
CONNECTICUT MEDICAID

Summary of Services



Medical Care Administration
Department of Social Services



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OVERVIEW

This document provides a brief summary of services paid for by Connecticut Medicaid. For further details on which services are covered please refer to the Medicaid regulations and policies found on our website at www.ctdssmap.com. Click on “Publications”, scroll down to Chapter 7 and choose one of the services area from the drop down menu.

Medicaid, also known as Title XIX, pays for many medical services, such as doctor visits, prescription drugs, inpatient and outpatient hospital care, laboratory services, home health care, transportation necessary to receive care and various other services. Medicaid pays for services only if they are medically necessary. Some services may need prior approval. Medicaid never pays for anything of an unproven, cosmetic, experimental or research nature or for services in excess of those deemed medically necessary.

Medicaid will make a payment for services only to a provider who is enrolled in Medicaid.

A list of participating Medicaid providers can be accessed on-line at the following web address: www.ctdssmap.com. Click on “Provider” then on “Provider Search”. Enter Provider Type and then enter Provider Type Specialty. Enter the city and state and then click on “Search”.

You may also contact the Department for a list of participating providers by calling DSS the Client Assistance Center (CAC) at 1-866-409-8430.

The Department cannot guarantee that all providers found on the website are currently accepting new Medicaid clients. Occasionally, a provider may discontinue their enrollment without notifying the Department or may not be accepting new Medicaid patients, but continue to see current patients.

AMBULATORY SURGERY

An ambulatory surgery center (ASC) is a health care facility that specializes in providing surgery and certain diagnostic (e.g., colonoscopy) services in an outpatient setting that is not a hospital. ASC procedures can be considered more intensive than those done in the average doctor's office but not so intensive as to require a hospital stay. Ambulatory surgery centers do not provide emergency services and may specialize in one or more of the following specialties.

- Dermatology
- Ear, Nose & Throat
- Gastroenterology
- General Surgery
- Gynecology
- Ophthalmology
- Oral Surgery
- Orthopedics
- Urology

DENTAL SERVICES

Medicaid provides comprehensive dental care for children and adults. These services are covered benefits when the dentist participates with the Connecticut Dental Health Partnership network.

Covered Dental Services:

- Cleanings
- Complete Dentures
- Crowns
- Examinations
- Extractions
- Fillings (silver amalgam and white composite)
- Oral Surgery
- Partial Dentures
- Root Canal Treatment
- X-Rays

Additional Covered Dental Services for Children Include:

- Fluoride treatments for children ages 1 – 21
- Orthodontia (Braces)
- Sealants for children ages 5 through 16

Service Limitations

- Dentures are covered only one time for every five year period
- Fixed Bridgework is not a covered benefit
- Dental Implants of any type are not a covered benefit

- Porcelain Crowns are limited to anterior teeth upper
- Orthodontia (Braces) is limited to children whose teeth are sufficiently crooked that a score of 26 points or greater is achieved on the Salzmann Scale
- Periodontal Services are not a covered benefit
- Root Canal Treatment is not performed when there are multiple missing teeth or the outcome is poor
- Sealants are replaced only one time for every five year period

Covered Services That Require Prior Authorization:

- Replacement of Complete Dentures
- Surgical Extractions
- Oral surgery for facial deformities
- Orthodontia (Braces)
- Replacement of Partial Dentures
- Replacement of Retainer for Orthodontia
- Re – treatment of a tooth with previous root canal therapy

DIALYSIS SERVICES

Medicaid reimburses for medically necessary dialysis services provided in a home, clinic, hospital, or institution which has an approved dialysis program. A free-standing dialysis clinic is a facility that is not part of a hospital that is licensed by the Department of Public Health to provide out-patient dialysis services.

DURABLE MEDICAL EQUIPMENT

Medicaid covers equipment that meets the general definition of durable medical equipment (DME) and that the Department considers medically necessary for clients. The doctor must first decide that the client needs the medical equipment and then write a prescription for it. DME can only be provided from a Medicaid enrolled durable medical equipment supplier.

Durable Medical Equipment (DME) is equipment that:

- Can be used over and over again;
- Is ordinarily used for medical purposes;
- Is generally not useful to a person who isn't sick, injured or disabled; and
- Is nondisposable.

