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# Vermont Medicaid
# Durable Medical Equipment (DME)
# Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

# Table of Contents

# Section 1 Introduction

This DME supplement contains information that is unique to Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies. It also contains some information concerning billing, payment and specific instructions for completion of the CMS-1500 Claim Form.

*Please note when a service or an item is limited to, for example, one per year, a year is defined as 365 days, unless otherwise specified.

The Vermont Medicaid website, http://www.vtmedicaid.com/#/, will have information regarding DME codes, the modifiers allowed, unit limitations (i.e., one unit per 365 days) and pertinent prior authorization requirements. This information will be located under the following two links: http://www.vtmedicaid.com/#/resources and http://www.vtmedicaid.com/#/feeSchedule/dmeCodes.

DME guidelines are available on the DVHA website at: https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment. It is imperative that you review the diagnosis restrictions in these guidelines.

Health Care Administrative Rule 4.209 Durable Medical Equipment and related rules can be found on the Agency of Human Services website at: https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules. All DME is subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

# Section 2 Rental Reimbursement Policies

Effective January 2018 the DVHA implemented new rental reimbursement policies which will deduct payments issued for equipment rentals from the payment to purchase that same equipment. In addition, all rentals will be subject to a 10-month cap on rentals at which time the item will be considered purchased and paid in full. If the 10-month limit is reached for a capped rental (CR), ownership transfers to the DVHA. All rentals will continue to be subject, like new and used equipment purchases, to the lesser of billed charges and rate on file. The implementation of these rental policies is intended to reduce the overpayment of items so that the full purchase price of an item is paid, either in monthly rentals or a purchase, but not more than the purchase price.

The DVHA rental reimbursement policies are specific to DME claims are specific to professional claims (type 'M'), provider type 009, 014 or 015. All rentals, including capped rentals, are required to be submitted with an 'RR' modifier. Also, any new or used equipment must be submitted with the appropriate modifier (NU or UE). If a claim for a non-capped rental code is processed without the 'RR' modifier or with the modifier 'NU' or 'UE' the indication is that the equipment is purchased. A 14-month historical look back period will be used to assess the need to reconcile previous rental payments and/or apply the 10-month cap. The historical look back period will be prospective such that claims with dates of service between 1/1/2018-1/30/2018 will comprise the first month of historic data on which to the new rental policies will be based.

## 2.1 Capped Rentals (CR)

In an effort to be consistent with Medicare's requirements, the DVHA will use the Medicare capped rental code list and, like Medicare, when renting, will only allow a RR rental modifier. The exception to this rule is the small sub-set of codes included within the capped rental category with a rent OR purchase option. This change has been in effect since 1/1/2018.

For a full list of codes, please see Medicaid's Capped Rental List here: http://www.vtmedicaid.com/#/resources.

DVHA will not institute variable rental pricing depending on the month of rental and instead, will use Medicare guidance to set the rental rates to equal 1/10 of the purchase price of the capped rental.

Specifically, CRs will be paid in the following manner:

- Like Medicare, only the RR modifier can be billed with these codes.
- For CR items not classified as "Power Wheelchairs", the purchase price reflected on the fee schedule will be equal to the RR * 10. The DVHA RR rate in months 1 – 10 will be equal to the Medicare Rate (Medicare RR Rate * 3 + Medicare RR Rate * .75 * 10)/10 but not adjusted differentially in months 1 -3 and 4-13 as Medicare does.
- For CR items classified as "Power Wheelchairs", the purchase price will be equal to the Medicare RR / 0.15 to reflect that Medicare RR rates for these items represents 15% of the purchase price. The DVHA RR rate, therefore, will be equal to the purchase price/10. DVHA will not adjust the RR rate in months 1 -3 and 4 -13 as Medicare does. At this time, DVHA will follow Medicare's classification of what is considered "Power Wheelchairs". A list of these codes will be provided upon request.
- At month 10, payments are capped and DVHA assumes ownership.

## 2.2 Rental/Loaned

The DVHA will rent equipment when it is expected to be cost-effective, medically necessary and short-term. The Department of Vermont Health Access has transitioned most, but not all rental reimbursements to rental (RR) logic. This logic calculates the rental modifier (RR) to allow 10% of the purchase price (rate on file) for the procedure code. Providers are required to pro rate rentals when the rental period is less than 30 days.

Certain DME requires prior authorization to begin monthly rental. Rental equipment that does not initially require prior authorization will require prior authorization when the rental time is to exceed three months. http://www.vtmedicaid.com/#/resources

If an item's code does not specify Rental, use modifier RR. The rental will be priced at a monthly amount and is to be billed at a monthly amount unless stated otherwise.

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are available for the following DME items: wheelchairs, speech generating devices, TENS units, and custom orthotics, and can found at: https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment. Use of these designated forms/tools is recommended to ensure that all required information is available for review by the DVHA Clinical Unit.

