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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☒ No limitations ☐ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise provided in the state plan.

   ☒ Provided: ☐ No limitations ☒ With limitations*
   ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   ☒ Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

ITEM 1. INPATIENT HOSPITAL:

No limitations

ITEM 2.a. OUTPATIENT HOSPITAL SERVICES

Emergency Care

Emergency Care shall be administered in accordance with 42 CFR 447.53(b)(4).

Rehabilitative Therapies

Physical, occupational and speech/language therapies are described on page 4e of Attachment 3.1-A.

Diagnostic Testing

Diagnostic testing is limited to those tests ordered by a physician for determining the nature and severity of an illness or medical condition. Administratively necessary or court ordered tests are not covered, unless they are medically necessary.

Psychiatric Partial Hospitalization

Psychiatric partial hospitalization is covered as a hospital service for those programs which have received and meet the conditions of a Certificate of Need for the Vermont Health Care Authority.

ITEM 2.b. RURAL HEALTH CLINIC SERVICES AND OTHER AMBULATORY SERVICES FURNISHED BY A RURAL HEALTH CLINIC

Limitations on rural health clinics are:

1) no more than 5 visits (encounters) per month.

2) no more than 1 visit (encounter) per day.

3) any exceptions to the above by prior authorization only.

ITEM 2.c. LIMITATIONS ON FEDERALLY QUALIFIED HEALTH CENTERS ARE:

1) no more than 5 visits (encounters) per month.

2) no more than 1 visit (encounter) per day.

3) any exceptions to the above by prior authorization only.

ITEM 3. OTHER LABORATORY AND X-RAY 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.

Limitations:

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.

Laboratory services for urine drug testing is limited to eight (8) tests per calendar month. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients. Exceptions to this limitation must be prior approved.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☐ No limitations ☒ With limitations*

4. b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4. c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No limitations ☒ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

5. b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☒ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

ITEM 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older: Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled such as head injured or ventilator dependent people require authorization prior to admission from the Medicaid Director or a designee. Coverage of this care is limited to one year.

A review to determine the continued medical necessity of this care may be requested by the Medicaid Director or a designee during the one year period of coverage.

ITEM 4.b. EPSDT for individuals under 21 years of age:

EPSDT services are provided to all Medicaid eligibles under age 21 in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act.

Coverage is provided for all medically necessary diagnosis and treatment services including the following services not otherwise provided under the State Plan:

- Dentures (Item #12b)
- Eyeglasses (Item #12d)
- Personal care in home (Item #24f)
- Personal care services (Item #26)

Christian Science nursing and Christian Science sanatoria services (Items #24b and #24c) are not currently available in Vermont.

Coverage and service limitations described in this State Plan do not apply to medically necessary EPSDT services, although some services may be subject to prior authorization requirements.

ITEM 4.c. Family planning services and supplies for individuals of child-bearing age: provided, with limitations.

Reversals of sterilization are not covered.

4. D 1) Face-to-Face Tobacco Cessation Counseling Services provided (by**):**

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations ☒ With limitations*

Face-to-face smoking cessation counseling is covered for pregnant Vermont Medicaid beneficiaries. The maximum number of visits allowed per calendar year is 16.

ITEM 5.a. PHYSICIAN'S SERVICES WHETHER FURNISHED IN THE OFFICE, A PATIENT'S HOME, A HOSPITAL, A NURSING FACILITY, OR ELSEWHERE

Physician's services are limited in the following ways:

A. Physician visits:
- Office visits - up to five visits per month
- Home visits - up to five visits per month
- Nursing facilities visits - up to one visit per week
- Hospital visits - up to one admission visit per patient per diagnosis per month, and up to one visit per day for acute care.

B. Services requiring prior authorization:
1) Visits in excess of those listed above,
2) Concurrent care by more than one physician,
3) Certain reconstructive surgical procedures,
4) New procedures of unproven value,
5) Procedures of questionable medical efficacy,
6) Procedures which tend to be redundant when performed in combination with other procedures,
7) Organ transplants,
8) Psychotherapy.

C. Services which require special reporting under Federal regulations:
1) Sterilization: signed consent within stipulated time frames on the approved HCFA Sterilization Consent form required
2) Hysterectomy: physician certification and patient signed consent required.
3) Abortion: physician certification required.

D. No reimbursement will be made for the following services:
1) Cosmetic surgery
2) Ineffective or unproven procedures
3) Unnecessary testing
4) Experimental procedures
5) Services provided without required consent

ITEM 5.b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST

See item 5a. Also, some dental services may require prior authorization.

ITEM 6. MEDICAL CARE AND ANY OTHER TYPE OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW

A. Podiatrist's Services

Podiatrists' services are limited to non-routine foot care.

