

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

AHS Bulletin No: 10-09

FROM: Susan Besio, Ph.D., Commissioner
Department of Vermont Health Access

DATE: 06/22/10

SUBJECT: Changes to VHAP - Limited and VHAP - Managed Care Procedures

CHANGES ADOPTED EFFECTIVE: 07/01/10

PROCEDURE REFERENCE(S):

P-4003 A P-4003 B P-4003 C P-4005 A P-4005 B P-4005 C

This bulletin updates VHAP Procedures with services that were changed in (H.789) Act 156 of the 2009 -2010 Legislative Session, An Act Making Appropriations for the Support of Government. It also incorporates multiple Interpretive Memos that have been issued explaining services, and applies consistent formatting.

REMOVE ALL PAGES OF P-4003 AND P-4005 AND REPLACE WITH ATTACHED PAGES

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P-4003 A

P-4003 VHAP-Limited Benefit Coverage Package

Until such time as Vermont Health Access Plan (VHAP) participants have access to and are enrolled in managed care plans, they are covered by an interim limited fee-for-service (FFS) benefit package, described in the following subsections.

A. Summary of Covered and Non-Covered Services

The following services are covered on a fee-for-service basis:

- hospital outpatient services, including lab tests, radiology procedures and treatments, or ambulatory surgical center services;
- physician and mid-level practitioner services, including services provided by rural health centers and federally qualified health centers, routine gynecological exams and related diagnostic services, family planning services, and prenatal and maternity care until the individual is enrolled in traditional Medicaid and services provided by a naturopathic physician (N.D.);
- home health care;
- hospice services furnished by a Medicare-certified hospice provider;
- outpatient therapy services (occupational, physical, speech and nutrition therapy);
- emergency ambulance services;
- emergency services, (emergency is when patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally the patient is admitted through emergency room.)
- hospital inpatient services;
- outpatient mental health and chemical dependency services;
- chiropractic services
- podiatry services; and
- prescription drugs.

The following services are not covered:

- short-term inpatient rehabilitation services;
- residential substance abuse treatment services;
- services provided in an institution for mental disease (IMD);
- skilled nursing facility services;
- vision services and any prescribed eyeglasses;
- dental services;
- medical equipment and supplies; and
- prosthetics and orthotics.

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package1. Hospital Carea. Inpatient Services

Benefits provided for inpatient care in a hospital include:

- facility room & board,
- services,
- medications, and
- supplies.

b. Outpatient Services

Benefits for services and supplies related to outpatient care in a hospital or acute surgical center are limited to:

- facility services and
- professional services.

2. Professional Care for Home and Office Visits

Benefits are provided for the following professional services in the individual's home or a provider's office:

- consultations between professional providers when an individual is an outpatient,
- immunizations and injections that are appropriate to the age of the individual (except chemotherapy, described in other parts of this section),
- outpatient medical care, and
- effective preventive care (for example: well child care, periodic OB/GYN exams, maternity care, physicals).

Benefits are also provided for emergency medical care or emergency accident care in the provider's office or in the emergency room.

Benefits are provided for professional services not described above, including

- required consultations between professional providers when an individual is an inpatient,
- outpatient diagnostic services, and
- inpatient professional medical care.

Requirements

Benefits will be provided for consultations between professional providers only if the consulting professional provider completes a formal consultation report which must be added to the individual's medical record.

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P-4003 B2

P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)2. Professional Care for Home and Office Visits (Continued)Limitations

Only one visit per day from each professional provider will be covered. Monthly visitation limits are specified in Medicaid Rule 7301.1.1.

3. Other Medical Carea. Surgery

Benefits are provided for surgical services in an office or facility setting.

Surgery is limited to:

- use of specialized instruments,
- endoscopic examinations,
- treatment of burns,
- correction of fractures and dislocations,
- anesthesia, and
- sterilization for beneficiaries age 21 and over, but not reversal of sterilization.

Normally no benefits are provided for pre- and post-operative care. (Most pre- and post-operative visits are considered part of the surgical service, so additional benefits for these services are not provided).

b. Maxillofacial Surgery

Maxillofacial surgery benefits are provided for the following services:

- treatment for accidental injury to the jaws, sound natural teeth, mouth or face;
- surgery to correct gross deformity resulting from major disease, congenital deformity, or surgery;
- surgery to correct temporomandibular joint syndrome.

Exclusions

No benefits are provided under this section for:

- periodontal care,
- repair or replacement of damaged dental prostheses,
- injury as a result of chewing or biting,
- oral surgery services not performed by a physician, or
- oral surgery care not specified as a benefit above.

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P-4003 B3

P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)c. Transplant Services

Only outpatient hospital and professional services related to transplantation services are covered.

d. Rehabilitative Therapy Services (Occupational, Physical and Speech Therapy)

Rehabilitative Therapy Services are defined in Medicaid Rule 7317.

Limitations

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

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

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

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

Services provided by a home health agency are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified in Medicaid Rule 7317.

e. Other Therapies

Benefits are provided for the treatment of an illness or injury on an outpatient hospital basis by means of:

- chemotherapy or radiation therapy (including radioactive isotopes),
- dialysis,
- infusion therapy, and
- inhalation therapy.

P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)f. Nutrition Therapy

Benefits for nutrition therapy services are provided when such services are:

- demonstrated as a cost-effective alternative to drug therapy or
- necessary to treat or prevent disease.