Effective for dates of service on or after May 1, 2018 providers may bill for supplies up to the DVHA quantity limit during the rental period for: E0445, E0465, E0466, E0470, E0471, E0565, E0600, and E0601. As part of the DVHA's annual Fee Schedule maintenance, the DVHA will solicit public comment on revisions to the code list. When billing for supplies on purchased equipment, the supplier must state on the claim or medical necessity form that the related piece of equipment is not being rented (e.g., "CPAP is not being rented" or "...is owned by the member").

When DME is loaned (provided without charge) or rented, as part of an equipment trial and the equipment is then approved for purchase: The claim for the equipment is required to include the UE modifier when the equipment is to be retained by the member and was not new at the time of the loan or initial rental. Only if the equipment was new, or if the used equipment is being replaced by new equipment, should this modifier be omitted. The provider is to document the DME serial number in the member's record.

# Section 3 Billing Information

## 3.1 Face-to-face Requirements

The Agency of Human Services (AHS) requires providers to document that a face-to-face encounter occurred for the initial ordering of specified durable medical equipment and supplies. This requirement only applies to certain types of durable medical equipment, supplies, and services that are also covered by Medicare as found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf.

Face-to-face Requirement also includes power wheelchairs.

Additional face-to-face visit requirements can be found in Health Care Administrative Rule 4.209 DME at: https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules.

## 3.2 Reimbursable/Non-Reimbursable Services

Reimbursable/non-reimbursable information and prior authorization information is available on the Department of Vermont Health Access website at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

DME guidelines, including wheelchairs and other mobility devices, augmentative communication devices, prosthetics, orthotics and medical supplies are available at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

See Medicaid Covered Services and Health Care Administrative Rules: 4.209 Durable Medical Equipment, 7504 Medical Supplies, 7508 Prosthetic Devices, 4.210 Wheelchairs, Mobility Devices and Seating Systems, 4.211 Augmentative Communication Devices and Systems, and 4.213 Audiology Services; at https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules.

## 3.3 Payment DVHA Primary/Manual Pricing

When the DVHA is the primary payer, payment amounts for DME (including augmentative communication devices and closed-circuit TV purchased from the Vermont Association for the Blind and Visually Impaired- VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

- When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or the rate on file;
- When the rate on file is $0.00 and the PAC is 6 (manually priced) the purchase invoice must be submitted with the claim. If the MSRP is present on the purchase invoice reimbursement will be whichever is lower, up to the billed charge.

The reimbursement methodology for manually priced codes is as follows:

- For dates of service prior to 1/1/2020 – the DVHA pays purchase invoice cost plus 67% or MSRP minus 15%, up to the billed charge, whichever is lower.
- For dates of service 1/1/2020 – 12/31/2020 – The DVHA pays purchase invoice cost plus 49% or MSRP minus 15%, up to the billed charge, whichever is lower.
- For dates of service 1/1/2021 and after – The DVHA pays purchase invoice cost plus 30% or MSRP minus 15%, up to the billed charge, whichever is lower.

Purchase invoice pricing documentation requirements:

- The purchase invoice must be submitted in its entirety. If any information (including pages) is missing or lines are marked out or whited out the claim will be denied.
- Online sales aggregator (such as Amazon) receipts are accepted only if the item is purchased by the DME supplier and not available from any other vendor. All below pricing documentation requirements still apply to online sales aggregator receipts.
- All discounts and totals must be clearly documented and disclosed.
- The purchase invoice or online sales aggregator receipt must be dated within one year from the date of service indicated on the claim. If the purchase invoice or online sales aggregator receipt date exceeds one year, the claim will be denied.
- The item(s) on the purchase invoice or online sales aggregator receipt must match the item(s) that are being billed on the claim. The applicable correct code must be written next to the item(s) on the purchase invoice, or online sales aggregator receipt. If the code for the item(s) are not documented on the purchase invoice or online sales aggregator receipt the claim will be denied. Item(s) that are specifically for the right or left side must be clearly documented with the correct modifiers for right or left next to the applicable code.
- Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of the DVHA.
- Vermont Medicaid is the payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.

## 3.4 Enhanced Pricing Criteria

Enhanced pricing is available to DMEPOS providers when the purchase price of an item exceeds the Medicaid rate on file. The same pricing methodology applies to enhanced pricing as manually priced items. Requests for enhanced pricing must be received within 3 months from the date of service.

Items excluded from enhanced pricing include continuous long-term rentals. Capped rental items are eligible for review.

Providers are required to complete the enhanced pricing request form, found here, http://www.vtmedicaid.com/#/forms, as well as submit relevant clinical documentation which would include one of the following:

- If there is a PA on file, providers must send a copy of the Notice of Decision for the PA with a copy of the invoice for reimbursement review.
- If no PA is needed, a clinical review is required, and providers must submit a copy of the Medical Necessity Form or other supporting clinical documentation. A quote is acceptable to initiate the clinical review.
- If clinical approval is granted, providers must then submit a copy of the request form along with the invoice indicating the purchase price of the item (including all discounts) for review of the enhanced reimbursement rate.
- Invoices must be within 1 year from the date of service. Shipping charges are not included as part of the item cost. MSRP is not acceptable for enhanced pricing.
- Claims approved for enhanced pricing should be submitted on paper with a copy of the signed approval form to the following address.

