

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
Department of Vermont Health Access (DVHA)**

**AHS Bulletin No: 12-07**

Secretary of State's ID Number: 12P-046

**FROM:** Mark Larson, Commissioner  
Department of Vermont Health Access

**DATE:** 12/04/12

**SUBJECT:** Dental Coverage for Pregnant and Postpartum Women

**CHANGES ADOPTED EFFECTIVE:** 12/26/12

**TYPE OF RULE CHANGE**

**Adopted Rule Changes**

**Final Proposed Rule Change**

**Proposed Rule Change**

**RULE REFERENCE(S):**

**7312            7313            7314**

This rule is being implemented pursuant to (H.781) Act 162 of the 2011 -2012 Legislative Session, An Act Making Appropriations for the Support of Government.

**Sec. E.307.4 DENTAL COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN**

(a) The secretary of human services shall apply to the Centers for Medicare and Medicaid Services for an amendment to the state Medicaid plan pursuant to 42 C.F.R. Section 430.12 to eliminate the adult dental benefit maximum as applied to pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program and to enable pregnant women to receive the same dental benefits that are available for children on Dr.

Dynasaur/Medicaid for the duration of the pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

(b) Upon approval of the state plan amendment pursuant to subsection (a) of this section, the secretary of human services shall adopt rules pursuant to 3 V.S.A. chapter 25 to implement the expansion of dental coverage for pregnant women.

***Specific Changes***

Table of Contents	Rule 7312, add: <i>and Pregnant and Postpartum Women</i>
7312	Title - add: <i>Pregnant and Postpartum Women</i>
7312.1	Sentence 1 – delete: <i>Pursuant to federal EPSDT regulations, coverage for dental services is required for and when such services are medically necessary</i> ; add: <i>or</i> ; and add second paragraph: <i>Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.</i>
7312.2	Re-number <u>Covered Services</u> to 7312.3 and add <u>Qualified Providers</u> from previous 7312.6; delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network.</i>