The following are routine foot care services and are excluded, regardless of who performs them:

1. Treatment of flat foot conditions and supportive devices used in such treatment.

2. Treatment of subluxations of the foot (structural misalignments of the joints of the feet) not requiring surgical procedures (i.e., treatment by strapping, electrical therapy, manipulations: massage, etc.)

3. Cutting or removal of corns or calluses, trimming of nails and preventative or hygienic care of the feet.

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

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

b. Optometrists' services.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Other practitioners' services.
☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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7. Home health services.

d. Physical therapy, occupational therapy, or speed pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

B. Optometrists' Services

Vision care services are limited to the following* (when provided by a licensed physician or optometrist approved to participate in Medicaid):

- One complete visual analysis including refraction once every two years per eligible beneficiary.
- One interim diagnostic eye exam once every two years per eligible beneficiary.
- Contact lenses/special lenses with prior authorization.
- Other aids to vision, such as closed circuit television, when the beneficiary 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).

* With the exception of services authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

C. Chiropractic Services

Chiropractic services are limited to treatment by means of manual manipulation of the spine for the correction of a misalignment of the spine.

Coverage is limited to ten (10) treatments per calendar year per beneficiary. Treatments beyond ten per year require prior authorization.

Treatments for children under 12 years of age require prior authorization.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

D. Other Practitioners' Services

1. Behavioral Health Services:
The services of a licensed psychologist, licensed clinical social worker, licensed mental health counselor or licensed marriage and family therapist practicing independently are covered for psychotherapy.

No reimbursement for this state plan service is allowed if the beneficiary is an inpatient or outpatient of a general hospital, resident in a mental hospital or a patient concurrently receiving services at a community mental health clinic.

2. Opticians' Services:
Vision care services are limited to the coverage of eyeglass-dispensing services.

3. High-Tech Nursing Services:
High-tech nursing services are nursing services furnished by licensed registered nurses and licensed practical nurses and are limited to technology-dependent beneficiaries who are receiving care through the Medicaid "High-Tech Program". All services must be prior authorized by the Medicaid Division.

4. Licensed Lay Midwife Services:
Services are limited to those specified in protocols for licensure and reviewed and accepted by the State of Vermont, Director of the Office of Professional Regulation.

5. Naturopathic Physician Services:
Services are limited to those specified in protocols for licensure and reviewed and accepted by the State of Vermont, Director of the Office of Professional Regulation, and are services covered by Medicaid.

ITEM 7. HOME HEALTH SERVICES

Home health services are listed to those required on an intermittent basis. Covered home health services under this Plan are those that are provided by the staff of a Medicare certified and Medicare participating home health agency or visiting nurse association.

A. Intermittent or part-time nursing ordered by and included in the Plan of treatment established by the physician.

An initial visit by a registered nurse or appropriate therapist for the assessment of the need for home health services by observation and evaluation of function may be covered either in the community or the hospital. If nursing care is ordered and provided during the visit, only one service (either the initial visit or the care) will be covered.

B. Home health aide services must be documented in the Plan of treatment and supervised by the appropriate therapist or the registered nurse. Personal care services may be performed by the aide when they are incidental to the medical care being provided.

C. Medical supplies are limited to those required to perform the services ordered by the physician. Routine small cost items (eg. cotton balls, tongue depressors, etc.) are covered in the visit or hourly rate paid to the agency. Agencies owning equipment may be reimbursed a rental fee for the loan of such equipment as meets the needs of the beneficiary as documented in the plan of treatment. Medicaid will not pay the agency for the purchase of equipment.

D. Therapy services whether occupational therapy, physical therapy or speech pathology services, are limited to four months, after which prior authorization must be requested of and granted by the DVHA for reimbursement to be made. Unless, the service may not be reasonably provided by the patient's support person(s) and the patient undergoes another acute care episode or injury, or experiences increased loss of function, or deterioration of the patient's condition requiring therapy is imminent and predictable, authorization will not be granted for more than one year from the start of treatment. Services requiring treatment which cannot be brought into the home, will be covered provided the agency has met the certifying standards for that service under their participation agreement with Medicare. Physical, occupational and speech/language therapist, assistant and aide qualifications are described on page 4f of Attachment 3.1-A.

ITEM 8. PRIVATE DUTY NURSING SERVICES

Private duty nursing services are provided to Medicaid eligible individuals only. All services require prior authorization. Services are provided in the home and community. The community setting refers to normal life activities outside of the home.

Private duty nursing services are provided in accordance with 42 CFR §440.80.