**Gainwell Technologies**
Attn: Special Pricing
PO Box 888
Williston, VT 05495

## 3.5 Payment-Dual Eligible/Medicare Primary

When Medicare is the primary payer, the provider must accept assignment of the claim in order to receive any DVHA payment. This applies to all claims for services and items. See the Vermont Medicaid General Billing and Forms Manual, Section 1.6, Medicaid & Medicare Crossover Billing. http://www.vtmedicaid.com/#/manuals

If the claim is submitted to Medicare on an assigned basis, when the DVHA receives the crossover claim, it will pay the coinsurance and deductible amounts due.

In order to assure access, the DVHA has created five exceptions to the above procedure. The exceptions are limited to claims for:

- Wheelchairs
- Seating systems
- Cushions that are part of a seating system
- Seat lifts, and
- Repairs to wheelchairs for which Medicare did not participate.

For these items, a provider may submit a prior authorization request to the DVHA asking for a medical necessity determination and provisional [or conditional] authorization for Vermont Medicaid coverage. When a provider submits a request for prior authorization of a wheelchair, seating system, cushions that are part of a seating system or seat lift for a dually eligible member, the DVHA will review the request for medical necessity and for sufficient information to support pricing. If the DVHA determines that the request is medically necessary, it will provisionally [conditionally] approve the request. The claim must then be submitted to Medicare.

If Medicare approves, the DVHA will pay the difference between the Medicare paid amount and the Vermont Medicaid allowed amount. If Medicare denies, the DME provider must submit proof of denial including the explanation of benefits (EOB) information. Then, Vermont Medicaid will review the request and, if approved, will pay the Vermont Medicaid allowed amount.

In addition, when a primary wheelchair is found by the DVHA to need repair, modification, and/or battery replacement, and Medicare denied or downgraded the purchase of the primary chair; or the DVHA determines that Medicare is unlikely to accept new documentation of medical necessity for the primary chair, the DVHA may approve the request with a prior authorization with specific wording that these items may be billed directly to Vermont Medicaid.

To assure access, the DVHA will consider creating additional exceptions for items of DME which cost over $100.00. Any request to add a service or item to the list of exceptions for access reasons must demonstrate to the satisfaction of the DVHA commissioner that the item is inaccessible statewide due to the Medicare payment level.

## 3.6 Medical Necessity Form (MNF)

A completed Medical Necessity Form is required for Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.

Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization. The form needs to contain the prescribing provider's signature, billing code and description of the item requested.

If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.

Both the ordering providers and the DME vendor are required to keep legible copies of all information in the patient record. The signature date on the MNF/order must be within 12 months of the dispensing date (billed DOS). (The order is good for one year). The MNF for Items on the capped rental program is good for 12 months. Medicaid will follow Medicare's Oxygen guidelines for Initial, Recertification, and Revised criteria for Certificate of Medical Necessity requirements. Medical Necessity and prior authorization forms are available at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

### 3.6.1 Standard Written Order (SWO) for Durable Medical Equipment (DME) and Supplies

The Department of VT Health Access (DVHA) will also allow the use of the Standard Written Order for DME and supplies. This will allow the DVHA to more closely align with Medicare. Details about the SWO can be found at:
https://med.noridianmedicare.com/web/jddme/topics/documentation/standard-written-order

For items that do NOT require prior authorizations, DVHA will allow providers to use a Medicare compliant SWO or an MNF. This documentation must be kept in the provider's files.

For items that require prior authorization, DVHA will allow providers to use the following documentation:

- A completed medical necessity form and supporting clinical documentation that clearly documents the medical necessity of the item, OR
- A Medicare compliant Standard Written Order and supporting clinical documentation that clearly documents the medical necessity of the item, OR
- A completed Wheelchair Evaluation and Prescription form, or a completed Speech Generating Device Evaluation and Prescription form.

## 3.7 Prescribing Provider

Doctor of Medicine (M.D.), Doctors of Osteopathy (D.O.), Nurse Practitioners (NP), Physician Assistants (PA), Naturopathic physicians (N.D.) and certain other licensed practitioners may write prescriptions for DME and medical supplies. Audiologists may prescribe hearing aids. Physical and occupational therapists may prescribe wheelchairs and seating systems however MD/DO/NP/PA endorsement of the prescription is required. All written prescriptions must be legible and contain the required information and applicable dates.

The MD/DO/NP/PA prescriber must be enrolled as a participating Vermont Medicaid provider and the prescribing/attending NPI number on the CMS-1500 claim must be valid. When billing for services to Vermont Medicaid, the prescribing/referring provider NPI number should appear in field locator 17a or b when billing on a CMS-1500 Claim Form. The billing provider name and address must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.

DME providers must keep prescriptions on file for five years for members in DVHA programs.

## 3.8 Dates of Service

The billed date of service on the claim must be the date that the item was dispensed /delivered to the member. The date of service may not be earlier than the date the item was dispensed/delivered. There are two exceptions:

- When the billings are for monthly DME rentals, the dates of service should span the rental month;
- When the member becomes ineligible after a customized item has been ordered but before it can be dispensed, the date may be the actual date of the order.