7312.3	Delete: <u>Conditions for Coverage</u> and move contents to 7312.3 and 7312.5; and add <u>Covered Services</u> from previous 7312.2; sentence 1 add: <i>Medically Necessary</i> , delete: <i>that have been pre-approved for coverage are</i> , and add: <i>the following general categories</i> ; to the second bullet add from 7312.5 <u>Conditions for Coverage</u> : <i>is limited to once every six months, except more frequent treatment can be authorized by the DVHA</i> , and add eleventh bullet: <i>Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint)</i> ; and add new paragraph: <i>The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.</i>
7312.4	Renumber: <u>Prior Authorization Requirements</u> to 7312.6 and add <u>Non-Covered Services</u> from previous 7312.5; paragraph 1, sentence 1, delete: <i>With the exception of services authorized for coverage via Rule 7104</i> , and delete: <i>and services that do not meet criteria specified in rules 7312.3 and 7312.4 where applicable are not covered</i> ; and add: <i>Non-covered services are</i> , and delete references to rules: 7312.2, 7312.2-7312.4 and add: 7312.3, 7312.5, and 7312.6; paragraph 2, delete: and add: <i>covered</i> ; paragraph 3, delete: <i>billed</i> , and add: <i>covered</i> .
7312.5	Renumber <u>Non-Covered Services</u> to 7312.4 and add <u>Prior Authorization Requirements</u> from previous Rule 7312.4; sentence 1, delete: <i>department's dental consultant</i> , and add: <i>DVHA</i> ; sentence 2, delete: <i>The dental procedures subject to prior authorization review are not specified here because they are unusually numerous and they change frequently due to product change, new product availability, and the departments need for utilization management</i> , and add: <i>The dental fee schedule contains a detailed list of covered dental services. It also indicates which procedures require prior authorization</i> ; second paragraph delete: <i>it also</i> , and add: <i>and</i> , and delete: <i>procedures and services</i> .
7312.6	Renumber <u>Qualified Providers</u> to 7312.2 and add <u>Reimbursement</u> from previous Rule 7312.7; Delete: <i>Provider Manual</i> , and Add: <i>Dental Fee Schedule</i> , and Add: <i>and the Dental Supplement</i> .
7313	Delete: preceding Interpretive Memo dated 10/01/12 as incorporated into Rule 7313. Introduction, sentence 2, Delete: <i>This definition was taken from the federal definition found at...</i> and Add: <i>See</i> , and brackets before and after CFR citation.
7313.1	First sentence, Delete: <i>As of January 1, 1989, coverage of dental services was extended to...</i> Add to second sentence: <i>For pregnant and postpartum women, age 21 and older, see Rule 7312.</i>
7313.2	Renumber <u>Covered Services</u> to 7313.3 and add <u>Qualified Providers</u> from previous 7313.6; delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network</i> .
7313.3	Delete Preceding interpretive memo dated 1/1/2007; and renumber <u>Conditions for Coverage</u> to 7313.5 and add <u>Covered Services</u> from previous 7313.2; sentence one delete: <i>that have been pre-approved for coverage are</i> , and add: <i>Medically necessary... include bur are... the following general categories</i> ; add to bullet two: <i>is limited to once every six months, except more frequent treatments can be authorized by the DVHA</i> ; after seventh bullet Add: <i>and</i> ; Add eight bullet: <i>non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint)</i> ; and add final paragraph: <i>The dental fee schedule contains a detailed list of covered dental procedures and services. It also indicates which procedures and services require prior authorization.</i>
7313.4	Renumber <u>Prior Authorization Requirements</u> to 7313.6 and add <u>Non-Coverage Services</u> from previous 7313.5; paragraph 1, sentence 1, delete: <i>Unless authorized for coverage via rule 7104</i> , and add: <i>Non covered services are those services not included under rule 7313.3 and services that do not meet criteria specified in rules 7313.5, and 7313.6</i> ; paragraph 2, delete: <i>billed</i> , and add: <i>covered</i> ; paragraph 3, delete: <i>billed</i> , and add: <i>covered</i> .
7313.5	Renumber <u>Non-Covered Services</u> to 7313.4 and add <u>Conditions for Coverage</u> from previous 7313.3; sentence 1 delete: <i>adults</i> and add: <i>beneficiaries age 21 or older</i> , and add: <i>of \$495</i> ; sentence 2, delete: <i>The current maximum dollar amount is \$400</i> ; paragraph 2 delete: <i>Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint)</i> ; paragraph 3 delete: <i>Coverage for prophylaxis is limited to once every six months</i> ,