Conditions for which nutrition therapy services are appropriate include:

- diabetes;
- hyperlipidemia;
- chronic kidney failure;
- eating disorders;
- inborn errors of metabolism; and
- malabsorption syndromes, conditions associated with oral-motor dysfunction, and conditions requiring feeding by enteral tube or vein.

g. Maternity Care

Benefits are provided for medical and surgical services for pregnancy until such time as the individual is determined to be eligible for Medicaid under traditional eligibility rules.

Benefits are provided for services of professionals whether the delivery occurs at home or in a facility.

h. Ambulance

Benefits are provided for transportation of sick and injured individuals from their home, the scene of an accident or the scene of a medical emergency to the nearest facility based on their perceived condition at the scene of the accident or medical emergency.

Exclusions

No benefits are provided if the individual could have been transported in a private car or other non-emergency vehicle, nor are benefits provided for ambulance services provided solely for the individual's convenience. Ambulance transportation between facilities and between hospitals and nursing homes are not covered benefits, except that transportation between hospitals will be covered when the recipient has an urgent condition that cannot be treated at the first hospital.

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P-4003 B5

P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)i. Cardiac Rehabilitation

Rehabilitation benefits are provided for outpatient cardiac rehabilitation.

Exclusions

No benefits are provided for chronic care.

j. Chiropractic Services

Benefits for VHAP-Limited are identical to those for Medicaid beneficiaries. See Medicaid Rule 7304 for coverage, limitations and exclusions.

4. Home Care

This section addresses benefits for supplies and services the individual receives in their home from home health agencies or visiting nurse associations, or home care organizations, including hospice services from these agencies.

a. Home Health Agency, Visiting Nurse Association, and Home Care Organization Care

Benefits are provided for the following services and are included in their bills:

- necessary skilled nursing procedures,
- training in the individual's home for family members or other caregivers who will perform necessary procedures,
- home health aide when supervised by a registered nurse or therapist, and
- other necessary services and supplies.

Requirements

Benefits for services are available only when the individual is under the care of a physician who:

- approves a plan of treatment for a reasonable amount of time; and
- includes the treatment plan in the individual's medical record.

Benefits are provided only if the treatment plan is approved by the individual's provider for a reasonable time not exceeding 60 days.

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P-4003 B6

P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)4. Home Care (Continued)a. Home Health Agency, Visiting Nurse Association, and Home Care Organization Care (Continued)Exclusions

No benefits are provided for:

- chronic care;
- custodial care;
- dietitian services;
- food;
- homemaker services; or
- maintenance therapy.

b. Hospice Care

Benefits are provided for the following hospice services included in the bills of hospice providers:

- skilled nursing visits;
- home health aide services;
- homemaker services;
- respite care services;
- social service visits before the patient's death and bereavement visits following the patient's death, including counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources; and
- other necessary services and supplies related to the terminal illness.

Requirements

Benefits are provided only if:

- a hospice program certified under the Medicare program is used;
- a physician certifies that the illness has a prognosis of six months life expectancy or less;
- the beneficiary or a legally responsible individual and his or her physician consent in writing to the hospice care plan; and
- a primary caregiver, other than the hospice provider, is available to be in the home.

c. Rehabilitative Therapy Services

Rehabilitative Therapy Services are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified in Medicaid Rule 7317.

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)4. Home Care (Continued)d. Nutrition Therapy

As defined in section 3f above.

5. Medical Equipment and Supplies

Medical equipment and supplies may only be covered when provided incidental to an acute condition treated in a physician's office or hospital outpatient department.

6. Mental Health

Benefits are provided for mental health services including:

- individual, family and group outpatient psychotherapy;
- psychological testing when integral to treatment;
- other non-hospital or non-inpatient intensive treatment services, including partial hospitalization services furnished by approved providers; and
- hospital inpatient services.

Exclusions

No mental health benefits are provided:

- for custodial care;
- for treatment services provided beyond the initial treatment evaluation from which there is no diagnosis, treatment plan, or expected clinical outcome; and
- when the DVHA determines that services will not produce continued improvement.

7. Chemical Dependency

Benefits are provided for the following chemical dependency services:

- outpatient treatment and rehabilitation (including services for the patient's family when necessary); and
- hospital inpatient detoxification services.

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)7. Chemical Dependency (Continued)Exclusions

No substance abuse health benefits are provided for the following:

- custodial care and treatment of organic conditions that, according to generally accepted professional standards, will not improve with treatment;
- treatment services provided beyond the initial treatment evaluation in which there is no diagnosis, treatment plan, or expected clinical outcome; and services that DVHA determines do not produce evidence of continued improvement;
- mandated treatment, including court ordered treatment; and
- hospital inpatient chemical dependency services other than those specifically listed as covered.

8. Podiatry Services

Benefits are provided for non-routine foot care, such as surgical removal of ingrown toenails and treatment of foot lesions resulting from infection or diabetic ulcers.

Exclusions

No benefits are provided for:

- routine foot care including removal of corns and calluses, trimming of nails, and preventive or hygienic care of the feet; and
- treatment of subluxations of the foot not requiring surgical procedures and treatment of flat feet.

9. Prescription Drugs

Benefits are provided for outpatient use of:

- prescription drugs;
- contraceptive medications, drugs, devices and supplies for the purpose of contraception;
- insulin and other diabetic supplies including glucose strips and tablets; and
- needles and syringes.