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9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist)

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 9. CLINIC SERVICES

a) Services of medical care clinics, physician group practices or Indian health services are limited in accordance with the limits to Physicians' Services set forth in this plan.

b) Mental Health clinic services are those services provided by mental health clinics which are facilities, not a part of a hospital, established for the purpose of providing mental health care and services to outpatients. A mental health clinic eligible for participation under the Plan must meet all of the following conditions:

(1) Be an incorporated, non-profit clinic governed by an elected board of directors, who reside in the catchment area of the facility;

(2) Have an organized, multi-disciplinary professional staff;

(3) Be a clinic which renders services without regard to the patient's ability to pay; and

(4) Be a clinic which conforms to the standards for mental health clinics published by the Commissioner of the Department of Mental Health.

Services eligible for reimbursement under the Plan shall be provided according to an individualized patient treatment plan which shall be prescribed by a physician or formulated with physician participation. The treatment plan or the process of treatment shall be regularly reviewed by the physician. Services shall be provided by the physician or by a qualified mental health professional on the staff of the clinic or other participating home and community based providers considered by the prescribing physician to be a competent therapist or practitioner.

c. Comprehensive service clinics operated by the Vermont Department of Health may provide all the services of medical care clinics, physician group practices, physical therapy and related services, and any other outpatient service covered in the state plan. All services provided are limited in amount, duration and scope, and qualified provider as set forth in this plan.

All patients of the comprehensive service clinics shall have an individualized patient treatment plan prescribed by a physician or formulated with physician participation. The treatment plan or the process of treatment shall be regularly reviewed by the physician. Clinic services shall be provided by a physician or by another qualified provider. All health care providers used by the clinic that are not enrolled in the Medicaid program must be credentialed by the Vermont Department of Health.

ITEM 9. CLINIC SERVICES (Continued)

1) Psychotherapy:

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes family therapy when only one family is being treated. Psychotherapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

2. Group Therapy:

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations. Group therapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

3) Day Hospital:

Day Hospital is an intensive service provided in clinic facilities that provides active treatment which can reasonably be expected to lead to full or partial recovery of the patient (client). Day Hospital services are provided as an alternative to inpatient care for clients with mental illness of an acute and/or episodic nature. A variety of treatment modalities is available, including individual, group and family therapy, chemotherapy and treatment-related activity programs.

4) Chemotherapy (Med-Check):

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs. Chemotherapy may be provided in any setting except skilled nursing or intermediate care facilities, or the facilities of the Vermont State Hospital or the Brandon Training School.

ITEM 9. CLINIC SERVICES (Continued)

5) Diagnosis and Evaluation

A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client s attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.

6) Emergency Care

A method of care provided for persons experiencing an acute mental health crisis is evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.

ITEM 10. DENTAL SERVICES

For beneficiaries under age 21, non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint). Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the department's dental consultant. Prior authorization is required for most special dental procedures.

For beneficiaries age 21 and older, the dental benefit is limited to $495.00 per beneficiary per calendar year. Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint). Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the department's dental consultant. Prior authorization is required for most special dental procedures.

Non-covered services include; cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

ITEM 11. PHYSICAL THERAPY AND RELATED SERVICES

A, B, & C Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders are covered as follows:

For beneficiaries under age 21, prior authorization is required beyond eight therapy visits per discipline (physical, occupational, or speech therapy).

For beneficiaries age 21 and older, thirty (30) therapy visits per calendar year and include any combination of physical therapy, occupational therapy and speech/language therapy. Exceptions to this limitation must be prior approved.

All therapy providers meet the provider qualification described in 42 CFR 440.110

PT, OT, and ST for an inpatient of the nursing facility are covered in the nursing facility per diem.

Analog or Digital hearing aids are limited to one hearing aid per ear every three years for specified degrees of hearing loss outlined below. Prior authorization is required for more frequent requests for a hearing aid. Hearing aid repairs are limited to one repair/modification per aid per year. Prior authorization is required when a second or subsequent repair/modification is requested within 365 days of a previous repair/modification. Hearing loss will have to meet one of the following conditions or if otherwise necessary under EPSDT; prior authorization is required for other degrees of hearing loss:

a. Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.

b. Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.

c. Hearing loss in the better ear is greater than 40dB base on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

(Continued)

All licensed therapy providers must meet the provider qualification described in 42 CFR 440.110. A physical therapist, occupational therapist, and speech language pathologist shall provide all of the therapeutic intervention that requires the expertise of a licensed therapist and shall determine the use of physical or occupational therapist assistants or therapy aides who provide for the delivery of care that is safe, effective and efficient, provided the assigned acts, tasks, or procedures do not exceed the person's education or training and provided:

1) Physical and occupational assistants are graduates of an accredited program and are licensed to practice in the state of Vermont. A physical therapist assistant shall work under a physical therapist's supervision; an occupational therapist assistant shall work under an occupational therapist's supervision. A physical therapist or occupational assistant may document care pursuant to an existing treatment plan from the supervising therapist. A speech language pathologist assistant is not a graduate of an accredited program and is not licensed in the state of Vermont, therefore is considered an aide.