Custom order items include: the evaluation, fitting, casting and measuring processes. There will be no separate payment to DME providers for these services. DME Providers may not seek additional reimbursement.

## 3.9 Procedure Codes & Pricing

A list of procedure codes for DME equipment, orthotics, prosthetics and supplies is available in electronic form. This list includes the code, rate on file, whether the code requires prior authorization, and other pertinent information. Fee Schedules are at https://dvha.vermont.gov/providers/codesfee-schedules. Items on the fee schedule with a PAC 5 or 6 are manually priced. DME Restrictions, located at http://www.vtmedicaid.com/#/resources, inform DME providers of current restrictions on certain DME items/supplies.

Changes in the price on file will be reflected on the Fee Schedule. The DVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons' providers should be careful to retain the changes noted in the Remittance Advice and updated versions of the fee schedule. This file is for the convenience of the provider. Although the DVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for payment is the only accurate price for the applicable date of service.

For items that do not have a price on file, when a vendor is requesting special pricing consideration, or for items that are manually priced, an invoice including the manufacturer's price to the vendor and any discounts must be submitted with the claim.

## 3.10 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid beneficiary.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

## 3.11 Individual Consideration/Manual Pricing

The rate on file for certain procedure codes does not have a specific dollar amount because no one amount is appropriate (e.g., code A4570, miscellaneous splints). In these cases, the rate at $0.00 and listed as PAC 5 or PAC 6 on the fee schedule and the allowed amount will be calculated in accordance with the Section 3.3, Payment DVHA Primary/Manual Pricing. This process is often called "manual pricing".

## 3.12 Repairs

Repairs to covered items are covered when the repairs are necessary to make the items useful, are not included in a warranty, have been ordered by an MD/DO/NP/PA, and do not total more than 50%

of replacement cost. Suppliers must check the procedure code listing in the Fee Schedule for the specific code representing the item requiring repair, to determine the need for prior authorization. Payment will not be made for repairs to equipment for use in skilled nursing homes, ICFs, ICF-MRs, mental or general hospitals or psychiatric facilities because these items are considered part of the per diem rate paid to those facilities

## 3.13 Mileage

Mileage incurred by providers associated with the repair of a DME item is reimbursable by Vermont Medicaid and cannot be charged to the member. The mileage must be determined from the DME provider's closest facility. If the vendor is making multiple deliveries the only portion that will be reimbursed is the portion of the mileage specific to the Vermont Medicaid member.

If the member is able to take the DME item that needs to be repaired to the DME provider, then that is the expectation. If the cost of the member's transportation to the DME provider's office outweighs the DME provider's cost of travel to the member, then the DME provider's cost will be covered.

## 3.14 Equipment Returns

DME purchased by Vermont Medicaid for eligible members remains the property of Vermont Medicaid. If a member no longer has a medical need for certain equipment purchased by Vermont Medicaid, the member must be instructed to contact the DVHA Clinical Review Unit at: 802.879.5903. DME suppliers must also contact this number if Vermont Medicaid-owned DME is returned to them.

## 3.15 Durable Medical Equipment (DME) Recycling

DME vendors who provide the following equipment to Vermont Medicaid members are required to affix a sticker on the item at the time of delivery that identifies Vermont Medicaid as the owner of the device.

- Manual Wheelchairs
- Power Operated Vehicles
- Power Wheelchairs
- Standers
- Lifts
- Hospital Beds
- Rehab Shower Commode Chairs
- Augmentative Communication Devices/Speech Generating Devices.

Vermont Medicaid provides the stickers with contact information to assist with return of the device when it is no longer required by the member. The sticker must be applied to an area of the device that is protected from daily wear and tear but is visible without excessive effort. The accompanying Durable Medical Equipment Ownership, Operation, and Maintenance Agreement form must be signed by the vendor and the member or the member's legal guardian. The completed form must be kept on file at the vendor's office and be available for inspection by DVHA, and a copy provided to the member for their records. The DVHA may request a copy of the completed form as part of the clinical review process for items which require prior authorization. The Durable Medical Equipment Ownership, Operation, and Maintenance Agreement form is available on the DVHA website at https://dvha.vermont.gov/forms-manuals/forms. Contact DVHA at 802.879.5903 to obtain stickers and forms.

**Exception:** No stickers are required for equipment for dual eligible members whose primary insurance covered the cost of the device.

## 3.16 Rehabilitation Equipment Review

The DVHA contracts with the Veteran's Administration to provide second opinion consults for select rehabilitation equipment that requires prior authorization. Members may be contacted by a VA representative to arrange this consultation. Consultations will take place at the member's home or at a VA clinic. Members and providers will be notified when the DVHA has required a consult.

## 3.17 Excess Quantity for DME and Supplies

This applies to Accountable Care Organization (ACO) and non ACO attributed members.

- PA is required for quantities in excess of allowed amounts for codes listed in the Capped Rental Program
    - For example, if a vendor requires a second wheelchair or wheelchair equipment for an ACO-attributed member and there is medical necessity for this item, a PA would be required for a second same/similar piece of equipment.
- If a code is NOT part of the capped rental program, prior authorization is waived for ACO attributed members

For non ACO attributed members supplies in excess of the monthly limitations are covered with DVHA approved prior authorization.

