treatment of the patient's condition.

Transportation

Transportation services are covered for transportation to and from necessary medical services when transportation is not otherwise available to the beneficiary. These services must be prior authorized. Medicaid is not required to cover transportation at unusual or exceptional cost in order to meet a person's personal choice of provider. The service is for the least expensive means of transportation that is suitable to the person's medical needs.

Contact Health Access Members Services (1-800-250-8427) for the phone number of a transportation provider in your area. All transportation questions should be handled through the provider.



General Medicaid Information

Premiums and Co-Payments

Some Medicaid beneficiaries will be responsible for premiums and co-payments, based on enrollment in specific programs. Co-payments are payments made for services such as inpatient hospital stays, outpatient services and prescriptions. Children, pregnant women, and residents of long-term care facilities do not have co-pays.

Medicaid IDs

Once you are found eligible for Medicaid, you will automatically receive a paper ID within a few days to use until you receive your green, plastic AIM card or a gold, Primary Care Plus card. It may take up to two weeks before you receive your card.

If your card is lost or stolen, please let your worker or Member Services (1-800-250-8427) know so that they can send you a temporary ID card until a new card arrives.

Before you or your eligible family member(s) receive a medical service, you will need to show the provider your temporary ID or card.

Health care providers are not required to accept Medicaid. If your provider does not accept Medicaid, and informs you before the service is provided, you will be responsible for paying the bill. You may want to find a provider who accepts your Medicaid.

Billing/Payments

If a service is covered by Medicaid and the provider agrees to take your Medicaid for payment, the provider must accept the amount Medicaid pays as payment in full (except for any required co-pays). If the provider has billed Medicaid for a service, the provider cannot bill you, even if Medicaid has paid nothing. If you have other insurance, your provider must bill that insurance company first. Any payment you receive from your health insurance company should be given to the provider.

If you are billed for a service that you believe should be paid by Medicaid, ask your worker for a Medicaid billing complaint form. If you suspect that charges are being made for services you haven't received, report this to: Office of Vermont Health Access, Program Integrity Unit, 312 Hurricane Lane Suite 201, Williston, VT 05495-2806 with the form located on OVHA's website at: http://www.ovha.state.vt.us/docs/Fraud_Referral_Form-PDF_Format.pdf, or call (802) 879-5603. You may also call Health Access Member Services for this form or to discuss the situation.

M108 Exceptions (Non-Covered Services)

Any *beneficiary* may request that the Office of Vermont Health Access cover a service or item that is ***not already included*** on a list of covered services and items. The beneficiary can request the M108 form from Member Services by calling 1-800-250-8427. The request should be sent to the Director of the Office of Vermont Health Access (OVHA). The director and other staff will review the request and supporting documentation and make a good faith effort to obtain any additional information quickly to make a decision within thirty days. A service or item will not be approved unless it is medically necessary.

If an individual requests that a service or item be covered, the following criteria are some of those that will be used in determining whether to cover the service or item.

1. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not provided?
2. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?
3. Has the service or item been identified in rule as not covered, and has new evidence about effectiveness been presented or discovered?
4. Have the medical appropriateness and effectiveness of the service or item been demonstrated in the literature or by experts in the field?
5. Are less expensive, medically appropriate alternatives not covered or not generally available?
6. Is FDA approval required, and if so, has the service or item been approved?



**If you still have questions, you may call
Health Access Member Services at
1-800-250-8427 or TTY 1-888-834-7898
(or 711), Monday through Friday
7:45 am to 4:30 pm.**