2) A licensed therapist may use aides for designated routine tasks, which do not include skilled therapy services. An aide shall work under the on-site supervision of a licensed therapist who is continuously on site and present at the facility, who is immediately available to assist the person being supervised in the services being performed, and who maintains continued involvement in appropriate aspects of each treatment session in which a component of treatment is assigned. The supervision by the licensed therapist may extend to off-site supervision of the aide only when the aide is accompanying and working directly with a physical or occupational assistant with a specific patient or when performing nonpatient-related tasks.

Speech therapy assistants and any other person regardless of discipline working under the supervision of a licensed therapist (for example, a massage therapist, an athletic trainer, an exercise physiologist, a kinesiotherapist) shall be considered an aide and is subject to the above supervision requirements. All aides are defined as individuals, trained under the direction of a licensed therapist, who performs designated and supervised routine tasks.

3) Students enrolled in accredited therapist/physical or occupational therapist assistant programs, while engaged in completing a clinical requirement for graduation must work under the direct line-of-sight supervision and direction of a licensed therapist.

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12. Prescribed drugs, dentures, and prosthetic devices; eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than provided elsewhere in the plan.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST

A. Prescribed Drugs

1. Drugs listed by the FDA as less than effective are not covered by Medicaid, nor are the generic equivalents of the listed drugs covered.
2. Physicians and Pharmacists are required to conform to Act 127 (18 VSA Chapter 91), otherwise known as the Vermont Generic Drug Law. In those cases where the Generic Drug Law permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. Medicaid will not pay if the recipient refuses the substitution required by law.
3. A pharmacist must fill prescriptions in quantities of between 30 and 90 days supply for all drugs prescribed for continued regular use. The physician may prescribe for particular patients or conditions in lesser amounts and in these instances the pharmacist is required to fill as directed. Effective July 15, 2009, when the DVHA is the primary payer, pharmacies will be required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. The first fill allows prescribers to test for therapeutic effectiveness and patient tolerance.
4. Coverage for certain other drugs is limited to specific conditions, e.g. amphetamines for the treatment of narcolepsy cataplexy syndrome only.
5. Generic over-the-counter (OTC) drugs are covered when medically necessary; without the option of prior authorization for brand products; prescribed by a qualified Medicaid provider; and a federal rebate agreement with the manufacturer is in force. Some OTC medications already managed on the Preferred Drug list (PDL) may have additional restrictions. The PDL can be found at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria.
6. Contraceptive drugs are covered and claimed at the increased Federal match under Family Planning.
7. No coverage is provided for items such as:
   - topical antiseptics
   - rubbing alcohol
8. [Reserved]

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

9. Medicaid Program: Requirements Relating To Covered Outpatient Drugs For The Categorically Needy

Citation (s)	Provision (s)
1935(d)(I)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency will cover the following classes of excluded drugs as listed below:

☒ (a) Drugs for anorexia, weight loss, or weight gain: Some drug categories covered under the drug class:

Hormone therapy is covered when used for anorexia or weight gain.

No drugs are covered for weight loss.

☒ (b) Some prescription vitamins and mineral products, except prenatal vitamins and fluoride:

Single vitamins or minerals when prescribed for the treatment of a specific disease;

☒ (c) All drug categories covered under the drug class: Barbiturates and

☒ (d) All drug categories covered under the drug class: Benzodiazepines

☒ (e) Nonprescription Drugs: Some drug categories covered under the drug class:

analgesics; antihistamines; decongestants; cough suppressants; dermatological agents; fluoride dental products; gastrointestinal agents; hematopoietic agents; insulin; ophthalmics; otics and all smoking cessation products.

☒ (f) All prescription smoking cessation drugs (except dual eligibles as Part D will cover):

Nicotine replacement and oral therapies are covered when prescribed for smoking cessation.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

9. Medicaid Program: Requirements Relating To Covered Outpatient Drugs For The Categorically Needy (Continued)

☒ Some drugs when used for the symptomatic relief of coughs and colds
- Decongestants
- Antihistamines
- Cough suppressants

☐ Drugs when used for cosmetic purposes or hair growth

☐ Drugs when used to promote fertility

These services provided are identical in the amount, duration and scope of services as provided to the medically needy for prescription drugs.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