	<i>except more frequent treatments can be authorized by the DVHA; paragraph 4, delete: Endodontic treatment is limited to Medicaid payment for three teeth per lifetime; and paragraph 5 delete: Approval granted by the department's dental consultant assures medical necessity and coverage.</i>
7313.6	Renumber <u>Qualified Providers</u> to 7313.2 and add Prior Authorization Requirements from previous 7313.4; sentence 1, delete: <i>OVHA Dental Consultant</i> , and add: <i>DVHA</i> ; sentence 2, delete: <i>Provider Manual</i> , and add: <i>Dental Fee Schedule</i> , and delete: <i>their codes, and fee schedule. It also, and procedure codes.</i>
7313.7	Paragraph 1, sentence 1, delete: <i>fee</i> and delete: <i>unless the beneficiary is in a long term care facility, pregnant, or in the 60-day post pregnancy period</i> ; sentence 2, delete: <i>parenthesis, and (4)</i> and add: <i>For exclusions, and (C.)</i> ; and Paragraph 2, delete <i>Provider Manual</i> , and add: <i>Dental Supplement and the Dental Fee Schedule</i> ; and paragraph 3, delete: <i>The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates when prior authorization is required at the code level.</i>
7314	Introduction, sentence 2, Delete: <i>This definition is consistent with the federal definition found at...</i> and Add: <i>See</i> , and brackets before and after CFR citation.
7314.1	Sentence 1, delete: <i>Coverage for orthodontic treatment is limited to beneficiaries under the age of 21</i> ; and add: <i>Beneficiaries under the age of 21 when such services are medically necessary; or.</i>
7314.2	Renumber <u>Covered Services</u> to 7314.3 and add <u>Qualified Providers</u> from previous 7314.5; paragraph 1 sentence 1, add: <i>or orthodontist</i> , and delete: <i>with Vermont Medicaid</i> , and add: <i>in the Green Mountain Care Network</i> ; paragraph 2, sentence 1, delete: <i>Comprehensive orthodontic services must be provided by a licensed dentist enrolled with Vermont Medicaid</i> , and paragraph 2, sentence 2, delete: <i>department's dental consultant</i> , and add: <i>DVHA</i>
7314.3	Delete <u>Conditions for Coverage</u> and add <u>Covered Services</u> from previous 7314.2; delete: <i>that have Been pre-approved for coverage are and medically necessary orthodontic treatment, as defined in Rule 7314.4</i> ; and add: <i>Medically necessary...include but are not...the following categories</i> ; and add: <i>The dental fee schedule contains a detailed list of covered orthodontic procedures and other orthodontic services. It also indicates which procedures and services require prior authorization.</i>
7314.4	Sentence 1, add: <i>all</i> , and delete: <i>interceptive and comprehensive</i> ; and add new paragraph 2: <i>To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by DVHA or if otherwise necessary under EPSDT found at rule 4100.</i>
7314.5	Renumber <u>Qualified Providers</u> to 7314.2 and add <u>Reimbursement</u> from previous 7314.6, and sentence 4 delete dental consultant and add: <i>DVHA</i> , and sentence 5, add: <i>and the Dental Supplement</i>
7314.6	Move <u>Reimbursement</u> to 7314.5.

### ***Responses to Public Comments***

A public hearing was held on Friday, September 28<sup>th</sup>, 2012 at 10:00 a.m. in the Department of Vermont Health Access (DVHA) Conference Room, 289 Hurricane Lane, Williston, Vermont.

Written Comments were allowed through 4:30 p.m. on Friday, October 5<sup>th</sup>, 2012. No members of the public attended the public hearing. DVHA received written comments from Vermont Legal Aid as well as a letter from Voices for Vermont's Children in support of the rule change and in agreement of the comments made by Vermont Legal Aid. Their comments are summarized below along with DVHA's responses.

#### Comments from Vermont Legal Aid

**Comment:** We understand that DVHA is interpreting “postpartum” throughout the proposed rules to mean the period following the end of the pregnancy. The relevant section of the statute, E.307.4, is titled “Dental Coverage for Pregnant and Postpartum Women.” The statute requires that the Secretary seek expanded dental coverage for pregnant women for the duration of their pregnancy and “through the end of the calendar month during which the 60<sup>th</sup> day following the end of pregnancy occurs.” Thus the statute defines “[p]ostpartum” as it relates to the end of the pregnancy, not birth. The proposed changes to 7313 and 7314 are consistent with the statutory definition of postpartum. However, 7312 is not consistent with the statutory definition. It states that expanded dental coverage is for pregnant women and for women through the end of the calendar month during which the 60<sup>th</sup> day “from the date of birth occurs.” In order to comply with the statute, 7312.1 should be amended by deleting “from the date of birth occurs”, and substituting the language “following the last day of pregnancy”, or its equivalent

**Response:** DVHA agrees and has made the appropriate language change to Rule 7312 in accordance with Act 162.

**Comment:** We understand and applaud that DVHA will be using the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of coverage for pregnant and postpartum women. EPSDT stands as a broad directive to the states that accept federal Medicaid subsidies that the state must provide preventive and comprehensive health services that are medically necessary for an eligible child. These services include all of the 29 mandatory and optional broad categories of services listed in the Medicaid Act. EPSDT’s mandate is broad and has a preventive thrust. It requires states to cover, “Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [§ 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” 42 U.S.C. Section 1396d(r)(5)