Prior authorization is required for several types of DME. Only a Medicaid enrolled vendor/supplier can submit a prior authorization request to the Department for those items that require prior approval.

DME services are available to all clients who live at home.

Some examples of DME are provided (please remember that prior authorization may be required for some of these items):

- Wheelchairs and accessories;
- Walking aides, such as walkers, canes and crutches;
- Bathroom equipment such as commodes and safety equipment;
- Inhalation therapy equipment such as IPPB machines, suction machines, nebulizers and related equipment.
- Hospital beds and accessories and;
- Enteral/parenteral therapy equipment.

FAMILY PLANNING SERVICES

Family planning services include procedures that diagnose, treat, and counsel individuals of child-bearing age. A consent form is required for services that render an individual incapable of reproducing, for example tubal ligation or vasectomy. This consent form is provided by the practitioner or clinic giving the service.

Covered Services:

- Wide-range of family planning services
- Laboratory services
- Diagnostic procedures to determine infertility

Services Not Covered:

- Infertility treatments
- Reversal of tubal ligation or vasectomy

HEARING AIDS/PROSTHETIC EYES

Medicaid provides hearing aids and prosthetic eyes for clients after a medical evaluation by a licensed practitioner.

For hearing aids, the following steps are required:

- Client is first seen by a physician and needs to get a prescription from their physician stating that the client is a candidate for hearing aid(s).
- The client then goes to a Connecticut Medicaid participating hearing aid vendor (audiologist/hearing aid dealer) for testing and possible hearing aids. The hearing aid vendor fits the client and then specifies the type of hearing aid that would be the most beneficial for the client.

Hearing aids are available to clients who live at home as well as clients who live in nursing homes, intermediate care facilities for the mentally retarded and group homes.

HOME HEALTH SERVICES

Medicaid reimburses medically necessary services provided by licensed home health agencies that are delivered in the home. Services must be ordered by a physician or nurse practitioner. The order is sent to a home health agency that will do an assessment of the client and work with the physician or nurse practitioner to complete an appropriate plan of care.

Covered Services:

- nursing
- home health aides
- physical, occupational and speech therapy
- nursing for high risk pregnancies

Service Limitations

- The department covers the services of a home health aide only when the aide is assisting with activities of daily living (ADL). ADLs are bathing, dressing, toileting, transferring and feeding. The department will not pay for an aide to do housework or other chores although an aide who is in the home to help with an ADL (for example feeding) may perform some minor housework at the same time (for example tidying up the kitchen).
- Prior authorization is needed from the department for:
 - all home health aide in excess of 14 hours per week
 - all nursing in excess of 2 visits per week
 - all nursing in excess of 2 hours per day
 - other services as described in department regulation
- The request for prior authorization must come from the home health agency who will be providing the service

HOSPITAL SERVICES

Medicaid covers inpatient and outpatient hospital services. Inpatient care is covered including maternity and newborn care. All inpatient hospital services, except emergency care and labor and delivery, require prior authorization (PA). The PA process is initiated by the physician caring for the client.

The following types of care are typically provided by a hospital outpatient department. Please be aware that each hospital offers some but possibly not all of these services.

- Emergency room care
- Urgent care visits
- Medical and dental check-ups
- Family planning
- Prenatal care
- Prescriptions

- Drug and alcohol treatment
- Mental health services
- Physical therapy
- Occupational therapy
- Speech therapy
- Diagnostic services such as CT Scans and MRI
- Therapeutic services such as pain management and oncology treatment

INDEPENDENT THERAPY SERVICES

Independent therapy includes: audiology, physical therapy, and speech pathology services. An independent therapist is someone who has a practice that is not part of a hospital outpatient department or a clinic. Independent therapy services are covered by Medicaid for clients age 20 and younger and clients eligible for Medicare and Medicare is the primary payer.