To determine which codes are in the Capped Rental program, review the Category Column of the most recent fee schedule in the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

# Section 4 DME Billing Information – Equipment Specific (Alphabetical)

## 4.1 Adaptive Weighted Eating Utensils

Vermont Medicaid allows for the reimbursement of "Adaptive Weighted Eating Utensils" when medically necessary for individuals who have significant tremors that interfere with daily activities (i.e., ability to self-feed).

These utensils must be ordered by an MD/DO/NP/PA, must be medically necessary, supplied by a Pharmacy or DME vendor, and billed using non-specific HCPCS code A9999. Only one of each type of utensil is allowed. The billing/supplying provider must submit an invoice with the claim in order to be reimbursed.

## 4.2 Apnea Monitors

Vermont Medicaid covers the rental of an Apnea Monitor for use in the home when medically necessary, as per the DVHA Clinical Criteria. Purchase is not covered. The DVHA Clinical Guideline for Apnea Monitors is available online at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment. For members under the age of one year (infants), prior authorization is not required. When the condition(s) which caused a need for the monitor have been resolved or are stable for two to four months, monitor rental must be discontinued.

## 4.3 Blood Pressure Monitors

Vermont Medicaid covers two types of blood pressure monitors for home use when medically necessary per the online DVHA guidelines at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

Providers are required to follow national correct coding requirements.

Non-Continuous Automatic Blood Pressure Monitors consist of a digital gauge and a stethoscope in one unit and are powered by batteries. The cuff may be inflated manually or automatically depending on the model.

Vermont Medicaid covers only the purchase of these monitors; coverage is not available for rental. The Medical need must be clearly documented in the patient's medical records. HCPCS has a specific billing code for these common BP monitors.

Continuous Automatic Blood Pressure Monitors measure blood pressure continuously in real time and comes with a recording device. They are non-invasive and can be used with a cuff or finger sensor.

Vermont Medicaid covers only the rental of these monitors; coverage is not available for purchase. Prior authorization is required. Vermont Medicaid will accept the miscellaneous durable medical equipment HCPCS code, since a specific code is not yet in place for these special monitors.

Vermont Medicaid does not cover new or refurbished Dinamap Monitors.

## 4.4 Breast Pumps

Providers and suppliers are responsible for ensuring medical necessity and should refer to the Coverage Guidelines for Electric Breast Pumps on the DVHA website https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

DME providers are allowed to bill using the mother's name and UID; a diagnosis must be specified for the baby.

## 4.5 Continuous Passive Motion (CPM) Devices

Per section 30.2.1 of CMS claims processing manual, CPM devices are to be billed as one billed unit = one day of rental and are limited to a maximum of 21 days of rental. The DVHA follows these CMS guidelines: "Continuous passive motion devices are covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home. Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21-day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the 3-week limited coverage period."

The current HCPCS code for the knee joint is E0935RR. Modifier RR is required since CPM devices are only rented (never purchased). Each billed unit is reimbursed at a daily rate.

For consecutive, multiple days of rental, the claim must be billed with a date range and the corresponding multiple units (total number of days).

Please note that HCPCS code E0936RR, a CPM device for joints other than the knee, is covered only with prior authorization from the DVHA.

## 4.6 CPAP & BIPAP

Prior authorization is not required for the rental of CPAP & BIPAP devices for the first three months under the capped rental program. The Department of Vermont Health Access will cover the humidifier separately from the positive airway pressure device whether it is built-in/integrated humidifier OR a stand-alone humidifier. Rentals recognize a three-month trial period, and months four through ten require prior authorization for completion of the capped rental period once medical necessity has been determined. Replacement CPAP, BIPAP and humidifier devices require a prior authorization and will be processed as new and should include the NU modifier. Prior authorization requests must include appropriate documentation of medical need to support current best practice guidelines. (See McKesson Smart Sheets on our website, http://www.vtmedicaid.com/#/home, navigate to the Transactions menu and choose login.

## 4.7 Crutches

An order for crutches usually refers to common, wood, underarm crutches. If other types are dispensed by the DME supplier, the medical necessity form must be specific as to the type ordered and why the common wood crutches are not sufficient.

## 4.8 10 Day Overlap – Enteral Nutrition and other supplies

Certain codes allow for the 10-day overlap.

Vermont Medicaid allows a 10-day overlap in dates of service for enteral nutrition codes. And certain other supplies as noted below. This overlap will allow for delivery or shipping of refills. The supplier must deliver the enteral nutrition or supplies no sooner than 10 days prior to the end of the usage for the current product. The DVHA Clinical Guidelines for enteral nutrition is available online at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment.