10. Supplemental Rebate Agreements: Certain covered products in accordance with Section 1927 of the Social Security Act may not be among the baseline preferred drugs identified by the State of Vermont's Drug Utilization Review (DUR) Board and/or the Pharmacy and Therapeutics (P & T) Committee for various therapeutic classes. The state may negotiate supplemental rebate agreements that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

    In addition the State has the following policies for the supplemental rebate program for the Medicaid population:

    - Supplemental rebate agreements are unique to each state. The supplemental rebate agreement submitted to CMS on June 6, 2009 amends the March 31, 2006 version of the "Vermont State Supplemental Drug Rebate Agreement" authorized under Transmittal 06-05. CMS has authorized this amended version of the "Vermont State Supplemental Drug Rebate Agreement." The addendum to this agreement, approved by CMS, entitled "Sovereign States Drug Consortium, Addendum to Member States Agreements" is not changed by this amendment. The June 6, 2009 supplemental rebate agreement and the approved SSDC Addendum apply to drugs dispensed beginning January 1, 2009.
    - Funds received from supplemental rebate agreements will be reported to CMS. The state will remit the federal portion of any supplemental rebates collected.
    - Manufacturers with supplemental rebate agreements are allowed to audit utilization data.
    - The unit rebate amount is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act.
    - The Department of Vermont Health Access (DVHA) may require prior authorization for covered outpatient drugs. Non-preferred drugs are available with prior authorization.
    - The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927(d)(5) of the Social Security Act.

11. The DVHA covers select active pharmaceutical ingredients (API) and excipients used in extemporaneously compounded prescriptions when dispensed by a participating pharmacy provider and issued by a licensed prescriber following state and federal laws. Select APIs are published at http://dvha.vermont.gov/for-providers.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

B. Dentures

Dentures are covered for EPSDT only.

C. Prosthetic Devices

Prosthetic devices are covered only by prior authorization except for breast prostheses, trusses, and prosthetic socks which require only a physician's order.

Augmentative communication devices are covered for all beneficiaries when medically necessary, with prior authorization.

Wheelchairs are covered, with limitations.

D. Eyeglasses and Other Aids to Vision

Eyeglasses are covered for EPSDT only.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN.

Additional diagnostic, screening, preventive or rehabilitative services provided to EPSDT eligible recipients may require medical necessity review.

1. Diagnostic Services

Diagnostic services provided by state and/or local education agencies are covered when provided pursuant to the development of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for special education students as defined under Part B or Part H of the Individuals with Disabilities Education Act.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than provided elsewhere in the plan. (Continued)

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Rehabilitation services;

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

14. Services for individual age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

2. Substance Abuse Services

Covered substance abuse services include detoxification and rehabilitation services provided in a residential treatment facility approved by the Vermont Office of Alcohol and Drug Abuse Programs. These services may be provided by a physician, psychologist or by a substance abuse counselor certified by the Vermont Office of Alcohol and Drug Abuse Programs.

Professional services provided to residents of approved treatment centers who are in need of detoxification is limited to seven days of service per acute episode.

Professional services provided to residents in need of post-detoxification services is limited to thirty days of service per calendar year.

Professional services provided to residents in need of extended post-detoxification services is available to eligible beneficiaries, as determined by the Office of Alcohol and Drug Abuse Programs, and is limited to 183 days per calendar year.

Professional services provided to non-residents is limited to ninety hours of counseling per episode.

3. Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Developmental and Mental Health Services. These services may be provided by physicians, psychologists, MSWs, psychiatric nurses, and qualified mental health professionals carrying out a plan of care approved by a licensed physician or licensed psychologist. Services may be provided in any setting; however, services will not be duplicated.

Beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under the 1115 waiver are ineligible for this State Plan service.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

A. Reserved

B. Diagnosis and Evaluation

A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to the family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

C. Emergency Care

A method of care provided for persons experiencing an acute mental health crisis as evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.

D. Psychotherapy

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes client-centered family therapy.

E. Chemotherapy (Med-Check)

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

F. Group Therapy

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations.

G. Specialized Rehabilitative Services

- Basic Living Skills

  Restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills.

- Social Skills

  Redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.

- Counseling

  Counseling services directed toward the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

G. Specialized Rehabilitative Services (Continued)

- Collateral Contact

  Meeting, counseling, training or consultation to family, legal guardian, or significant others to ensure effective treatment of the recipient. These services are only provided to, or directed exclusively toward, the treatment of the Medicaid eligible person.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

4. Private Non Medical Institutions

A. Child Care Services

Covered services are child care services provided by qualified staff to recipients who are in residential child care facilities. These services are psychiatric/psychological services, counseling services, nursing services, physical, occupational, and speech therapy services, and care coordination services.