Limitations

Coverage of prescribed over-the-counter and prescription smoking cessation products is provided with a limit of two treatment regimens per beneficiary, per calendar year.

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by VHAP - Limited, except in an individual case when the quantity has been changed in consultation with the physician.

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)B. Description of Benefit Package (Continued)9. Prescription Drugs (Continued)

Payment may be made for any preparation, except those unfavorably evaluated, either included or approved for inclusion in the latest edition of official drug compendia: American Hospital Formulary Service Drug Information; United States Pharmacopeia-Drug Information (or its successor publications); and the DRUGDEX Information System; and the peer-reviewed medical literature. These consist of "legend" drugs for which a prescription is required by State or Federal law.

Physicians and pharmacists are required to conform to Act 127 (18-VSA-Chapter 91), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest priced equivalent shall be considered medically necessary. If, in accordance with Act 127, the beneficiary does not wish to accept substitution, VHAP - Limited will not pay for the prescription.

Exclusions

No benefits are provided for:

- refills beyond the original and five refills per script up to one year maximum;
- multi-vitamins;
- hair replacement therapies;
- drugs, and contraceptive medications, devices or supplies for which there is no prescription;
- drugs for the sole purpose of fertility; and
- over-the-counter drugs and medicinals, except loratadine and Prilosec OTC®, non-steroidal anti-inflammatory analgesics (NSAIDS), Cetirizine swallow tablets and Zyrtec OTC Syrup. The manufacturer of the drug is required to be enrolled in the federal rebate program.

10. Family Planning Services

Family planning services, defined as those services that either prevent or delay pregnancy, are a covered benefit. Treatment of infertility and reversals of sterilizations are not covered.

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P-4003 C1

P-4003 VHAP-Limited Benefit Coverage Package (Continued)C. General Exclusions

In addition to the specific exclusions listed elsewhere in VHAP-Limited rules and procedures, benefits will not be provided for the following:

1. services or supplies which must be covered by a prior health plan as extended benefits;
2. services or supplies for which the individual would have no legal obligation to pay if they were not covered by the interim limited FFS benefit package or similar coverage;
3. services or supplies for which there is no charge;
4. services or supplies paid directly or indirectly by a local, state or non-VA federal government agency, except as otherwise provided by law;
5. services or supplies in excess of the limitations or maximums set forth in the VHAP limited FFS benefit plan;
6. services or supplies the Department of Vermont Health Access (DVHA) determines are not medically necessary;
7. services or supplies that are investigational, mainly for research purposes or experimental in nature; this exclusion also applies to drugs or other items or procedures that require approval from the Food and Drug Administration when such approval has not been made;
8. services or supplies that are not provided in accordance with accepted professional medical standards in the United States;
9. acupuncture, acupressure or massage therapy;
10. all forms of self-care or self-help training and health club memberships;
11. automatic ambulatory blood pressure monitoring;
12. whole blood (DVHA will, however, provide benefits for the administration, processing and storage of blood or its derivatives);
13. clinical ecology, environmental medicine or similar treatment;
14. cognitive retraining;
15. corneal microsurgery to correct near- or far-sighted conditions;

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)C. General Exclusions (Continued)

16. cosmetic surgery;
17. custodial care, domiciliary care or rest cures;
18. except as noted, drugs that do not require a prescription, other than insulin;
19. eye exercises or visual training;
20. contact lenses;
21. educational testing and evaluation, programs or therapy;
22. foot care as follows (except in cases of circulatory or neurological disease involving the feet, such as arteriosclerosis or diabetic neuropathy):
 - palliative or cosmetic foot care including flat foot conditions, treatment of subluxations of the foot, weak feet, chronic foot strain and symptomatic complaints of the feet;
 - orthotic shoe inserts, whether they are custom made or not; and
 - cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care.
23. hearing aids or examinations for the prescription or fitting of hearing aids;
24. illnesses or injuries which are sustained on or after the effective date of enrollment while in active military service or required:
 - as a result of an act of war, declared or undeclared, within the United States, its territories or possessions; or
 - during combat, unless otherwise required by law.
25. charges for care prior to the effective date of eligibility;
26. nonmedical charges, such as:
 - a penalty for failure to keep a scheduled visit or
 - fees for completion of a claim form.
27. medical food supplements, other than medical nutritional formulae;
28. personal hygiene and convenience items not primarily medical in nature, including, but not limited to air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, barrier free or other home modifications, even if prescribed by a provider;
29. personal service or comfort items;

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P-4003 VHAP-Limited Benefit Coverage Package (Continued)C. General Exclusions (Continued)