**Response:** See the DVHA response to your general comment regarding Rule 7312 and EPSDT.

#### Rule 7312

**Comment:** We are concerned that 7312 conflicts with federal EPSDT law. Proposed 7312 provides that there are only certain dental services, treatment, and other measures, that are covered services, namely those listed in 7312.3, and those, per 7312.6, that are listed in a Provider Manual referred to in the rules. It appears that the rules are limiting dental services to those on specified lists, particularly listed in a separate Provider Manual. If so then 7312 violates EPSDT law. This approach is routinely rejected as a violation of federal EPSDT law. EPSDT prohibits an across-the-board exclusion of particular dental services and its corollary, a pre-determined list of dental services that the state will cover. See Jacobus vs. Department of PATH, (177 Vt. 496; 847 A.2d 785, 2004) This issue is discussed more specifically below, in our comments about particular subsections of 7312.

**Response:** The purpose of this rule change is expansive in providing additional dental services to pregnant and postpartum women where they have been limited or not-covered previously. None of the covered dental services for beneficiaries under the age of 21 are being reduced or limited. The covered dental service for beneficiaries under the age of 21 in Rule 7312 have been in existence and unaltered since April 1, 1999 and remain substantively unchanged in this rule filing. States may reasonably limit Medicaid services to those that meet the state’s definition of medical necessity. The provision of dental services for beneficiaries under age 21 is based on medical necessity. Per Vermont Medicaid Rule 7103: medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and a

determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition. Again, this rule change expands coverage for pregnant and postpartum and places no further limitations or burdens on services for beneficiaries under the age of 21. The covered services for beneficiaries under the age of 21 and pregnant and postpartum women are based on medical necessity and clinical best practice. It is also worth highlighting that the cumulative rule change also removes the lifetime limitation for endodontic treatment for beneficiaries 21 and older.

**Comment:** The first sentence of 7312 sets out Medicaid’s definition of dental services. The introduction also should include a statement of what dental services are covered. This is not set forth in the proposed rule and would it easier to understand. The proposed rule deletes the first sentence of existing 7312.1 regarding federal EPSDT law. A sentence requiring compliance with federal EPSDT law should be added. It could state, for example, “Pursuant to the requirement of federal EPSDT law, all medically necessary dental services are required to be covered. Some medically necessary dental services require prior authorization and others do not.”

**Response:** Rule 7312.3 serves to provide an overview of covered services therefore it would be redundant to also list them in the introduction. As part of the technical changes to this rule it is the intention of DVHA to format rules when practical and as part of a larger comprehensive rule re-write project to align more closely with the CFR format for coverage rules; the deleted reference in 7312.1 is redundant. The EPSDT mandate is addressed in Rule 7410 and in Rule 4100. The comprehensive rule re-write process will further address these and other issues of redundancy.

**Comment:** Our understanding of this subsection is that the ten bulleted services are covered by DVHA as long as they are medically necessary. It is our further understanding that the determination of medical necessity is made solely by the medical provider prescribing the treatment, and that the provider is not required to get prior authorization from DVHA. Based upon the foregoing, the heading of the section is confusing because it does not accurately describe the section. The section does not purport to list all covered services, as the heading suggests, but only those that are covered without requiring prior authorization. We suggest that 7312.3 be titled “Covered Services That Do Not Require Prior Authorization.” We further suggest that the first sentence be changed by replacing the language “have been pre-approved for coverage” with “do not require prior authorization” in order for the language of 7312 to be clearer and more consistent.

**Response:** VLA’s understanding that the *provider is not required to get prior authorization* is incorrect; DVHA covers a multitude of dental services which are subject to prior authorization review but are not specified here because the dental services covered by DVHA are too numerous to list completely in rule. This section provides an overview of general coverage categories. DVHA agrees that the language “*have been pre-approved for coverage*” is confusing and has altered the first sentence and added clarification language after the bulleted list that with respect to prior authorization which makes it more consistent with language in the prior authorization section, by adding the following: *The Dental Fee Schedule contains a detailed list of covered dental procedures and services. It also indicates which procedures and services require prior authorization.*

**Comment:** We strongly encourage DVHA to delete the sub-heading, Non-Covered Services. No similar sub-heading is contained in 7314.

