

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:

- ◆ Private duty nursing (Item #8)
- ◆ Respiratory care (Item #22)
- ◆ Personal care in home (Item #24f)

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.

Personal care services, home visiting, and health education are provided as special EPSDT services when prior authorized by the Title V agency as part of the Healthy Babies Program.

ITEM 8. PRIVATE DUTY NURSING SERVICES

Private duty nursing services are provided to EPSDT eligible individuals only. Some services may require medical necessity review. Services are provided in the home and community.

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

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 limited as follows:

- 1) to those provided in the outpatient department of a hospital, nursing facility\*or Medicare certified rehabilitation agency; by private practitioners who are active Medicaid providers; and by staff therapists of a home health agency or comprehensive outpatient rehabilitation facility;  
\* PT, OT, and ST for an inpatient of the nursing facility are covered in the nursing facility per diem.
- 2) 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.
- 3) Analog or Digital hearing aids are covered when they are determined to be medically necessary pursuant to §1905(r) of the Social Security Act.

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

State: VERMONT

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

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.

TN No. 02-21  
Supersedes  
TN No. 02-19

Approval Date: 01/23/03

Effective Date: 11/01/02

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

B. Dentures

Dentures are not covered.

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 not covered.

Other aids to vision, such as closed circuit television, are covered 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).

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

Provided: No Limitations.

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 1902(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.

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TN No. 91-12  
Supersedes  
TN No. 87-17

Approval Date: 04/27/92

Effective Date: 11/01/91

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 22. RESPIRATORY CARE SERVICES

Provided to EPSDT eligible recipients only. Some services may require medical necessity review.

ITEM 23. PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Services are limited to those covered in the State Plan and as contained in protocols reviewed and accepted by the Vermont State Board of Nursing and the Vermont State Board of Medical Practice.

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:

- Medicare 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.

Mental Health Clinics

Transportation is provided to and from community mental health clinics for clinic services in instances where no other transportation is available.

Medical Services

Coverage for transportation to and from medical service providers is provided where no other means of transportation is available. See Attachment 3.1-D.

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

A. Transportation (continued)

School Health Service Providers

Covered transportation services are limited to transportation beyond the scope routinely provided to all students. Coverage is provided for transportation to enable the student to reach a destination to receive medically related services for which the school is responsible, pursuant to an IEP/IFSP.

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.

- 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.