30. care and services provided in a foreign country, except payment for emergency inpatient hospital care and related ambulance and physicians services as allowed in Medicare regulation 42 C.F.R. Part 424 Subpart H if the following conditions are met:
 - the beneficiary was present in the U.S. when the emergency arose, or was traveling to Alaska by the most direct route without delay, and
 - the foreign hospital is closer to, or more accessible from the site of the emergency than the nearest U.S. hospital equipped to deal with and available to treat the individual's illness or injury.
31. support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, smoking cessation therapy beyond the benefits covered in the benefit plan, and stress management;
32. telephone consultations between the individual and a provider;
33. TENS (transcutaneous electrical nerve stimulation), except for physician prescribed TENS units;
34. therapy services as a part of chronic pain control, diabetic, developmental, pulmonary or other form of rehabilitation services, except with prior approval from DVHA;
35. travel/transportation (non-ambulance), even if prescribed by a physician;
36. treatment for conditions related to specific delays in development and learning disabilities (ICD-9-CM codes 315.00 through 315.99); mental retardation (ICD-9-CM codes 317.00 through 319.99), except for interventions for acute care services covered by the benefits described in this document; and psychic factors associated with diseases classified elsewhere in ICD-9-CM (ICD-9-CM code 316.00) unless approved by DVHA;
37. treatment leading to, or in connection with, artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
38. treatment leading to, or in connection with, transsexual surgery, including transsexual surgery;
39. treatment of obesity, except when:
 - the physician determines that the body mass index is over 40 (according to Table 1 in the Methods for Voluntary Weight Loss and Control booklet by the National Institute of Health Technology Assessment Conference Statement of March 1992);
 - there are other medical conditions present which could be significantly and adversely affected by this degree of obesity; and
 - the DVHA approves the treatment in advance.
40. augmentative communication devices;

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P-4003 C4

P-4003 VHAP-Limited Benefit Coverage Package (Continued)C. General Exclusions (Continued)

41. work-related illnesses or injuries (or those which the individual claims to be work related, until otherwise finally adjudicated) and those which are (or by law should be) covered by workers' compensation;
42. services and supplies not specifically described as covered;
43. services or supplies provided by:
 - a person who provides these services as part of their education or training program,
 - a member of the individual's immediate family,
 - a VA medical center facility treating an eligible veteran, or
 - an individual (including health care practitioners) not enrolled as a Medicaid provider.
44. Athletic and employment physicals, and physicals required for administrative purposes are not covered benefits;

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P-4005 A

P-4005 VHAP-Managed Care Benefit Package

Until such time as Vermont Health Access Plan (VHAP) beneficiaries have access to and are enrolled in a managed care plan, they are covered by an interim limited fee-for-service (FFS) benefit package. (See P-4003.) Once enrolled in managed care, the benefit package is limited to the items and services described in the following subsections..

A. Summary of VHAP-Managed Care Covered and Non-Covered Services

The following services are covered:

- inpatient hospital services;
- outpatient services in a hospital or ambulatory surgical center;
- physician and mid-level practitioner services, including services provided by rural health centers and federally qualified health centers, routine gynecological exams and related diagnostic services, family planning services, and prenatal and maternity care until the individual is enrolled in traditional Medicaid and services provided by a naturopathic physician (N.D.);
- oral surgery;
- organ, bone marrow and tissue transplants;
- one comprehensive vision examination in a 24-month period;
- outpatient therapy services (occupational therapy, physical therapy, speech therapy);
- nutrition therapy;
- ambulance services;
- inpatient rehabilitation services;
- home health care;
- hospice services;
- medical equipment and supplies;
- skilled nursing facility services (up to 30 day length of stay per episode);
- mental health and chemical dependency services;
- outpatient mental health and chemical dependency services;
- residential substance abuse treatment services;
- podiatry services;
- chiropractic services
- prescription drugs; and
- family planning services.

The following services are not covered:

- dental services; and
- eyeglasses and contact lenses.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package1. General Hospital Carea. Inpatient Services

Benefits provided for inpatient care in a hospital include:

- facility room & board,
- services,
- medications, and
- supplies.

b. Outpatient Services

Benefits are provided for services and supplies related to outpatient care in a hospital or ambulatory surgical center including:

- facility services, and
- professional services.

2. Professional Care for Home and Office Visits

Benefits are provided for the following professional services in the individual's home or a provider's office:

- consultations between professional providers when an individual is an outpatient,
- immunizations and injections that are appropriate to the age of the individual (except chemotherapy, which is described in other parts of this section),
- outpatient medical care, and
- effective preventive care (e.g., well child care, periodic OB/GYN exams, maternity care, physicals).

Benefits are also provided for emergency medical care or emergency accident care in the provider's office or in the emergency room.

Limitations

Only one visit per day from each professional provider will be covered. Monthly visitation limits are specified in Medicaid Rule 7301.1.1.

Benefits are provided for professional services not described above, including:

- required consultations between professional providers when an individual is an inpatient,
- outpatient diagnostic services, and
- inpatient professional medical care.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Carea. Surgery

Benefits are provided for surgical services in an office or facility setting. Surgery includes:

- use of specialized instruments,
- endoscopic examinations,
- treatment of burns,
- correction of fractures and dislocations,
- anesthesia, and
- sterilization procedures for beneficiaries age 21 and older, but not reversal of sterilization or any type of fertility services.

b. Oral Surgery

Oral surgery benefits are provided only for the following services:

- treatment for accidental injury to the jaws, sound natural teeth, mouth or face;
- surgery to correct gross deformity resulting from major disease, congenital deformity, or surgery;
- surgery to correct temporomandibular joint syndrome.

Exclusions

No benefits are provided under this section for:

- periodontal care;
- repair or replacement of damaged dental prostheses;
- injury as a result of chewing or biting;
- dental services not performed by a physician; or
- dental care not specified as a benefit above.

c. Transplant Services

Benefits are provided for organ transplantation services when not experimental or investigational; including benefits for a live donor's related medical expenses, when the beneficiary is covered.

Benefits are also provided for the following related transplant expenses:

- search for a live donor; and
- costs associated with the recovery and provision of a cadaveric organ by a federally designated organ procurement organization.