**Response:** DVHA disagrees and believes it is necessary to continue to provide an overview of these particular non-covered services. Rule 7314 only addresses orthodontic treatment which is a considerably more narrowly focused dental specialty compared to the general dental services referred to in Rule 7312 which are much more numerous and broad-based.

- Comment:** As discussed above, there are no specific dental services that are non-covered under EPSDT law except for those that are not medically necessary.
- Response:** See DVHA's response to VLA's general comment regarding Rule 7312 - Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women and EPSDT.
- Comment:** This sub-heading, along with the sub-headings of 7312.1 and 7312.6, provides a framework that suggests that there are specific dental services that are covered, those that are non-covered, and some finite list of services that may be covered if prior authorization is obtained. However, such a regulatory scheme violates EPSDT law for the reasons previously discussed.
- Response:** See DVHA's response to VLA's general comment regarding Rule 7312 - Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women and EPSDT.
- Comment:** Finally, the first sentence of 7312.4 is confusing because of the double negatives. Our reading of this sentence is that unless a particular type of dental service is listed in 7312.3 or in the Provider Manual, as set forth in 7312.6, that the service is not covered. Again, a rule that covers only a pre-defined list of dental services violates EPSDT.
- Response:** The first sentence in this section has been revised. See DVHA's response to VLA's general comment regarding Rule 7312 - Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women and EPSDT.
- Comment:** We understand that the changes to this section were not meant to be substantive. However, the sub-heading does not appear to serve a purpose. The text of this portion of the rule shows no relationship to the sub-heading. Proposed 7312 would be more logical and easier to understand if, like was done in 7314, this sub-heading were eliminated.
- Response:** DVHA agrees and has eliminated the subject heading and moved the content to Rule 7312.3 Covered Services.
- Comment:** The first sentence of this subsection states that non-surgical treatment of temporomandibular joint is limited to a particular treatment, namely the fabrication of an occlusal orthotic appliance. Such a restriction, on its face, violates EPSDT law. The touchstone of EPSDT is that treatment that is medically necessary for a particular child (here to be expanded to pregnant and postpartum women) must be covered. This provision precludes an individualized assessment of medical necessity.
- Response:** See DVHA's response to VLA's general comment regarding Rule 7312 - Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women and EPSDT. Also there are other non-dental treatments for TMJ that DVHA covers which are not applicable to the dental coverage section of rule. DVHA has moved the TMJ language to Rule 7312.3 Covered Services.
- Comment:** The second sentence, regarding the coverage of prophylaxis, should be reworded to clarify our assumption of its intent, that is, that medically necessary prophylaxis is covered once every six months without prior authorization and that it is covered more frequently if it is medically necessary and prior authorization from DVHA is obtained.
- Response:** This language had been moved to Rule 7312.3 Covered Services.

**Comment:** Proposed 7312.6 sets forth that there is a specific list of dental services, set out in the referenced Provider Manual, that are covered if prior authorization is obtained. As previously stated, an across-the-board exclusion of any dental service which necessarily includes the use of a pre-defined list of dental service, violates EPSDT law.

**Response:** See DVHA's response to VLA's general comment regarding Rule 7312 - Dental Services for Beneficiaries Under Age 21 and Pregnant and Postpartum Women and EPSDT.

**Comment:** The text of 7312.6 should be stricken in its entirety. In its place should be language clarifying that prior authorization is required for all dental care that is not listed in 7312.3. There cannot be any reference to a "list" of procedures that may be covered. Proposed 7312.6 should clearly state that all prescribed dental services, except those listed in 7312.3, require prior authorization.

**Response:** As previously stated many more dental services are covered and may be subject to prior authorization review as is practical to list in the rule document; DVHA has however restated the following language which was added to Rule 7312.3 Covered Services: The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

**Comment:** The last sentence in 7312.5 should be moved to this section and changed to state, "Prior authorization by DVHA assures that a service is medically necessary and will be covered."