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

Services may be provided by physicians, psychologists, R.N.s, L.P.N.s, speech therapists, occupational therapists, physical therapists, licensed substance abuse counselors, Masters degree social workers, and other qualified residential child care facility 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. Covered services also include administrative costs related to the provision of direct services covered by the Medicaid Program.

B. Assistive Community Care Services

Assistive Community Care Services are provided to adults with functional impairments or cognitive disabilities. Services are provided in licensed level III facilities. Services provided to beneficiaries are case management, assistance with the performance of activities of daily living, medication assistance monitoring and administration, 24-hour on-site assistive therapy, restorative nursing, nursing, assessment, health monitoring, and routine nursing tasks. Any services that constitute the practice of nursing under the Vermont Nurse Practice Act will be provided by a licensed registered nurse or will be delegated by a licensed registered nurse in accordance with the procedures of the Board of Nursing.

Individual plans of care are reviewed at least annually by the Department of Aging and Disabilities. The services are furnished by providers who are licensed by and meet the qualifications established by the Department of Aging and Disabilities.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

4. Private Non Medical Institutions (Continued)

C. Therapeutic Substance Abuse Treatment Services (TSATS)

Therapeutic Substance Abuse Treatment Services are provided to individuals, who have a history and primary diagnosis of substance abuse and who meet the placement and medical necessity criteria established by the Agency of Human Services. In this program, participation is voluntary but participants must be willing to enroll for a period of at least six and no more than twelve months.

Services provided to beneficiaries are 24-hour on site assistive therapy; medication assistance, monitoring and administration; health monitoring; primary care coordination; random substance screenings; and individual and group therapy services provided on-site.

Individual plans of care are written upon admittance to the program and are adhered to for the duration of the participant's stay in the program. Individual plans of care may be modified with the agreement of the beneficiary and the program director. Services are provided by providers who are licensed by the state of Vermont and/or meet the qualifications established by the Agency of Human Services.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

5. School Health Services

School health services are ordered by an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for special education students as defined under Part B or Part C of the Individuals with Disabilities Education Act (IDEA). Services are administered by state agencies, or state or local education agencies and must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law. Covered services may be provided by employees of the state or local education agencies or by the health professionals under contract with the education agencies, or providers who meet applicable state licensure or certification requirements.

A. Assessment and Evaluation

Included are services for the assessment and evaluation of an existing IEP/IFSP. Services provided for the purposes of evaluating an individual's treatment needs may include medical, psychiatric, psychological, developmental and/or behavioral assessment, including the administration and interpretation of psychological tests. It may be performed by one or more of the following providers: physician, psychiatrist, psychologist, clinical social worker, school nurse, specialized therapist or a licensed or certified mental health practitioner.

B. Medical Consultation

Services provided by a licensed physician whose opinion or advice is requested in the evaluation or treatment of an individual's problem or disability.

C. Durable Medical Equipment

Items of durable medical equipment provided pursuant to an IEP may be covered subject to prior authorization requirements established by the Office of Vermont Health Access.

D. Vision Care Services

Covered services include visual analysis with refraction, and diagnostic and treatment services for diseases of the visual system.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

5. School Health Services (Continued)

E. Nutrition Services

Evaluation and treatment services related to a child's nutritional needs, as allowed by 42 CFR 440.130(d). Nutrition services are child specific and must be medically necessary to treat and correct problems such as eating disorders, food intake deficits, and excessive weight gain or loss which result from other medical problems, psychological issues, metabolic diseases, etc. The service includes assistance with assessments and care plan development. More specifically, it includes modification of child-specific food menus and counseling so as to provide the maximum reduction of physical and/or mental disability and the restoration of the child to his/her best possible functional level. Services do not include coverage of general nutritional services such as those provided by a school's hot lunch program.

Services must be furnished by dieticians who meet state certification requirements.

F. Physical Therapy

Evaluation and treatment services for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by or under the direction of a qualified physical therapist. A qualified physical therapist is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent, and is licensed by the State of Vermont.

G. Speech. Hearing and Language Services

Evaluation and treatment services related to speech, hearing or language disorders which result in communication disabilities. Services are performed by or under the direction of a speech-language pathologist or audiologist who has a certificate of clinical competence from the American Speech and Hearing Association, or who has the equivalent education and work experience, or who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

5. School Health Services (Continued)

H. Occupational Therapy

Evaluation and treatment services to implement a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in daily pursuits. Services are performed by or under the direction of a qualified occupational therapist who is registered by the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and is engaged in the supplemental clinical experience required before registration by the AOTA.

I. Mental Health Counseling

Evaluation and treatment services involving mental, emotional or behavioral problems, disturbances and dysfunctions. Services are individual, group, or family counseling when provided by a psychiatrist, psychologist, clinical social worker, or other licensed or certified mental health practitioner.