Covered Services:

- Services provided in a an office or in a client's home
- One evaluation of each therapy type (physical therapy, speech therapy, or audiology) per year;
- More than two (2) visits of physical, speech audiology covered with PA

Services Not Covered:

- Independent therapy for clients age 21 and older (Clients age 21 and older may access therapy services through a clinic, home health agency or hospital outpatient setting enrolled with the Medicaid program)
- Occupational therapy services provided through an independent practitioner are not covered. Occupational therapy services are provided through a clinic, home health agency or hospital outpatient enrolled with the Medicaid program

LABORATORY SERVICES

Medicaid covers clinical diagnostic laboratory services provided by certified laboratories enrolled in Medicaid. Diagnostic tests and lab services are done to help your doctor diagnose or rule out a suspected illness or condition. These tests can be performed in a hospital lab, physician's office or an independent lab.

LONG TERM CARE SERVICES

Medicaid reimburses for medically necessary services to clients in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR).

The Department pays an all-inclusive rate for each day a client is in a nursing facility or ICF/MR. This fee covers all nursing, home health aid, therapy services, therapeutic recreation and room and board.

Service Limitations:

- The Department will pay the nursing facility or ICF/MR to hold the bed for a client who is in the hospital for up to 15 days per hospital admission when certain criteria are met.
- The Department will pay the nursing facility or ICF/MR to hold the bed for a client during a temporary absence for home leave for up to 21 days or 36 days, respectively, per calendar year.
- Payment for both hospital and home leave in a nursing facility is dependent on the vacancy rate at the facility. The nursing facility is required to hold the client's bed even if the vacancy rates are not low enough to support payment.

MEDICAL CLINIC SERVICES

A free-standing medical clinic is a licensed facility not associated with a hospital. Medicaid covers services provided at a medical clinic determined to be medically necessary as long as the clinic is enrolled with the Medicaid program.

Covered Services:

- Clinic visits
- Immunizations

Services Not Covered:

- Treatment of obesity
- Any examinations and lab tests or immunizations that are available free of charge

MEDICAL SURGICAL SUPPLIES

Medicaid covers medical surgical supplies for clients who live at home. A doctor must first decide that medical surgical supplies are needed and then write a prescription for them.

Prior authorization may be required for a few types of medical surgical supplies. Only a Medicaid enrolled vendor/supplier can submit a prior authorization request to the Department for those items that require prior approval.

Services Covered: Examples of medical and surgical supplies paid for by Medicaid are: surgical dressings, diabetic supplies, sterile gloves, blood pressure kits and incontinence supplies.

MENTAL HEALTH

Clients who are eligible for Medicaid can receive a variety of medically necessary behavioral health services. Behavioral health services are services to treat mental health or substance abuse problems. If you think that you may need behavioral health services contact your physician, a hospital or a freestanding outpatient clinic. Some of the covered services include:

- Inpatient services at a hospital

- Detoxification services at a hospital or detox facility
- Crisis services
- Day treatment programs
- Individual therapy, group therapy and family therapy
- Methadone treatment services
- Medication evaluation, prescription and management

OVERVIEW OF THE CONNECTICUT NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM

Transportation will be available to eligible clients who have no other means of transportation, and who reserved a ride with at least 48 hours notice and the trip is to and from a Medicaid covered medical service and that service provider is the closest appropriate provider of service.

ORTHOTIC AND PROSTHETIC DEVICES

Orthotic or prosthetic device means a corrective or supportive device prescribed by a licensed practitioner, designed to:

- artificially replace a missing portion of the body;
- prevent or correct physical deformity or malfunction; or
- support a weak or deformed portion of the body;

Medicaid covers orthotic and prosthetic devices for clients. A doctor must first decide that a client needs the orthotic or prosthetic device and then write a prescription for it. Orthotic and prosthetic devices can only be provided from Medicaid enrolled suppliers.

Prior authorization may be required for a few types of orthotic and prosthetic devices. Only a Medicaid enrolled vendor/supplier can submit a prior authorization request to the Department for those devices that require prior approval.

OXYGEN THERAPY

Medicaid provides oxygen therapy for clients that are prescribed by a licensed practitioner. Prior authorization may be required for different types of oxygen therapy. Only a Medicaid enrolled vendor/supplier can submit a prior authorization request to the Department for oxygen therapy.

The Department will not pay for the “as needed” use of oxygen therapy.

PARENTERAL – ENTERAL SUPPLIES

Medicaid covers parenteral and enteral supplies for clients who live at home. The doctor must first decide that the client needs the supplies and write a prescription for them.