**Response:** DVHA has removed the language as redundant per rule 7102.

#### Rule 7313

**Comment:** The structure and overlap regarding pregnant and postpartum women in 7312 and 7313 is confusing. Proposed 7312, by its title and text, applies in its entirety to pregnant and postpartum women age 21 and older. By contrast, 7313 does not clarify that it is not applicable to pregnant and postpartum women age 21 and older although it must be read to mean so in order to give meaning to 7312. It should be clarified that 7313 does not apply to pregnant and postpartum women who are 21 and older. The dental rules would be easier to understand if 7313 stated, in its title or its introduction, that the rule does not apply to pregnant and postpartum women.

**Response:** DVHA agrees and has clarified the language to Rule 7313.1 Eligibility for Care.

**Comment:** There are only two provisions in 7313 that make specific reference to pregnant and postpartum women who are 21 or older and both would be more logical if moved to 7312.

**Response:** One reference was already marked for deletion and DVHA has removed the second reference from 7313.

**Comment:** The second of the two references to pregnant and postpartum women is in 7313.7. It provides that pregnant and postpartum women are no longer excluded from having a co-payment for dental care. The proposed rule requires that pregnant and postpartum women pay a \$3.00 co-payment to each provider for services rendered on that day. We oppose the implementation of co-payments to pregnant and postpartum women. Requiring a co-payment would represent a change in policy in Vermont. The purpose of the expansion of dental coverage is to increase healthier pregnancies and better health outcomes for children. Co-payments would be a barrier to this goal, especially for Vermont's poorest pregnant women. Studies related to other important health services, such as prescription medications, show that after the implementation of allegedly nominal co-payments, utilization of clinically important prescription medications declined significantly, by 17.2%, among Medicaid beneficiaries.

**Response:** VLA's assertion is incorrect; pregnant and postpartum women are exempt from paying copayments per Rule 7101, Medicaid Rule 4161(B), and 42 CFR § 447.53. Per VLA's suggestion DVHA removed all references to pregnant and postpartum women except for the reference per VLA's recommendation under Rule 7313.1 Eligibility for Care.

#### Rule 7314

**Comment:** In addition to setting out Medicaid's definition of prosthetic devices, the introduction should include a statement of what orthodontic treatment is covered and that coverage must be consistent with federal EPSDT law.

**Response:** Coverage is more concisely describe in Rule 7314.3 Covered Services. As previously indicated, the EPSDT mandate is addressed in the Rule 7410 and in Rule 4100. The rule re-write process will further address these and other issues of redundancy.

**Comment:** Like 7312.2, 7314.2 states that qualified providers must be enrolled in Green Mountain Care Network. Unlike 7312.2, this provision also states that providers must be enrolled in Vermont Medicaid. We would like to know why there is this difference between the two rules.

**Response:** The DVHA deleted sentence one of paragraph two making the language more consistent between the two rules.

**Comment:** The language of this rule, that services that have been pre-approved are limited to medically necessary orthodontic treatment, as defined in 7314.4, is confusing. Proposed 7314.4 states that orthodontic treatments require prior authorization, which seems to conflict with the language of this subsection which suggests some treatment does not require prior authorization. This should be clarified. Sentence two of 7314.4 regarding medical necessity should be moved to this subsection.

**Response:** The language has been amended, the covered services have been more clearly specified in the rule, and DVHA also added a reference to the Dental Fee Schedule. DVHA believes the medical necessity language is more appropriately stated in the prior authorization section as it is in Rules 7312 and 7313. Rule 7314 format follows the CFR prescribed format for coverage rules.

**Comment:** As stated above, the first sentence of this subsection, when read with 7314.3, is confusing. Do all orthodontic treatments require prior authorization? If so, this should be clarified.

**Response:** All orthodontic treatment with the exception of one orthodontic service requires PA. The rule has been changed to state that all orthodontic treatment requires PA.