No benefits are provided if the donor is covered, but not the beneficiary.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)c. Transplant Services (Continued)Requirements

The department has the right to review all requests for transplantation benefits based on:

- the patient's medical condition;
- the qualifications of the physicians performing the transplant procedure; and
- the qualifications of the facility hosting the transplant procedure.

d. Maxillofacial Surgery

Maxillofacial surgery benefits are provided for the following services:

- treatment for accidental injury to the jaws, sound natural teeth, mouth or face;
- surgery to correct gross deformity resulting from major disease, congenital deformity, or surgery;
- surgery to correct temporomandibular joint syndrome.

Exclusions

No benefits are provided under this section for:

- repair or replacement of damaged dental prostheses,
- injury as a result of chewing or biting,
- oral surgery services not performed by a physician, or
- oral surgery care not specified as a benefit above.

e. Vision Care

Benefits are provided for one comprehensive vision examination and one interim eye exam, if needed (e.g. for glaucoma check), once in a 24 month period. Vision exams assess an enrollee's visual functions to:

- determine if they have any visual problems and/or abnormalities; and
- prescribe and dispense any necessary corrective eyewear.

Coverage for vision care services are limited to:

- one comprehensive visual analysis and one interim eye exam within a two-year period; and
- diagnostic visits and tests.

Exclusions

- eyewear, including but not limited to eyeglasses and contact lenses.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Caref. Rehabilitative Therapy Services (Occupational, Physical and Speech Therapy)

Rehabilitative Therapy Services are defined in Medicaid Rule 7317.

Limitations

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

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

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

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

Services provided by a home health agency are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified in Medicaid Rule 7317.

g. Other Therapies

Benefits are provided for the treatment of an illness or injury on an outpatient hospital basis by means of:

- chemotherapy or radiation therapy (including radioactive isotopes),
- dialysis,
- infusion therapy,
- inhalation therapy.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)h. Nutrition Therapy

Benefits for nutrition therapy services are provided when such services are:

- demonstrated as a cost-effective alternative to drug therapy or
- necessary to treat or prevent disease.

Conditions for which nutrition therapy services are appropriate include:

- diabetes;
- hyperlipidemia;
- chronic kidney failure;
- eating disorders;
- inborn errors of metabolism; and
- malabsorption syndromes, conditions associated with oral-motor dysfunction, and conditions requiring feeding by enteral tube or vein.

i. Maternity Care

Benefits are provided for medical and surgical services for pregnancy until such time as the individual is determined to be eligible for Medicaid under traditional eligibility rules.

Benefits are provided for services of professionals whether the delivery occurs at home or in a facility.

j. Ambulance

Benefits are provided for transportation of sick and injured enrollees:

- from their home, the scene of an accident or the scene of a medical emergency to the nearest facility based on their condition, as perceived by emergency personnel, at the scene of the accident or medical emergency;
- between facilities if the enrollee's physician deems it necessary for the enrollee's treatment; and
- between a hospital and a nursing facility when such facility is the closest that can provide covered services appropriate to the enrollee's condition. If no facility in the area can provide appropriate covered services, transportation to the closest facility outside the local area that can provide the appropriate service will be covered.

Exclusions

No benefits are provided if the enrollee could have been transported in a private car or other non-emergency vehicle, nor are benefits provided for ambulance services provided solely for the enrollee's convenience.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)3. Other Medical Care (Continued)k. Cardiac Rehabilitation

Rehabilitation benefits are provided for outpatient cardiac rehabilitation including:

- inpatient rehabilitation for a medical condition requiring acute care; and
- outpatient cardiac rehabilitation.

Exclusions

No benefits are provided for chronic care.

l. Chiropractic Services

Benefits for VHAP-Managed Care are identical to those for Medicaid beneficiaries. See Medicaid Rule 7304 for coverage, limitations and exclusions.

4. Home Care

This section addresses benefits for supplies and services the individual receives in their home from home health agencies or visiting nurse associations, or home care organizations, including hospice services from these agencies.

a. Home Health Agency, Visiting Nurse Association, and Home Care Organization Care

Benefits are provided for the following services and are included in their bills:

- necessary skilled nursing procedures,
- training in the individual's home for family members or other caregivers who will perform necessary procedures,
- home health aide when supervised by a registered nurse or therapist, and
- other necessary services and supplies.

Requirements

Benefits for services are available only when the individual is under the care of a physician who:

- approves a plan of treatment for a reasonable amount of time, and
- includes the treatment plan in the individual's medical record.

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P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)4. Home Care (Continued)a. Home Health Agency, Visiting Nurse Association, and Home Care Organization Care (Continued)Exclusions

No benefits are provided for:

- chronic care,
- custodial care,
- dietitian services,
- food,
- homemaker services, or
- maintenance therapy.

b. Hospice Care

Benefits are provided for the following hospice services included in the bills of hospice providers:

- skilled nursing visits
- home health aide services;
- homemaker services;
- respite care services;
- social service visits before the patient's death and bereavement visits following the patient's death, including counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources; and
- other necessary services and supplies related to the terminal illness.

b. Hospice CareRequirements

Benefits are provided only if:

- a hospice program certified under the Medicare program is used;
- a physician certifies that the illness has a prognosis of six months life expectancy or less;
- the beneficiary or a legally responsible individual and his or her physician consent in writing to the hospice care plan; and
- a primary caregiver, other than the hospice provider, is available to be in the home.

c. Rehabilitative Therapy Services

Rehabilitative Therapy Services are covered for up to four months based on a physician's order. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified in Medicaid Rule 7317.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)4. Home Care (Continued)d. Home Infusion Therapy

Benefits are provided for the following services and supplies delivered in the enrollee's home:

- chemotherapy or radiation therapy (including radioactive isotopes);
- dialysis;
- inhalation therapy;
- intravenous antibiotic therapy;
- total parenteral nutrition;
- enteral nutrients through a feeding tube;
- hydration therapy;
- intravenous/subcutaneous pain management;
- therapy for hemophilia or hypogammaglobulinemia; and
- other therapies approved by the department.