- Enteral Nutrition
- Ostomy Supplies - A4361-A4435
- Additional Miscellaneous Supplies - A4450-A4608
- Supplies for Oxygen and Related Respiratory Equipment - A4615-A4629
- Additional Ostomy Supplies - A5051-A5093
- Additional Incontinence Supplies - A5102-A5114
- Supplies for either Incontinence or Ostomy Appliances - A5120-A5200
- Dressings, Wound Care and Burn Supplies - A6000-A6457
- Respiratory Supplies - A7000-A7527
- National T Codes for State Medicaid - T4521-T4535, T4541-T4543, T4544, A4554

## 4.9 Glucometers

The basic glucometer does not require prior authorization. The prescribing provider's medical necessity form must document that the member is a diagnosed diabetic.

Glucometers with special features (such as voice response) require prior authorization from the Department of Vermont Health Access. The prescribing provider's medical necessity form must document that the member is a diagnosed diabetic. Information on the special feature(s) of the unit, why the unit is medically necessary and pricing information is required.

The Department of Vermont Health Access limits the quantity of diabetic supplies for eligible Vermont Medicaid members (such as glucose meters and test strips). Extra equipment and supplies require prior authorization.

Vermont Medicaid will reimburse pharmacies only for the following meters and the test strips for those meters:

FreeStyle® Lite, FreeStyle Flash®, FreeStyle Freedom®, Precision Xtra™, One Touch® Ultra® 2, One Touch® UltraMini™ and One Touch® Ultra® Smart.

All other meters and test strips will require a prior authorization.

## 4.10 Hospital Beds

All semi-electric and fully electric hospital beds for use in the home require prior authorization from the DVHA. This includes rentals and all other modifier-code combinations. Regardless of the procedure code/modifier to be used, prior authorization must be obtained prior to placement of the bed in the home.

The only exception is the "Immediate Needs" exception as explained in the Vermont Medicaid General Billing and Forms Manual, Section 2, Prior Authorization. This prior authorization requirement is not new, as semi-electric and fully electric hospital beds have required prior authorization for many years. http://www.vtmedicaid.com/#/manuals

## 4.11 Incontinence Supplies

Incontinence supplies are covered under HCPCS procedure codes. Dispensing providers are required to maintain a complete and current medical necessity form on file for each item, justifying the medical need and quantities used.

## 4.12 Medical Supplies

Medical supplies will be covered when:

- Prescribed by an enrolled physician or other authorized practitioner
- Used in a member's home due to a post-surgical or chronic condition

- Billed first to Medicare when the member is dual eligible
- Billed first to any other insurer or applicable organization
- Prior authorization is obtained for excess quantities

Medical supplies may be dispensed in three-month time periods. The "from" and "to" dates of service on the CMS-1500 Claim Form must accurately reflect the three-month date span. Providers are not allowed to dispense more than a three-month supply at a time.

## 4.13 Oxygen and Oximeter

**Oxygen**

VT Medicaid criteria will follow the current Medicare Guidelines as outlined under LCD33797 effective 1/1/2020.

https://med.noridianmedicare.com/documents/2230703/7218263/Oxygen+and+Oxygen+Equipment+LCD+and+PA

Exceptions **-** Per Medicare- if the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems. Medicaid elects to not allow member or itself to own oxygen equipment and supports the beginning of a new 36-month rental period.

**Oximeter**

Medicaid will cover E0445 oximeter as a capped rental item and allow A4606 disposable probe replacement of 6 per month, effective 1/1/2020.

## 4.14 Peak Flow Meters

Members with a diagnosis of asthma or reactive airway disease may obtain Peak Flow Meters (e.g., Access, MiniWright, Pulmograph) from any qualified provider (MD/DO/NP/PA or DME provider).

## 4.15 Special Needs Feeder Bottles

HCPCS procedure code S8265 is accepted by Vermont Medicaid to bill for the Haberman Feeder (special needs bottle with nipple) when medically necessary for dysphagia due to cleft lip/palate. When the cause of the dysphagia is other than cleft lip/palate or the bottle is not Haberman, unlisted procedure code A9999 is allowed.

All special needs feeder bottles are reusable, must be ordered by a physician, MD/DO/NP/PA, and supplied by a DME/pharmacy vendor. Quantity is limited to 10 bottles with nipples per six months. Prior authorization is not required. The medical need must be clearly documented in the patients' medical records and an invoice is required with each claim submission.

## 4.16 Speech Generation Devices

The purpose of a speech generating device (SGD), alternately called an alternative and augmentative communication device (AAC), is for communication that originates from the beneficiary and not from a facilitator or support person, and the device must be used as determined by the prescribing speech language pathologist to ensure the safety and maximum benefit of the beneficiary.

The Department of Vermont Health Access covers both traditional devices and tablet devices such as iPads and iPods for Vermont Medicaid members whose severe communication impairment prevents

writing, telephone use, and/or talking. DVHA does not cover this or any other device to be used solely for educational, vocational, or avocational purposes. Multiple devices are not covered.

Vermont Medicaid utilizes a supplier for tablet devices who is not a standard Durable Medical Equipment (DME) provider. For this reason, the Speech Language Pathologist (SLP) performing the evaluation will be considered the provider of record during the ongoing authorization process when Small Dog Electronics is identified as the supplying provider. The prescribing SLP is required to be an enrolled Vermont provider. If the member has more than one SLP, for example a school and a medical model SLP or an expert consultant, and one SLP is an enrolled Vermont Medicaid provider, SLP collaboration will be allowed during the evaluation/ prescribing process; the enrolled SLP submits the request. If the device is approved, the DME provider becomes the supplying provider of record. For all other situations, the supplying provider is the DME provider.