**Comment:** Proposed 7314.4 provides that for interceptive orthodontic treatment to be medically necessary, "the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by DVHA or if otherwise necessary under EPSDT found at rule 4100." This standard is the same as the one challenged in the Vermont Supreme Court in Jacobus. Following an extensive analysis of federal EPSDT law, the Vermont Supreme Court, in Jacobus, found that the Petitioners, while not meeting the "one major or two minor malocclusions" test of the rule, were eligible for interceptive orthodontic treatment. Id. The Court held in Jacobus that PATH (now DCF) "must provide EPSDT Medicaid coverage of interceptive orthodontic treatment whenever an eligible beneficiary's conditions meet the States' listed diagnostic treatment criteria or when the evidence shows that they have conditions of equal or greater severity." Id. The Court found that contrary to federal EPSDT law, the rule and the practice for determining coverage of orthodontic treatment failed to provide an individualized

assessment of the beneficiary to determine medical necessity and that that the rule violated EPSDT law by providing a pre-defined list of criteria for coverage. Id. Proposed 7314.4 violates the Court's order entered in Jacobus. We strongly encourage that 7314.4 be brought into compliance with Jacobus by explicitly stating that, "Consistent with federal EPSDT and Medicaid law, an individualized assessment of medical necessity of orthodontic treatment for a beneficiary is required." Further, 7314.4, to be brought into compliance with Jacobus, must be amended to add the language "when the evidence shows that the beneficiary has a condition of equal or greater severity", following the language in the rule "must have one major or two minor malocclusions". Without this change, the State is vulnerable to a legal challenge to 7314.

**Response:** The clinical criteria used by the DVHA for reviewing requests for orthodontic treatment was developed in response to the Jacobus decision.

**Comment:** This language, at 7314.4, setting out the standard for coverage for orthodontic treatment, should be moved to 7314.3.

**Response:** DVHA believes the PA criteria is more appropriately stated in the prior authorization section. The Rule 7314 format follows the CFR prescribed format for coverage rules.

**Comment:** Finally, the third sentence of 7314.4 is inconsistent with a similar sentence in 7312.5 which states that approval granted by DVHA assures "medical necessity and coverage." By contrast, 7314.4 states that approval from DVHA assures "medical necessity only." Proposed 7314.4 should be amended to state that prior authorization assures "medical necessity and coverage", a reasonable outcome of the prior authorization of a service.

**Response:** DVHA has made this change.

#### Comments from Voices for Vermont's Children

**Comment:** Voices for Vermont's Children is writing in strong support of the proposed rule change to eliminate the adult dental benefit maximum as applied to pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program. We consider this a great step forward in the ongoing battle against oral health disease on behalf of women and their newborns. We have read and considered the comments of the Office of the Health Care Ombudsman and want to indicate our agreement. We ask that you make the changes requested in their comments. Thank you for implementing this important Medicaid expansion.

**Response:** Thank you for your letter in support of the rule change. DVHA has made a significant number of the changes requested by Vermont Legal Aid.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Department of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://www.leg.state.vt.us/schedules/schedule2.cfm> or call 828-5760.

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7504	Medical Supplies
7505	Durable Medical Equipment (DME)
7506	Wheelchairs, Mobility Devices and Seating Systems

7507	Augmentative Communication Devices/Systems
7508	Prosthetics Devices
7601	Long-Term Care Services
7602	Supplementation Prohibition
7603	Services Covered in a Nursing Facility
7604	Duration of Coverage
7605	Authorization for Long-Term Care
7606	Nursing Facility Care in Hospitals — Swing Beds
7700	Pharmacy Administration
7701	Pharmaceutical Manufacturer Fee

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### 7312 Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women

Dental services are preventive, diagnostic or corrective procedures involving the oral cavity and teeth.  
[See 42 CFR §440.100 & §440.120(b)]

#### 7312.1 Eligibility for Care

Beneficiaries under the age of 21; or

Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

#### 7312.2 Qualified Providers

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

#### 7312.3 Covered Services

Medically necessary services include but are not limited to the following general categories:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis, including topical fluoride applied in a dentist's office, is limited to once every six months, except more frequent treatments can be authorized by the DVHA;
- periodontal therapy;
- treatment of injuries;
- treatment of disease of bone and soft tissue;
- oral surgery for tooth removal and abscess drainage;
- treatment of anomalies;
- endodontics (root canal therapy);
- restoration of decayed teeth;
- replacement of missing teeth, including fixed and removable prosthetics (i.e. crowns, bridges, partial dentures and complete dentures); and
- non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

For coverage of orthodontic services see rule 7314.

