VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086
http://dvha.state.vt.us/

[Phone] 802-879-5900

Agency of Human Services

Health Care Program Coverage
July 1, 2011

SERVICE	MEDICAID/ DR. DYNASAUR FFS	MEDICAID/ DR. DYNASAUR MANAGED CARE	VHAP LIMITED FFS†	VHAP MANAGED CARE†
Ambulance	Y	Y	Y	Y
Certified Nurse Midwife	Y	Y	Y	Y
Chiropractic (Adult) *	Y	Y	Y	Y
Chiropractic (Children) *	Y	Y	N/A	N/A
Community Mental Health Center	Y	Y	Y	Y
Dental (Adult) *	Y	Y	N	N
Dental (Children)	Y	Y	N/A	N/A
Dentures (Adult)	N	N	N	N
Dentures (Children)	Y	Y	N/A	N/A
Diabetic Supplies	Y	Y	Y	Y
Emergency Room	Y	Y	Y	Y
Eye Exams *	Y	Y	Y	Y
Eyeglasses (Adults)	N	N	N	N
Eyeglasses (Children) *	Y	Y	N/A	N/A
Family Planning	Y	Y	Y	Y
Gynecological Services (ob-gyn)	Y	Y	Y	Y
Hearing Aids *	Y	Y	N	N
Home-Based Waivers	Y	N	N	N
Home Health Nursing	Y	R	R	R
Home Health Aide	Y	R	R	R
Hospice	Y	R	R	R
Immunizations	Y	Y	Y	Y
Inpatient Hospital *	Y	Y	Y	Y
Lab Tests and X-rays/Imaging *	Y	Y	Y	Y
Medical Equipment (DME)	Y	Y	Y	Y
Maxillofacial Surgery	Y	R	R	R
Medical Supplies	Y	Y	Y	Y
Mental Health Counselors	Y	Y	R	R
Naturopaths *	R	R	Y/R	Y/R
Nurse Practitioners	Y	Y	Y	Y
Nursing Facility *	Y	Y	Y	Y

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Nutrition Therapy	Y	R	R	R
Occupational Therapy *	Y	R	R	R
Ophthalmologist	Y	R	R	R
Optometrist	Y	Y	Y	Y
Organ Transplants	Y	R	R	R
Orthodontics (Adult)	N	N	N	N
Orthodontics (Children)	Y	Y	N/A	N/A
Orthotics	Y	Y	Y	Y
Outpatient Hospital	Y	R	R	R
Over-the-Counter Drugs	Y	Y	Y	Y
Physical Therapy *	Y	R	R	R
Podiatry	Y	R	R	R
Prescription Drugs	Y	Y	Y	Y
Primary Care Provider (PCP)	Y	Y	Y	Y
Prosthetics	Y	Y	Y	Y
Psychiatrist	Y	Y	Y	Y
Psychologist	Y	Y	Y	Y
Psychiatric Hospital *	Y	Y	Y	Y
Respiratory Therapy	Y	R	R	R
Specialist Services (non-PCP)	R	R	R	R
Speech/Language Therapy *	Y	R	R	R
Substance Abuse Treatment	Y	Y	Y	Y
Transportation	Y	Y	N	N

Managed Care = PC Plus

Y = covered service; referral from a primary care provider (PCP) is not required (unless otherwise stated – see Limitations for Naturopaths)

R = covered service; referral from PCP is required

N = non-covered service

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† = If a physician referral, order or prior authorization (PA) is required for VHAP Managed Care it is also required for VHAP Limited; therefore, a beneficiary may need to have selected a Primary Care Physician (PCP) prior to receiving a service. If a beneficiary does not pay their initial premium, the beneficiary is responsible for the costs of any services incurred.

Many of the services/items listed above require a physician referral, order or prior authorization (PA). There may be other limitations or specific conditions required for coverage that are not included in the above chart. Beneficiaries should check with Member Services or their providers about specific criteria for coverage. Providers may check with HP about requirements and other limitations not noted here.

For additional information on coverage and limitations see Medicaid Covered Services Rules ("Rules") or VHAP Coverage Procedures ("Procedures"); for any discrepancies between this chart and Rules or Procedures, Rules and Procedures shall take precedent.