Benefits are also provided for the following services and supplies associated with the services above:

- solutions and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment;
- ancillary medical supplies; and
- nursing services including patient and/or caregiver training, monitoring of intravenous therapy regimen and emergency medical care.

5. Medical Equipment and Suppliesa. Durable Medical Equipment

Benefits are provided for the rental or purchase of durable medical equipment. The department has the right to determine whether rental or purchase of the equipment is more cost effective and/or appropriate. The department also has the right to recover equipment that is no longer needed by the enrollee. The equipment then becomes the property of the department.

Items of durable medical equipment are limited to:

- alternating pressure pumps and mattresses, gel mattresses, and decubitus care pads;
- ambulatory uterine monitoring devices;
- apnea monitors and related supplies and services;
- bathtub chairs and seats, including shower chairs and transfer benches;
- biostegenic stimulators;
- blood glucose monitors;

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)5. Medical Equipment and Supplies (Continued)a. Durable Medical Equipment (Continued)

- beds (hospital frame and mattress) and bed accessories for severe medical conditions, e.g., cardiac disease, chronic obstructive lung disease, spinal cord injuries including quadriplegia (Note: Craftomatic beds, oscillating/lounge beds, bed boards, ordinary mattresses, beds larger than single occupancy, tables and other bed accessories are not covered.);
- blood pressure cuffs/machines (including stethoscopes) when prescribed for patients who require frequent monitoring for a specific disease and when used as an alternative to home health nursing visits;
- canes, crutches, walkers;
- circulatory aids;
- commodes (including bed pans, urinal pans and raised toilet seats) when the beneficiary is unable to access typical bathroom facilities;
- continuous passive motion devices (CPM) for homebound beneficiaries who have received total knee replacements;
- cushions and invalid rings;
- diabetic equipment and supplies;
- digital electronic pacemaker monitor;
- external infusion pumps;
- heating pads/lights;
- lifts (hydraulic or electric, including one sling), if safe transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person;
- oxygen systems;
- portable sitz baths;
- protective helmets when the beneficiary is prone to falling (e.g. seizures, ataxia);
- repair of durable medical equipment originally bought by the department, including parts and labor;
- respiratory equipment, supplies and services;
- seat lift chairs when the beneficiary is unable to achieve a standing position without assistance;
- suction equipment;
- stethoscopes when acquisition is less costly than an alternative covered item or service;
- TENS/EMS units;
- traction equipment;
- ultra violet light box - prescribed by a dermatologist (or physician skilled in the treatment of dermatological disorders) and for use in the home by beneficiaries with severe dermatological conditions. Prior authorization is required.
- vaporizers; and
- wheelchairs

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)5. Medical Equipment and Supplies (Continued)b. Medical and Surgical Supplies

Medical supplies necessary for the care and treatment of an eligible person and suitable for use in the home are covered. The full range of covered items falls into the general categories listed below. The list of general categories of items pre-approved for coverage is limited to¹:

- adhesive tape and removers;
- antiseptics;
- briefs, diapers and underpads;
- catheters and catheter supplies;
- cotton and cotton-like products;
- diabetic diagnostics and daily care supplies;
- eye care and gauze pads and rolls;
- gloves;
- irrigation supplies;
- Low protein modified food products for treatment of an inherited metabolic disease, as required by Act 128 of the 1998 Legislative Session
- lubricating jelly;
- ostomy care supplies (including adhesives, irrigation supplies, bags and miscellaneous);
- respiratory/tracheostomy care supplies; and
- secondary dressings.

Medical supplies provided to a beneficiary by a physician or other provider may be covered if the supply is not expected to be included in the cost of the service provided.

Medical supplies must be consistent with the patient's medical condition and plan of care.

All items are subject to a maximum allowable payment amount.

Quantity limits may not be exceeded.

In unusual circumstances, providers may purchase medical supplies for the personal use of a patient. When a hospital (inpatient or outpatient) provides medical supplies not otherwise reimbursed, payment will be made only to the hospital.

¹ Some supplies in each category are subject to quantity limits. See the Provider Manual for specific quantity limitations.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)5. Medical Equipment and Supplies (Continued)c. Prosthetics/Orthotics

Items and services that are limited to:

- artificial limbs;
- artificial larynx;
- breast forms;
- prosthetic shoes;
- ostomy products;
- parenteral and enteral nutrition services;
- prosthetic eyes;
- braces and trusses for the purpose of supporting a weak or malformed body member;
- orthotic shoes as an integral part of a leg brace or affixed to an integral part of a leg brace;
- aircast splints;
- foot abduction rotation bars;
- shoe lifts, elevation heels, wedges; and
- molded orthopedic shoes when prescribed for diabetes, severe rheumatoid arthritis, ischemic, intractable ulcerations, congenital defects, and deformities due to injuries.