#### 7312.4 Non-Covered Services

Non covered services are those services not included or referenced under rule 7312.3.

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Local anesthesia is considered part of the dental procedure and shall not be covered as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be covered as separate procedures.

#### 7312.5 Prior Authorization Requirements

Prior authorization by the DVHA is required for most special dental procedures.

The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

#### 7312.6 Reimbursement

Reimbursement for dental services is described in the Dental Supplement and the Dental Fee Schedule.

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### 7313 Dental Services for Beneficiaries Age 21 and older

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth.

[See 42 CFR § 440.100]

#### 7313.1 Eligibility for Care

Beneficiaries age 21, or older. For dental services for pregnant and postpartum women see Rule 7312.

#### 7313.2 Qualified Providers

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

#### 7313.3 Covered Services

Medically necessary services include but are limited to the following general categories:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the DVHA;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endontics (root canal therapy);
- restoration of decayed teeth; and
- non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

The dental fee schedule contains a detailed list of covered dental procedures and services. It also indicates which procedures and services require prior authorization.

#### 7313.4 Non-Covered Services

Non covered services are those services not included under rule 7313.3 and services that do not meet criteria specified in rules 7313.5, and 7313.6.

Services that are not covered 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.

Local anesthesia is considered part of the dental procedure and shall not be covered as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be covered as separate procedures.

#### 7313.5 Conditions for Coverage

Coverage of dental services for beneficiaries age 21 or older is limited to a maximum dollar amount of \$495 per beneficiary per calendar year. Medical and surgical services of a dentist, as described in rule 7311, are not subject to this maximum dollar amount.

#### 7313.6 Prior Authorization Requirements

Prior authorization by the DVHA is required for most special dental services. The Dental Fee Schedule contains a detailed list of covered dental procedures and services schedule and indicates which require prior authorization.

#### 7313.7 Reimbursement/Copayments

Beneficiaries are required to pay a \$3.00 co-payment to each provider for services rendered on that day. For exclusions See rule 4161 (C).

Reimbursement for dental services is described in the Dental Supplement and the Dental Fee Schedule.

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### 7314 Orthodontic Treatment

Medically necessary orthodontic treatment involves the use of one or more prosthetic devices to correct a severe malocclusion. [See 42 CFR §440.120(c)]

#### 7314.1 Eligibility for Care

Beneficiaries under the age of 21 when such services are medically necessary; or.

Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs when such services are medically necessary.

#### 7314.2 Qualified Providers

Interceptive or comprehensive orthodontic services must be provided by a licensed dentist or orthodontist enrolled in the Green Mountain Care Network.

#### 7314.3 Covered Services

Medically necessary services include but are not limited to the following categories:

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Treatment to Control Harmful Habits

The Dental Fee Schedule contains a detailed list of covered orthodontic procedures and indicates which require prior authorization.

#### 7314.4 Prior Authorization Requirements

Prior authorization is required for all orthodontic treatment.

To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by DVHA or if otherwise necessary under EPSDT found at rule 4100.

#### 7314.5 Reimbursement

Approved interceptive treatment is reimbursed in one installment when treatment is started.

Comprehensive orthodontic services are reimbursed in four installments. The first payment is made

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when treatment is started. The next three payments are made at the end of subsequent six-month intervals. As long as the beneficiary is eligible on the first day of the six-month period, full payment will be made for that period, except when the beneficiary will lose coverage during the period due to age limits. In the latter case, partial payment will be made for that portion of the period in which the beneficiary was eligible. If a beneficiary is receiving orthodontic services and becomes eligible for Medicaid coverage and the treatment plan is approved by the DVHA, a partial payment will be made based on the portion of the period covered by Medicaid.

Reimbursement for orthodontic services is described in the Dental Supplement and the Dental Fee Schedule.