J. Rehabilitative Nursing Services

Services provided by a licensed nurse including medical monitoring and provision of other medical rehabilitative services.

K. Developmental and Assistive Therapy

Services provided in order to promote normal development by correcting deficits in the child's affective, cognitive, behavioral, or psychomotor/fine motor skills development, when such services are identified in the IEP/IFSP. Services include application of techniques and methods designed to overcome disabilities, improve cognitive skills, and modify behavior. Services are furnished by or under the direction of licensed professionals who meet qualifications established by the LEA, or who meet applicable state licensure or certification requirements.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

5. School Health Services (Continued)

L. Personal Care

Services related to a child's physical or behavioral requirements, including assistance with eating, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, use of adaptive equipment, ambulation and exercise, behavior modification, and other remedial services necessary to promote a child's ability to participate in, and benefit from, the educational setting. Services are furnished by providers who have satisfactorily completed a training program for home-health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions and meet qualifications established by the LEA. Person Care providers must be employed by a school, school district or Supervisory Union. Personal care services are not covered when provided to recipients by their parents, including natural, adoptive and step-parents.

M. Case Management

Services designed to assist children in gaining access to, and coordinating the delivery of, medical services, including interaction with providers, monitoring treatment and interaction with parents and guardians. Services are furnished by qualified providers who based on their education, training and experience, have been designated as such by either the Agency of Human Services, Department of Education or LEA.

N. Medical Transportation

Transportation services to or from necessary medical care. Services are furnished by providers who meet the qualifications established by the LEA.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

6. Child Sexual Abuse and Juvenile Sex Offender Treatment Services

Child Sexual Abuse and Juvenile Sex Offender treatment services are individual, group and client-centered family counseling; care coordination; and clinical review and consultation services provided to children who have been sexually abused or who are sexual offenders. Services must be authorized by the Department of Social and Rehabilitation Services.

These services are not available to inmates of public institutions and/or prisons. Also, reimbursement by Medicaid is non-duplicative of other public or private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

7. Intensive Family Based Services

Intensive Family Based Services are family-focused, in-home treatment services for children that include crisis intervention, individual and family counseling, basic living skills and care coordination. Services are authorized by the Department of Social and Rehabilitation Services or the Department of Mental Health and Mental Retardation and are furnished by providers who meet qualifications specified by the Department of Social and Rehabilitation Services.

Reimbursement for Intensive Family Based Services will not duplicate reimbursement from other State Plan, other public, or other private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

8. Developmental Therapy

Evaluation and treatment services provided to a child in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor development. Services must be specified in a child's Individualized Family Service Plan (IFSP) under Part H of the Individuals with Disabilities Education Act (IDEA) and must be furnished by providers who meet applicable state licensure or certification requirements.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

9. Day Health Rehabilitation Services

Day Health Rehabilitation Services are provided to individuals with physical or cognitive impairments who are not residing in a nursing home, nor receiving enhanced residential care services or other similar services. Day Health Rehabilitation Services are intended to maintain optimal functioning and prevent or delay the need for the level of services provided in a nursing facility. The services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services. Beneficiaries are determined eligible for Day Health Rehabilitation Services by the Department of Aging and Disabilities. The intensity of services provided to each individual is in accordance with the individual's plan of care and is provided under the supervision of a registered nurse.

The services are furnished by providers who meet the qualifications specified by the Department of Aging and Disabilities. Prior authorization of this service is required from the Department of Aging and Disabilities.

Reimbursement for Day Health Rehabilitation Services will not duplicate reimbursement from other State Plan, public or private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

This page describes the WAM M108 procedure (which went through public notice) for requesting services or items to be approved for Medicaid beneficiaries in addition to those services or items on a pre-approved list. For services or items in Attachment 3.1-A with pre-approved lists the service or item description includes a reference to this page (6o) of the State Plan.

Procedure for Requesting Medicaid Coverage of a Service or Item

This procedure provides a way for beneficiaries to seek Medicaid coverage for medically-necessary items or services that are not already listed as pre-approved for coverage in Vermont's current Medicaid regulations. The procedure requires that a beneficiary's situation must be unique and that serious detrimental health consequences will result if the service or item is not approved for coverage, then the item or services may be approved for coverage.

Beneficiaries send a request for coverage to the department, accompanied by their physician's written recommendation for the service or item. The department reviews the request, seeks additional information as necessary, and endeavors to make the coverage decision within 30 days from the date of the request. The department evaluates each request using 10 criteria.

Each decision results in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list of pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.