Prosthetic devices must be prescribed by a physician or podiatrist who is enrolled with Vermont Medicaid.

Devices must be appropriate for beneficiary's age, gross and fine motor skills, developmental status, mental functioning, and physical condition.

Duplicate items are not covered (e.g., two pairs of customized orthotics).

Coverage for Medicaid-approved shoes is limited to two pairs per adult beneficiary per calendar year unless a prior authorization review finds special circumstances that warrant additional pairs.

Custom-made arch supports prescribed by a physician or podiatrist are covered when they meet the definition of an orthotic (i.e., are used as a brace, truss or other similar device for the purpose of supporting a weak or deformed body member).

Exemptions

Items that are not covered include:

- orthopedic shoes when prescribed for flat feet; and
- orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need.

P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)6. Skilled Nursing Facility

Benefits are provided for the following services and supplies provided by skilled nursing facilities and included in their bills:

- room, board (including special diets), general nursing care and therapies; and
- medical services, over the counter medications, incontinence supplies, and other medical supplies.

Limitations

Benefits in a skilled nursing facility care are limited to not more than 30 days per episode and 60 days per calendar year.

7. Mental Health

Benefits are provided for outpatient mental health services including:

- individual, family and group outpatient psychotherapy;
- psychological testing when integral to treatment; and
- psychotherapeutic and prevention programs approved by the department directed toward improving compliance with prescribed mental health and medical treatment regimens for long term physical and mental health conditions.

Benefits are provided for inpatient or intensive services including:

- all inpatient hospital admissions, including psychiatric units not classified as Institutions for Mental Disease (IMD);
- psychiatric admissions in an IMD that has a contract with the department, except payment for care is limited to 30 days per episode and 60 days per year; and
- other intensive treatment services approved by the department provided by entities that have a contract with the department.

Exclusions

No mental health benefits are provided:

- for custodial care;
- for treatment services provided beyond the initial treatment evaluation from which there is no diagnosis, treatment plan, or expected clinical outcome, and
- when the DVHA determines that services will not produce continued improvement.

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P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)8. Chemical Dependency

Benefits are provided for the following chemical dependency services:

- hospital inpatient detoxification services; and
- outpatient rehabilitation (including services for the patient's family when necessary).

Exclusions

No substance abuse health benefits are provided for the following:

- custodial care and treatment of organic conditions that, according to generally accepted professional standards, will not improve with treatment;
- treatment services provided beyond the initial treatment evaluation in which there is no diagnosis, treatment plan, or expected clinical outcome; and services that the department determines do not produce evidence of continued improvement;
- mandated treatment, including court ordered treatment, unless such treatment is determined to be medically necessary by a state certified alcohol and drug abuse counselor or the department; and
- services outside Vermont unless the services are necessitated by an emergency, or the physician, professional or facility has a contract with the department, or the enrollee receives prior approval from the department.

9. Podiatry Services

Benefits are provided for non-routine foot care, such as surgical removal of ingrown toenails and treatment of foot lesions resulting from infection or diabetic ulcers.

Exclusions

No benefits are provided for:

- routine foot care including removal of corns and calluses, trimming of nails, and preventive or hygienic care of the feet; and
- treatment of subluxations of the foot not requiring surgical procedures and treatment of flat feet.

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P-4005 VHAP-Managed Care Benefit Package (Continued)B. Description of Benefit Package (Continued)10. Prescription Drugs

Benefits are provided for outpatient use of:

- prescription drugs;
- generic pre-natal vitamins for pregnant and lactating women;
- vitamins and over-the-counter drugs which are prescribed for the treatment of a specific disease;
- contraceptive medications, drugs, devices and supplies for the purpose of contraception;
- insulin and other diabetic supplies including glucose strips and tablets; and
- needles and syringes.

Exclusions

All Medicaid exclusions and limitations.

No benefits are provided for:

- refills beyond the original and five refills per script up to one year maximum;
- multi-vitamins;
- hair replacement therapies;
- drugs, and contraceptive medications, devices or supplies for which there is no prescription;
- drugs for the sole purpose of fertility; and
- over-the-counter drugs and medicinals, except when prescribed for a chronic health condition.

Smoking Cessation Products

Coverage of over-the-counter and prescription smoking cessation products is provided with a limit of two treatment regimens per beneficiary, per calendar year.

Payment may be made for any preparation, except those unfavorably evaluated, either included or approved for inclusion in the latest edition of official drug compendia: American Hospital Formulary Service Drug Information; United States Pharmacopeia-Drug Information (or its successor publications); and the DRUGDEX Information System; and the peer-reviewed medical literature. These consist of "legend" drugs for which a prescription is required by State or Federal law.

Physicians and pharmacists are required to conform to Act 127 (18-VSA-Chapter 91), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest priced equivalent shall be considered medically necessary. If, in accordance with Act 127, the beneficiary does not wish to accept substitution, VHAP - Managed Care will not pay for the prescription.

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by VHAP - Managed Care, except in an individual case when the quantity has been changed in consultation with the physician.

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P-4005 VHAP-Managed Care Benefit Package (Continued)

B. Description of Benefit Package (Continued)

11. Family Planning Services

Family planning services, defined as those services that either prevent or delay pregnancy, are a covered benefit.

Treatment of infertility and reversals of sterilizations are not covered.