Prior authorization may be required for a few types of parenteral/enteral supplies. Only a Medicaid enrolled vendor/supplier can submit a prior authorization request to the Department for those items that require prior approval.

PHARMACY BENEFITS

The Connecticut Medical Assistance Programs (Medicaid) provides comprehensive prescription drug coverage for children and adults.

Most but not all drugs that need a prescription are covered. Medicines that you can buy “off the shelf” (also known as ‘over-the-counter’) are also covered for clients under 21 years of age when a doctor writes a prescription for it.

Covered Drugs

Doctors must prescribe generic drugs or drugs on the Preferred Drug List when they are available. Sometimes your doctor may think you need a brand name drug instead of a generic. If that happens, your doctor can ask for prior authorization. They must also get prior authorization if you refill a prescription early.

Not Covered Drugs

The Connecticut Medical Assistance Program *does not* cover the following drugs:

- Drugs to quit smoking, unless you’re pregnant
- Drugs to treat sexual problems
- Drugs to treat cosmetic conditions
- Drugs to treat obesity
- Experimental drugs or drugs for unapproved uses
- Drugs to help you get pregnant
- Free shots from the Department of Health
- Drugs that have not been proven to work
- Enteral Nutritional Supplements for those 21 years or older.

You must always show your CONNECT card and all other insurance cards to the pharmacy in order to get your medicines.

PHYSICIAN SERVICES

Medicaid covers services provided by licensed, doctors and certain allied health professionals, such as an advanced practice registered nurse, physician assistant or licensed counselor, who is working in conjunction with a physician.

Covered Services:

- Office visits
- Laboratory services
- Drugs and devices administered by a provider
- A second opinion for surgery when requested
- Family planning and hysterectomy services
- Early periodic screening, diagnostic and treatment
- For surgical services necessary to treat morbid obesity when another medical illness is caused by or is aggravated by the obesity. An individual is considered morbidly obese if his/her body weight is at least twice the ideal body weight, he/she is at least 100 lbs over the ideal body weight or he/she has a BMI over 39.

Services Not Covered:

- Immunizations available free of charge
- Cosmetic surgery
- Infertility treatment
- More than one visit per day to the same physician
- Transsexual surgery

REHABILITATION CLINIC

A rehabilitation clinic is an independent clinic, not part of a hospital that provides outpatient rehabilitation services to clients who are disabled or injured.

Services Covered:

- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology
- Limited mental health services
- Functional therapy (short term rehabilitation program for adolescents or adults who are disabled or handicapped)
- Day treatment programs for clients with Acquired Brain Injury
- Neuropsychological testing

Services Requiring Prior Authorization

In some cases the rehabilitation clinic must call the Department to get a prior authorization for specific services. Examples of such service(s) include:

- Physical and Speech therapy, or Audiology: 3 or more visits per week
- Occupational therapy: 2 or more visits per week

Services Not Covered:

- Services related solely to employment, work skills, or academic skills (reading, writing, and math)
- Services provided in a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded

VISION SERVICES

Medicaid provides coverage of vision services performed by a licensed ophthalmologist, optometrist, or optician enrolled with the Medicaid program. These services may be performed in the practitioner's office, client's home, hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-operated institution, or rest home.

Covered Services:

- Eye exams performed by an ophthalmologist or optometrist
- A second opinion (eye exam) from a different enrolled provider
- One (1) pair of eyeglasses per two years for clients 21 years of age or older.
The only exception for payment of an additional pair during the two-year time period is when a client's health care provider determines that such eyeglasses are medically necessary because of a change in the client's medical condition.
The limit of one pair per two years does not apply to clients under the age of 21.
- Glass or plastic prescription lenses and frames
- Simple tinting for lenses only when medically necessary
- Polycarbonate lenses
- Prescription sunglasses only when medically necessary
- Contact lenses when determined medically necessary by a practitioner

Services Not Covered:

- Spare pair of eyeglasses
- Replacements for lost, broken or stolen eyeglasses for clients 21 years of age or older
- Featherweight lenses for eyeglasses
- Anti-glare and scratch resistant coating
- Titanium frames
- Progressive lenses