A packet that includes the DVHA evaluation and prescription form, the DVHA Ownership form, Rule related to speech generating devices and a procedure checklist is available at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment. See the link titled Augmentative Communication Device Packet.

## 4.17 Splints

When a miscellaneous splint code must be used because there is no specific code available, providers must submit a request for prior authorization and a completed Medical Necessity Form. Claims must also be submitted with an invoice for identification and cost.

## 4.18 TENS/NMES

TENS and NMES units must have a trial period of up to three months to determine effectiveness for the member. Purchase will be considered only when the continuing medical need is documented, and benefit is proven.

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are found at: https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipmentUse of these designated forms/tools will ensure that all required information is available for review by the DVHA Clinical Unit.

## 4.19 Tracheostomy Care Kits

Tracheostomy care kits are not approved unless a compelling clinical case can be made, and prior authorization is obtained. The necessary supplies for tracheostomy care come in bulk quantities and providers are advised to furnish bulk supplies when appropriate. All these supplies have individual procedure codes.

## 4.20 Ventricular Assist Devices

Vermont Medicaid's coverage of Ventricular Assist Devices is based on the CMS National Coverage Determination 20.9, entitled "NCD for Artificial Hearts and Related Devices". Hospital and physician providers are referred to the current CPT and HCPCS manuals for proper coding.

## 4.21 Wheelchairs & Seating Systems

The purchase and rental of wheelchairs requires prior authorization. Wheelchairs and seating systems are covered under various procedure codes (see current HCPCS manual). Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules to determine the procedure codes that require prior authorization. To obtain prior authorization, providers are required to submit a completed medical necessity form and supporting clinical documentation to the clinical staff at the DVHA. When a member is also covered by Medicare, see the Vermont Medicaid General Billing and

Forms Manual, Section 6.4, General Hospital Billing Information.
http://www.vtmedicaid.com/#/manuals

To obtain individual consideration pricing, providers are required to submit pricing information to the Reimbursement Unit at the DVHA.

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are found at: https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment. Use of these designated forms/tools will ensure that all required information is available for review by the DVHA Clinical Unit.

Vermont Medicaid follows Medicare's lead in requiring that certain wheelchairs must come from a supplier employing a RESNA-certified Assistive Technology Professional (ATP) who is directly involved in the wheelchair selection for the member. An ATP cannot review and sign off on the work of an individual who is not an ATP. The ATP must submit documentation that clearly demonstrates their in-person presence at the clinical evaluation. The wheelchairs that require ATP assessment are Group 2 single- or multiple-power option power wheelchairs, All Group 3, Group 4 and Group 5 power wheelchairs, power assist devices, ultra-lightweight manual wheelchairs, and tilt-in-space wheelchairs.

All ATP certified suppliers must sign all documentation certifying the ATP designation of the professional involved in the clinical selection of the various types of wheelchairs as described in this section. All ATP certified suppliers must keep a copy of their certification on file, to be available upon request from the DVHA.

## 4.22 Wheelchair Repairs

All repairs on wheelchairs less than one year old require prior authorization from the DVHA. The DVHA expects that these chairs would still be under the manufacturer's warranty and therefore any repairs, regardless of the dollar amount, require prior authorization. For wheelchairs over one year old and not under warranty, prior authorization is required only for repairs greater than $500.00.

Requests for prior authorization for wheelchair repairs must include a completed Medical Necessity form in addition to the following:

- The date the wheelchair was delivered
- When the chair is less than 5 years old, the cost of repair vs. cost of replacement
- Equipment guarantees, warranty and denial of third-party coverage
- The condition of the existing equipment

Durable Medical Equipment (DME) providers who service wheelchairs may make repairs to wheelchairs provided to a Vermont Medicaid member by another DME provider if the initial provider has gone out of business or the device records are unobtainable (for example, the records of the Scooter Store). In these instances, DME providers are allowed to make repairs to the device in order to assure the safety and independence of the Vermont Medicaid member. If there is any concern that the device is not medically appropriate to the medical needs of the member, an assessment by a physical or occupational therapist is advisable.

Health Care Administrative Services Rule 4.210: https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

# Section 5 CMS-1500 Paper Claim Billing Instructions/Field Locators

## 5.1 Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 19, "Local Use" of the CMS-1500 claim form. To indicate the conclusion of the entire claim, field 28 of the last page of the claim must also include the total billed amount.

Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

## 5.2 Field Locators

All information on the CMS-1500 Claim Form should be typed or legibly printed. Only the 02-12 version of this form is accepted for processing. The field locators listed below are used by Gainwell Technologies when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable. The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

| FIELD LOCATOR | REQUIRED INFORMATION |
|---|---|
| 1. CARRIER IDENTIFICATION | Check the Medicaid box |
| 1a. INSURED'S ID NUMBER* | Enter the Vermont Medicaid ID number as shown on the member's Member ID card. |
| 2. PATIENT'S NAME* | Enter the member's last and first name. |
| 10. CONDITION RELATED TO* | Check appropriate box to indicate:<br>a. If condition is related to employment<br>b. If condition is related to an auto accident<br>c. If condition is related to any other type of accident.<br>If yes is checked in any of these boxes, enter the accident date in field locator 15. |
| 11. INSURED'S POLICY NUMBER | If the member has other health insurance (excluding Medicare), enter the applicable policy number.<br>a. Enter the insured's date of birth in MMDDYY format; check the appropriate box to indicate insured's sex.<br>b. Enter the insured's employer or school name.<br>c. Enter the name of the other health insurance carrier |
| 11b. OTHER CLAIM ID (DESIGNATED BY NUCCU) | Property casualty payers (e.g. automobile, homeowner's, or worker's compensation insurers and related entities are to use qualifier "Y4" and the Agency (property casualty) claim number as the identifier. Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For workers compensation and property casualty enter the claim number assigned by the payer (if known). |

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| 11d. IS THERE ANOTHER HEALTH BENEFIT PLAN* | Check the appropriate box. If yes, complete fields 9 a-c. Health benefits provided under Green Mountain Care are not considered other insurance. Other insurance only pertains to a private health insurance carrier. |
| 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY | Enter the first date of present illness injury, or pregnancy. For pregnancy, use the date of last menstrual period. Use qualifier "431" - Onset of Current Symptoms or Illness or "484" – Last Menstrual Period (LMP) |
| 15. OTHER DATE (ACCIDENT DATE) | If your response indicates a 'yes' in field locators10b or 10c, enter the date of the occurrence and qualifier "439". |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | Enter the name (First, Middle Initial, Last) followed by the credentials of the professional who referred/ordered the service or supply. If multiple providers apply, enter one provider/qualifier in the following order:<br>1) DN – Referring Provider<br>2) DK – Ordering Provider<br>3) DQ – Supervising provider<br>*Exception:* Professional/Professional Crossover Claims require the Ordering qualifier "DK" to be used 1st when the provider in Field 17 is an Independent Lab, Independent Radiology, DME Supplier, Prosthetics/Orthotics or Sole source Eye Glass provider. |
| 17a. | Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field immediately to the right of 17b. Refer to http://nucc.org/ for list of valid qualifiers. Entry must support information entered in field 17. If applicable, field is required. |
| 17b. NPI* | Enter the referring, ordering or supervising provider's NPI. Entry must support information entered in field 17. If applicable, field is required. |
| 19. LOCAL USE | Use this field to explain unusual services or circumstances and to indicate "page x of y" of a multiple page claim. |
| 21. ICD Ind.* | Enter "0" for ICD-10 diagnosis codes. |
| 21. DIAGNOSIS CODE(S)* | Enter the appropriate ICD-10 diagnosis code that relates to the service rendered. You may use up to twelve diagnosis codes. |
| 24a. DATE(S) OF SERVICE* | Enter the date of each service provided. If the "From" and "To" dates are the same, the "To" date is not required. |

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|---|---|
| 24b. PLACE OF SERVICE* | Enter the appropriate two-digit place of service code. |
| 24c. EMG | Enter '1' to indicate if the service provided was the result of an emergency. *This field is mandatory only if emergency services were provided. |
| 24d. PROCEDURE CODE* | Enter the appropriate procedure code to explain the service rendered. |
| 24e. DIAGNOSIS POINTER* | Enter the appropriate diagnosis 'pointer' that relates to the service rendered from field locator 21.<br>NOTE: The pointer character has changed from numbers to letters. |
| 24f. CHARGES* | Enter the usual and customary charge for the service rendered. |
| 24g. DAYS OR UNITS* | Enter the number of days or units of service which were rendered. |
| 24h. EPSDT/FAMILY PLAN | Enter one of the following Vermont Medicaid EPSDT and Family Planning indicators:<br>1-Both EPSDT and Family Planning<br>2-Neither EPSDT nor Family Planning<br>3-EPSDT Only<br>4-Family Planning Only |
| 24j. ATTENDING PROVIDER* | Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers.<br>If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area. |
| 26. PATIENT'S ACCOUNT NUMBER | Enter the account number you have assigned to the member. Gainwell Technologies can accept up to 12 digits; alpha, numeric, or alpha/numeric in this field. This information will print on the Remittance Advice summary for your accounting purposes. |
| 28. TOTAL CHARGE* | Add the charges from field locator 24f for each line and enter the total in this field. |
| 29. AMOUNT PAID* | Enter the amount paid by other health insurance coverage (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is $3.00 or less. |

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|---|---|
| 31. SIGNATURE | Enter the provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature. |
| 33. BILLING PROVIDER* | Enter the payee provider name and address (Individual provider format: last name, first name) |
| 33a. BILLING PROVIDER'S NPI* | Enter the billing provider's NPI. |
| 33b. BILLING PROVIDER'S TAXONOMY | Enter the billing provider's taxonomy code when applicable. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area. |