LIMITATIONS:

- **Chiropractic Care:** Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine. Chiropractic care is limited to 10 visits per patient per calendar year. Additional services require prior authorization. Chiropractic care for children under age 12 requires prior authorization.
- **Dental Care:** Dental care for adults includes a limited range of services up to an annual cap of $495.
- **Eye Exams:** Coverage for comprehensive eye exams and interim eye exams are limited to one exam every two years per beneficiary. A repeat comprehensive exam within 24 months requires prior authorization. All refraction exams are covered.
- **Eyeglasses:** Coverage (for children) for eyeglasses is limited to one pair of glasses every two years per beneficiary. Earlier replacement requires prior authorization. Eyeglasses must be purchased under the state's sole-source contract.
- **Hearing Aids:** Coverage for hearing aids is limited to one hearing aid per ear every three years for specified degrees of hearing loss. Prior authorization is required for more frequent requests for a hearing aid. Hearing aid repairs are limited to one repair/modification per aid per year. Prior authorization is required when a second or subsequent repair/modification is requested within 365 days of a previous repair/modification.
- **Inpatient Hospital**: Prior authorization is required for all out-of-state elective hospital admissions (Select border hospitals are designated as "in-state").
- **Lab Tests and X-rays/Imaging:**
  - **Lab Tests:** Urine drug testing is limited to eight (8) tests per calendar month for Medicaid/Dr. Dynasaur beneficiaries age 21 and older and all VHAP beneficiaries. Exceptions must be prior approved.

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- **Imaging:** Coverage for all outpatient high-tech imaging services require prior authorization. Examples of these services are CT/CAT scans, MRIs, and PETs. Prior authorization is not required when the service is provided during an emergency room visit or while an inpatient in a hospital.

* **Naturopaths (ND):** NDs having either local admitting hospital privileges or a formal arrangement with a physician who has local hospital admitting privileges, and arrange 24 hour-a-day / 7 day-a-week coverage for their patients may enroll as PCPs; NDs who do not meet these conditions are considered specialists. Services from an ND as a specialist require a PCP referral.
* **Occupational Therapy, Physical Therapy, and Speech/Language Therapy:** For Medicaid/Dr. Dynasaur beneficiaries under age 21 and all beneficiaries receiving this service from a home health agency, services after the first four months require prior authorization. For Medicaid/Dr. Dynasaur beneficiaries age 21 and older and all VHAP beneficiaries, services are limited to a combination of 30 visits across all three types of therapy each calendar year. Prior authorization for more than 30 visits may only be requested for beneficiaries diagnosed with spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.
* **Psychiatric Hospital:** Prior Authorization requirements are the same as for inpatient hospital.
* **Skilled Nursing Facility:** Limited to 30 days per episode of illness. After 30 consecutive days, the individual must meet Medicaid/Dr. Dynasaur long-term care criteria for continued coverage under Medicaid/Dr. Dynasaur Fee for Service.

COPAYMENT/COINSURANCE REQUIREMENTS (what the beneficiary must pay):

Copayments are never required for the following:
* Beneficiaries living in a LTC facility
* Beneficiaries under age 18
* Beneficiaries who are pregnant or in a 60 day post-pregnancy period
* Family planning services

MEDICAID/DR. DYNASAUR FEE-FOR-SERVICE and MANAGED CARE

- $75.00 per inpatient hospital admission
- $ 3.00 per day per hospital for outpatient services
- $ 3.00 per visit for dental services for age 21 or older
- $1.00 for prescriptions costing $29.99 or less
- $2.00 for prescriptions costing $30.00 to $49.99
- $3.00 for prescriptions costing $50.00 or more

VHAP- LIMITED

- $25.00 per emergency room visit
- $1.00 for prescriptions costing $29.99 or less
- $2.00 for prescriptions costing $30.00 or more

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VHAP MANAGED CARE

- $25.00 per emergency room visit
- $1.00 for prescriptions costing $29.99 or less
- $2.00 for prescriptions costing $30.00 or more

VPHARM and VSCRIPT

- $1.00 for prescriptions costing $29.99 or less
- $2.00 for prescriptions costing $30.00 or more

Note: The co-payments for prescriptions are based on the cost to the state.