P-4005 VHAP-Managed Care Benefit Package (Continued)C. General Exclusions

In addition to the specific exclusions listed elsewhere in VHAP rules and procedures, benefits will not be provided under the VHAP-Managed Care benefit plan for the following:

1. services or supplies which must be covered by a prior health plan as extended benefits;
2. services or supplies for which the individual would have no legal obligation to pay if they were not covered by the interim limited FFS benefit package or similar coverage;
3. services or supplies for which there is no charge;
4. services or supplies paid directly or indirectly by a local, state or non-VA federal government agency, except as otherwise provided by law;
5. services or supplies in excess of the limitations or maximums set forth in the VHAP-Managed Care benefit plan protocol;
6. services or supplies the Department of Vermont Health Access (DVHA) determines are not medically necessary;
7. services or supplies that are investigational, mainly for research purposes or experimental in nature; this exclusion also applies to drugs or other items or procedures that require approval from the Food and Drug Administration when such approval has not been made;
8. services or supplies that are not provided in accordance with accepted professional medical standards in the United States;
9. acupuncture, acupressure or massage therapy;
10. all forms of self-care or self-help training and health club memberships;
11. automatic ambulatory blood pressure monitoring;
12. whole blood (DVHA will, however, provide benefits for the administration, processing and storage of blood or its derivatives);
13. clinical ecology, environmental medicine or similar treatment;
14. cognitive retraining;
15. corneal microsurgery to correct near- or far-sighted conditions;
16. cosmetic surgery or experimental surgery;

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P-4005 VHAP-Managed Care Benefit Package (Continued)C. General Exclusions (Continued)

17. custodial care, domiciliary care or rest cures;
18. drugs that do not require a prescription, other than insulin (see 4005 B10 for prescription drug benefit);
19. eye exercises or visual training;
20. other aids to vision;
21. educational testing and evaluation, programs or therapy;
22. foot care as follows (except in cases of circulatory or neurological disease involving the feet, such as arteriosclerosis or diabetic neuropathy):
 - palliative or cosmetic foot care including flat foot conditions, treatment of subluxations of the foot, weak feet, chronic foot strain and symptomatic complaints of the feet;
 - orthotic shoe inserts, whether they are custom made or not; and
 - cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care.
23. hearing aids or examinations for the prescription or fitting of hearing aids;
24. illnesses or injuries which are sustained on or after the effective date of enrollment while in active military service or required:
 - as a result of an act of war, declared or undeclared, within the United States, its territories or possessions; or
 - during combat, unless otherwise required by law.
25. charges for care prior to the effective date of eligibility;
26. nonmedical charges, such as
 - a penalty for failure to keep a scheduled visit or
 - fees for completion of a claim form.
27. medical food supplements, other than medical nutritional formulae;
28. personal hygiene and convenience items that are not primarily medical in nature, including, but not limited to air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, barrier free or other home modifications, even if prescribed by a provider;
29. personal service or comfort items;

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P-4005 VHAP-Managed Care Benefit Package (Continued)C. General Exclusions (Continued)

30. care and services provided in a foreign country, except as provided in Medicare regulation 42 C.F.R. Part 424 Subpart H, which allows payment for emergency inpatient hospital care and related ambulance and physicians services if the following conditions are met:
 - The beneficiary was present in the U.S. when the emergency arose, or was traveling to Alaska by the most direct route without delay, and
 - The foreign hospital is closer to, or more accessible from the site of the emergency than the nearest U.S. hospital equipped to deal with and available to treat the individual's illness or injury.
31. support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, smoking cessation therapy beyond the benefits covered in the benefit plan, and stress management;
32. telephone consultations between the individual and a provider;
33. TENS (transcutaneous electrical nerve stimulation), except for physician prescribed TENS units;
34. therapy services as a part of chronic pain control, diabetic, developmental, pulmonary or other form of rehabilitation services, except with prior approval from DVHA;
35. travel/transportation (non-ambulance), even if prescribed by a physician;
36. fertility services including but not limited to treatment leading to, or in connection with, artificial insemination, in vitro fertilization, embryo transplantation, gamete intrafallopian transfer (GIFT), sperm banks, and surrogacy;
37. full dentures, dental implants or partial dentures;
38. treatment of obesity, except when:
 - the physician determines that the body mass index is over 40 (according to Table 1 in the Methods for Voluntary Weight Loss and Control booklet by the National Institute of Health Technology Assessment Conference Statement of March 1992);
 - there are other medical conditions present which could be significantly and adversely affected by this degree of obesity; and
 - the DVHA approves the treatment in advance.
39. augmentative communication devices;
40. work-related illnesses or injuries (or those which the individual claims to be work related, until otherwise finally adjudicated) and those which are (or by law should be) covered by workers' compensation;
41. services and supplies not specifically described as covered;

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P-4005 VHAP-Managed Care Benefit Package (Continued)C. General Exclusions (Continued)

42. services or supplies provided or ordered by:

- a person who provides these services as part of their education or training program;
- a member of the individual's immediate family;
- a VA medical center facility treating an eligible veteran; or
- an individual not enrolled as a Medicaid provider.

43. dental services related to the treatment of Temporomandibular Joint Syndrome (TMJ); however, medical services as described are covered for the treatment of TMJ;

44. Athletic and employment physicals, and physicals required for administrative purposes are not covered benefits;

45. treatment leading to, or in connection with uncovered surgery, including gender reassignment surgery; and

46. repair of items not covered by VHAP-Managed Care.