

Health Care Program Coverage July 1, 2010

SERVICE	MEDICAID/ DR. DYNASAUR FFS	MEDICAID/ DR. DYNASAUR PC PLUS	VHAP LIMITED FFS	VHAP PC PLUS
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	Y	R
Home Health Aide	Y	R	Y	R
Hospice	Y	R	Y	R
Immunizations	Y	Y	Y	Y
Inpatient Hospital	Y*	Y*	Y*	Y*
Institution for Mental Disease	Y*	Y*	N	Y*
Lab Tests and X-rays/Imaging	Y*	Y*	Y*	Y*
Medical Equipment (DME)	Y	Y	N	Y
Maxillofacial Surgery	Y	R	Y	R
Medical Supplies	Y	Y	N	Y
Mental Health Counselors	Y	Y	Y	Y
Naturopaths	R*	R*	R*	R*
Nurse Practitioners	Y	Y	Y	Y
Nursing Facility	Y	Y*	N	Y*

Health Care Program Coverage July 1, 2010

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

- Y = covered service; referral from a primary care provider (PCP) is not required
- R = covered service; referral from PCP is required
- N = non-covered service
- Y* = covered service with limitations (see Limitations); referral from a PCP is not required
- R* = covered service; referral from PCP is required unless Naturopath is PCP

NOTE: Many of the services/items listed above require prior authorization (PA). There may be other limitations or specific conditions required for coverage that are not included in the above chart. Beneficiaries

Health Care Program Coverage July 1, 2010

should check with their providers about specific criteria for coverage. Providers may check with EDS about PA requirements and other limitations not noted here.

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").
- * **Institution for Mental Disease:** For Medicaid/Dr. Dynasaur, service is limited to beneficiaries either under age 22 or age 65 and over. For VHAP-Managed Care, coverage is limited to 30 days per episode of illness and 60 days per calendar year. After 30 consecutive days, the service is no longer eligible for coverage.
- * **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.
 - **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.
- * **Medical Supplies:** For VHAP-Limited, coverage is limited to supplies that are incident to physician services furnished for acute conditions in the office or hospital outpatient setting.
- * **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

Health Care Program Coverage July 1, 2010

older and all VHAP beneficiaries, services are limited to a combination of thirty 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:** For Medicaid/Dr. Dinosaur PC Plus and VHAP PC Plus, coverage is limited to 30 days per episode of illness. After 30 consecutive days, the individual must meet Medicaid/Dr. Dinosaur long-term care criteria for continued coverage under Medicaid/Dr. Dinosaur Fee for Service.

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

Copayments are never required for the following beneficiaries:

- * Patients living in a LTC facility
- * Those under age 18
- * Those who are pregnant or in a 60 day post-pregnancy period

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

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.