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15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

18. Hospice care (in accordance with §1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 15.a. INTERMEDIATE CARE FACILITY SERVICES (OTHER THAN SUCH SERVICES IN AN INSTITUTION FOR MENTAL DISEASES) FOR PERSONS DETERMINED, IN ACCORDANCE WITH SECTION 1902(A)(31)(A) OF THE ACT, TO BE IN NEED OF SUCH SERVICES.

Provided: No Limitations.

ITEM 15.b. INCLUDING SUCH SERVICES IN A PUBLIC INSTITUTION (OR DISTINCT PART THEREOF) FOR THE MENTALLY RETARDED OR PERSONS WITH RELATED CONDITIONS.

Provided: No Limitations

ITEM 16. INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE.

Provided: No Limitations.

ITEM 18. HOSPICE CARE

Provided: No Limitations.

Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act and must comply with the requirement in section 4305 of the State Medicaid Manual. A physician must certify that the eligible person is within the last six (6) months of life. These services may be provided on a 24 hour, continuous basis. Coverage is available for an unlimited duration. All services must be performed by appropriately qualified personnel, for the nature of service being provided.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case Management Services and Tuberculosis Related Services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

☒ Additional coverage **

b. Services for any other medical conditions that may complicate pregnancy.

☐ Additional coverage **

** Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

22. Respiratory care services (in accordance with section l902(e)(9)(A) through (C) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 20. EXTENDED SERVICES TO PREGNANT WOMEN

Personal care services, home visits, and health education are included as extended services to pregnant and postpartum women when prior authorized by the Title V agency as part of the Healthy Babies Program.

ITEM 23. PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Services are limited pursuant to Item 5a of the State Plan.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 24. ANY OTHER MEDICAL CARE AND ANY TYPE OF REMEDIAL CARE RECOGNIZED UNER STATE LAW, SPECIFIED BY THE SECRETARY

A. Transportation

Ambulance

Ambulance service coverage is limited to:

- Medicaid certified and participating ambulance providers;
- instances where other methods of transportation are medically contraindicated; and
- service is ordered by a physician or certified by the receiving facility physician as medically necessary;
- where the patient is transported to the nearest appropriate facility for admission or emergency outpatient treatment; or
- an inpatient is transported home from a hospital or nursing facility; or
- an inpatient is transported to another hospital and returned for specialized diagnostic or therapeutic services not available at the first hospital.

Prior authorization is required for coverage of ambulance service to an out-of-state hospital. Transport to a border hospital does not require prior authorization.

Non-Emergency Services

Coverage for transportation to and from medical service providers is provided when no other means of transportation is available. Coverage for transporting a beneficiary and a medically necessary escort to and out-of-state appointment with appropriate meals and lodging is outlined at: http://dvha.vermont.gov/for-providers. See Attachment 3.1-D.

Prescription Drug Services for full-benefit Dual Eligibles

Transportation is provided for full-benefit dual-eligible beneficiaries to and from pharmacies in order to obtain Medicare Part D prescription drugs if no other means of transportation is available.

ITEM 24. ANY OTHER MEDICAL CARE AND ANY TYPE OF REMEDIAL CARE RECOGNIZED UNER STATE LAW, SPECIFIED BY THE SECRETARY (Continued)

B. Services of Christian Science nurses: not available in Vermont.

C. Care and services provided in Christian Science Sanitoria: not available in Vermont.

D. Nursing facility services for patients under 21 years of age: Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled such as head injured or ventilator dependent people require authorization prior to admission from the Medicaid director or a designee. Coverage of this care is limited to one year.

E. Emergency Hospital Services: Medicaid will cover services provided on an emergency basis by a hospital that does not participate in Medicare but services must be reviewed and approved prior to payment.

F. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse: provided to EPSDT eligible recipients only. Some services may require medical necessity review.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided: ☒ State Approved (Not Physician) Service Plan Allowed
☒ Services Outside the Home Also Allowed
☒ Limitations Described on Attachment
☐ Not provided.

ITEM 26: PERSONAL CARE SERVICES

A. EPSDT Personal Care Services

EPSDT Personal care services are defined as services related to a beneficiary's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications.

EPSDT personal care services are provided only to eligible beneficiaries under age 21 when they are determined to be medically necessary pursuant to §1905(r)(5) of the Social Security Act.

B. Participant-Directed Attendant Care Services

Participant-Directed Attendant Care Services are services which provide physical assistance with activities of daily living and instrumental activities of daily living.

Participant directed attendant care services are 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.)

Participant-Directed Attendant Care Services will be reviewed and prior authorized at least annually.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE State Plan Amendment Pre-Print

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

☒ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☐ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Free Standing Birth Center Services

a. Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations:

b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☐ With limitations (please describe below)

☒ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: