FINAL PROPOSED RULE # 18-P34

Administrative Procedures – Final Proposed Rule Filing

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, the Legislative Committee on Administrative Rules and a copy with the Chair of the Interagency Committee on Administrative Rule.

All forms requiring a signature shall be original signatures of the appropriate adopting authority or authorized person, and all filings are to be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Wheelchairs, Mobility Devices, and Seating Systems

_____, on 10/25/18.
(signature) (date)

Printed Name and Title:
Martha Maksym, Deputy Secretary of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
   Wheelchairs, Mobility Devices, and Seating Systems
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   18P-034
3. ADOPTING AGENCY:
   Agency of Human Services (AHS)
4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Ashley Berliner

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive Waterbury, VT 05671-1000

   Telephone: 802 578 - 9305 Fax: 802 241 - 0450

   E-Mail: ashley.berliner@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   http://humanservices.vermont.gov/on-line-rules
5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Susan Coburn

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive Waterbury, VT 05671-1000

   Telephone: 802 578 - 9412 Fax: 802 241 - 0450

   E-Mail: susan.coburn@vermont.gov
6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:
7. LEGAL AUTHORITY / ENABLING LEGISLATION:
   (THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

3 V.S.A. § 801(b)(11); 33 V.S.A. § 1901(a)(1)

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
AHS's authority to adopt rules as identified above, includes by necessity, authority to amend those rules to ensure continued alignment with federal and state guidance and law. The statutes authorize AHS as the adopting authority for administrative procedures and afford rulemaking authority for the administration of Vermont's medical assistance programs under Tile XIX (Medicaid) of the Social Security Act.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

The proposed rule sets forth the criteria for Medicaid coverage and reimbursement for wheelchairs, mobility devices, and seating systems under Vermont's Medicaid program. It revises and will replace current Medicaid covered services rule 7506 as part of the sequential adoption of Health Care Administrative Rules designed to improve public accessibility and comprehension of the numerous rules concerning the operation of Vermont's Medicaid program.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:
The rule is necessary to define coverage and reimbursement for wheelchairs, mobility devices, and seating systems. Amendments align with federal and state guidance and law, provide clarification, improve clarity and make technical corrections. Substantive

revisions include clarifying terms in the definitions and clarifying coverage limitations. These amendments align with federal regulations and current practices.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rules are required to implement state and federal health care guidance and laws. Additionally, the rules are within the authority of the Secretary, are within the expertise of AHS, and are based on relevant factors including consideration of how the rules affect the people and entities listed below.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Medicaid beneficiaries; Agency of Human Services including its Departments; Durable medical equipment suppliers; Hospitals; Health law, policy and related advocacy and community-based organizations and groups including the Office of Health Care Advocate; and health care providers.

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

The rule does not increase or lessen an economic burden on any person or entity including no impact on the State's gross annualized budget in fiscal year 2019. The changes and amendments conform the rule with current practice and changes to federal and state laws that have already been implemented.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 8/6/2018

Time: 12:00 PM

Street Address: Conference Room Ash A213

Waterbury State Office Complex

280 State Drive, Waterbury, VT

Zip Code: 05671

Date:
Time: AM
Street Address:
Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/13/2018

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Durable Medical Equipment
Wheelchairs
Medicaid
Mobility Devices
Seating Systems
Health Care Administrative Rules
HCAR

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Al Gobeille, Secretary
[phone] 802-241-0440
[fax] 802-241-0450

MEMORANDUM

To: Jim Condos, Secretary of State, Vermont Secretary of State Office
Mark A. MacDonald, Chair, Legislative Committee on Administrative Rules (LCAR)

From: Ashley Berliner, Director of Health Care Policy and Planning, Agency of Human Services

Cc: Al Gobeille, Secretary, Agency of Human Services
Charlene Dindo, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss, Administrative Assistant, Secretary of State's Office

Date: November 5, 2018

Re: Agency of Human Services Final Proposed Rule Filing

Enclosed are the final proposed rule filings for the following Health Care Administrative Rules:

New:
- 18P030 Telehealth

Amended:
- 18P031 Health Care Administrative Rules Definitions
- 18P032 Home Health Services
- 18P033 Durable Medical Equipment
- 18P034 Wheelchairs, Seating Systems and Mobility Devices

Repealed:
- 18P035 Telemonitoring

Public comments were received on the new and amended rules. Comments were not received on the repealed rule and Health Care Administrative Rules Definitions rule. The rules were amended in response to comments received during the public comment period. Changes are highlighted in grey on the annotated rules. The specific changes include:

- 18P030 Telehealth
  - 3.101.3 removed licensed in Vermont from the qualified providers requirement.
  - 3.101.5(a)(2)(B) changed the term transmissions to services.
  - 3.101.5(a)(2)(C) changed "Beneficiary agreement" to "A statement".
  - 3.101.5(a)(2)(E) removed the word "and".
  - 3.101.5(a)(2)(F) removed "Requirement for express beneficiary consent to forward patient identifiable information to a third party" and replaced it with "A statement that the provider will follow all applicable federal and state legal requirements of medical and health information privacy".
  - Added 3.101.5(a)(2)(G) to address exceptions to informed consent.

- 3.101.5(a)(6) removed the term ensure and added an example of continuity of care.
- 3.101.5(a)(7) revised the language to include traditional standards of care.

- 18P032 Home Health Services
  - Revised the title from home health agency services to home health services.
  - Revised at 4.231.1(b), 4.231.2(a), 4.231.3(b), (d), 4.231.4(a)(1), (2), 4.231.4(c)(1), (2), 4.231.4(c)(4)(A) and 4.231.4(d)(1), (2) to align with the title.
  - 4.231.1(b) revised to include text moved from 4.231.4(a)(3) including "when provided according to a plan of care described at 4.231.4(b), by a home health agency on a part-time or intermittent basis",
  - 4.231.4(a)(3) removed, moved to 4.231.1(b).
  - 4.231.4(b)(1)(C) added long term prognosis as a result of the services.
  - 4.231.4(b)(3) added text clarifying the provider types who can accept and document oral orders for services.
  - 4.231.4(c)(1) revised to clarify that a qualified provider can conduct the face-to-face encounter.
  - 4.231.4(c)(4) revised to clarify documentation by the physician ordering home health services.

- 18P033 Durable Medical Equipment
  - 4.209.3(b) replaced the word "physician" with "provider".
  - 4.209.4(a) revised to clarify the providers who may order durable medical equipment, also moved from 4.209(b) to (a) for clarity. Changed the cross reference at 4.209.3 from (b) to (a) to align.
  - 4.209.4(b) revised to clarify the providers who may order durable medical equipment and conduct the face-to-face visit also included the refence to 4.209.4(b)(3).
  - 4.209.4(b)(4) revised to clarify the face-to-face visit documentation requirement.
  - 4.209.4(b)(5) revised to clarify communication of face-to-face visit is required for home health services.
  - 4.209.4(c) removed the requirement for a physician to review the need for DME annually.

- 18P034 Wheelchairs, Seating Systems and Mobility Devices
  - 4.210.1(a) added "with a significant impairment in the ability" to functionally ambulate.
  - 4.210.1(b) corrected the error in the rule reference from 4.210.2(a)(1) to 4.210.2(b)(1).
  - 4.210.6(b)(2) added "integral component of a wheelchair" instead of seating system.

These changes to the final proposed rules do not have any economic impact.

The full text of comments received for these Health Care Administrative Rules and description of the amendments to the rules are enclosed with each rule filing. The comments and responses are also posted on the Agency of Human Services Website available via http://humanservices.vermont.gov/on-line-rules/health-care-administrative-rules-hcar/hcar-proposed-rule-changes

If you have any questions regarding these rules, please contact Ashley Berliner, Director of Health Care Policy and Planning, at 802-578-9305.

280 STATE DRIVE
WATERBURY, VERMONT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

AL GOBEILLE, SECRETARY
MARTHA MAKSYM, DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: **Jim Condos, Secretary of State**

FROM: **Al Gobeille, Secretary, Agency of Human Services**

DATE: **Tuesday, January 17, 2017**

SUBJECT: **Signatory Authority for Purposes of Authorizing Administrative Rules**

I hereby designate Deputy Secretary of Human Services Martha Maksym as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Martha Maksym

Administrative Procedures – Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Wheelchairs, Mobility Devices, and Seating Systems
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   Renumbering and Restructuring of Vermont Rules, includes 7506 Wheelchairs, Mobility Devices, and Seating Systems, SOS Log# 08-048 October 1, 2008

No impact

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   No impact

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Not applicable

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There is no economic impact for there to be a comparison.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
   AHS has analyzed and evaluated the anticipated costs to be expected from the adoption of this rule. There are no additional costs associated with this rule because the amendments reflect existing practice and coverage policies for Medicaid in Vermont. There are no alternatives to the adoption of the rule; it is necessary to ensure continued alignment with federal and state guidance and law for covered services and benefits within Vermont's Medicaid program.

State of Vermont
Agency of Administration
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
[fax] 802-828-3320

Office of the Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: June 18, 2018, Pavilion Building, 5th floor conference room, 109 State Street, Montpelier, VT 05609

Members Present: Dirk Anderson, Diane Bothfeld, Jennifer Mojo, John Kessler, and Steve Knudson as Acting Chair

Members Absent: Chair Brad Ferland, Ashley Berliner, Matt Langham and Clare O'Shaughnessy

Minutes By: Melissa Mazza-Paquette

- 2:00 p.m. meeting called to order, welcome and introductions.
- Review and approval of minutes from the May 14, 2018 meeting.
- No additions/deletions to agenda.
    - Motion made to accept the agenda as drafted by Diane Bothfeld, seconded by John Kessler, and passed unanimously.
- No public comments made.
- Presentation of Proposed Rules on pages 2-9 to follow.
    1. Health Care Administrative Rules Definitions, Agency of Human Services, page 2
    2. Home Health Agency Services, Agency of Human Services, page 3
    3. Durable Medicaid Equipment, Agency of Human Services, page 4
    4. Wheelchairs, Mobility Devices, and Seating Systems, Agency of Human Services, page 5
    5. Telemonitoring Repeal, Agency of Human Services, page 6
    6. Telehealth, Agency of Human Services, page 7
    7. Organization and Rules of Procedure, Department of Taxes, page 8
    8. Vermont Sales and Use Tax Regulations, Department of Taxes, page 9
- Next scheduled meeting is July 9, 2018 at 2:00 p.m.
- 2:55 p.m. meeting adjourned

Proposed Rule: Wheelchairs, Mobility Devices, and Seating Systems, Agency of Human Services
Presented by: Susan Colburn

Motion made to accept the rule as presented by Diane Bothfeld, seconded by Dirk Anderson, and passed unanimously with no recommendations presented.

Administrative Procedures – Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Wheelchairs, Mobility Devices, and Seating Systems

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   There are no additional costs associated with this rule because the amendments reflect existing practice and coverage policies for Medicaid in Vermont.

4. IMPACT ON SCHOOLS:

   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   No impact

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Not applicable

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There is no economic impact for there to be a comparison.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*
   AHS has analyzed and evaluated the anticipated costs to be expected from the adoption of this rule. There are no additional costs associated with this rule because the amendments reflect existing practice and coverage policies for Medicaid in Vermont. There are no alternatives to the adoption of the rule; it is necessary to ensure continued alignment with federal and state guidance and law for covered services and benefits within Vermont's Medicaid program.

Administrative Procedures – Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Wheelchairs, Mobility Devices, and Seating Systems

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   No impact

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ENVIRONMENTAL IMPACT ANALYSIS.*
   This rule has no impact on the environment.

Administrative Procedures – Public Input

Instructions:

In completing the public input statement, an agency describes the strategy prescribed by ICAR to maximize public input, what it did do, or will do to comply with that plan to maximize the involvement of the public in the development of the rule.

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Wheelchairs, Mobility Devices, and Seating Systems

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. PLEASE DESCRIBE THE STRATEGY PRESCRIBED BY ICAR TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE:

   The ICAR hearing was held on June 18, 2018. ICAR prescribed that AHS maximize public involvement by completing the public rulemaking process, including holding a public hearing and considering public comments that are received.

4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   AHS shared the proposed rule with Vermont Legal Aid (VLA) on February 27, 2018. AHS reviewed and considered comments in drafting this proposed rule.

   AHS notified the Medicaid and Exchange Advisory Board (MEAB) on February 27, 2018. No comments were received.

   The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 6, 2018.

   When the rule is filed with the Office of the Secretary of State, AHS provides notice and access to the rule, through the Global Commitment Register. The Global Commitment Register provides notification of policy changes and clarifications of existing Medicaid policy,

including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. The proposed, final proposed, and adopted rules and all public comments and responses to this rulemaking will be posted on the Register on the Agency of Human Services website. Subscribers receive email notification of rule filings including hyperlinks to posted documents and an explanation of how to provide comment and be involved in the rulemaking.

5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

   Agency of Human Services, and the Department of Vermont Health Access;

   Vermont Legal Aid;

   Medicaid and Exchange Advisory Board;

VERMONT LEGAL AID, INC.

SENIOR CITIZENS LAW PROJECT
264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(802) 863-5620 (VOICE AND TTY)
FAX (802) 863-7152
(800) 747-5022

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

By email to: AHS.MedicaidPolicy@vermont.gov

August 8, 2018

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, Vermont 05671-1000

Re: Comments on GCR 18-037; HCAR Rules 4.231 Home Health Services; 4.209 Durable Medical Equipment; 4.210 Wheelchairs, Mobility Devices, and Seating Systems

We submit these comments on behalf of the Vermont Long Term Care Ombudsman, the Senior Citizens Law Project of Vermont Legal Aid, and the Community of Vermont Elders. The Medicaid services here are critically important to older Vermonters. We understand that the intent of the HCAR process is to update and consolidate the Medicaid coverage rules, but not to make substantive changes. Our primary concern in commenting on these proposed rules is to ensure that a beneficiary's Medicaid coverage for these services is not limited or restricted by these rule changes.

Home Health Services

4.231.4 Conditions for Coverage
(a) General Conditions
(2) Coverage of home health agency services are not contingent upon the beneficiary needing nursing or therapy services.

This provision appears to be new, but is based on the federal regulation, 42 C.F.R. §440.70. We support this concept. We also note that understanding the intersection of personal care provided under this home health benefit with personal care covered by waiver services like Choices for Care is confusing. The Department should clarify how and when a beneficiary may receive personal care under one or both coverage options. The Department could provide clarification in this rule and/or within the Choices for Care rules. Such clarification would be beneficial to many seniors, and their health care providers, both of whom may not be aware that seniors can receive personal care in their home when medically necessary, without first being required to apply for long-term care Medicaid.

In addition, in order to receive personal care by an aide under this rule, those services must be supervised by a skilled nurse or therapist. Our view is that the supervision of unskilled care is a skilled service. Medicare coverage rules are explicitly clear that supervision can be a skilled

condition *without* changes. It may be more accurate to revise this concept to "(C) the patient's long term prognosis as a result of the treatment".

4.231.4 Conditions for Coverage
(c) Face-to-Face Visit Requirements

(1) For the initiation of home health agency services, the ordering physician or NPP must *conduct* a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

Incorporating the face-to-face to requirement for Medicaid is complicated. However, it appears that this section conflicts with the provision under 4.231.3(d) that allows the attending acute or post-acute physician to perform the face-to-face. Specifically, in this situation there can be two different physicians, the attending acute physician, who performs the face-to-face (usually as part of the discharge to home health services) and the "ordering" physician who completes the home health plan of care and orders services, and documents that there was a face-to-face encounter. The Medicaid regulation, 42 C.F.R. §440.70(f)(3)(v), seems to allow this split in responsibility, and that seems to be the practice, at least some of the time, for Medicare home health services and the face-to-face requirement in that program. Changing the term "conduct" to "document" would be consistent with the requirements of the federal regulation, and would incorporate the "post-acute" exception as to which physician is required to perform the face-to-face.

4.231.4 Conditions for Coverage
(h) Requirements Specific to Therapy Services

(1) Physical therapy, occupational therapy, and speech language pathology services are (A) Directly related to an active treatment regimen designed or approved by the physician, and require a level of complexity such that the judgment, knowledge, and skills of a qualified therapist are required, and covered for up to four months per medical condition, based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. Therapy services must be: (B) Reasonable and necessary under accepted standards of medical practice for the treatment of the patient's condition.

The four month coverage period before prior authorization is required was carried over from the existing rule. What is the basis for setting a four month limit on therapy services? Medicaid coverage includes maintenance therapy services. Maintenance therapy services may be reasonable and necessary on an ongoing basis (meaning such services can extend for longer than a four month period), in order to preserve strength and capabilities or to slow or prevent decline in functioning. This important principle should be incorporated into this section by adding to the end of 4.231.4(h)(1)(4) "...treatment of the patient's condition, or to establish or continue a maintenance therapy program."

4.210.4 Conditions for Coverage
(a) The requirements in 4.209 Durable Medical Equipment apply to wheelchairs.

This cross reference to the DME rule is potentially confusing because it does not clarify which aspects of the DME rule apply to wheelchairs. An example of a difference is that there is a different definition of medical necessity for DME than for wheelchairs. Does the DME rule on purchasing DME vs renting DME apply to wheelchairs?

4.210.5 Prior Authorization Requirements
(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.

Access to wheelchairs is a long standing problem in Vermont and in other states. These access problems often relate to medical supplier concerns about reimbursement rates, particularly for Medicare and Medicaid dually eligible beneficiaries. In order to address access concerns for wheelchairs, DVHA has adopted an exception to the general requirement that Medicare be billed first on an "assigned" basis for the purchase and repair of wheelchairs and seating systems. *See* Green Mountain Care Provider Manual 11.7. Under the exception process, the provider may submit a prior authorization request to DVHA for provisional authorization, before billing Medicare. A reference to this exception process should be incorporated into this rule in order to clarify this billing practice: "For beneficiaries eligible for Medicare, providers may submit a claim for provisional authorization before submitting the claim to Medicare on an unassigned basis as set out in the provider manual". As the HCAR rules process may be updated to include Third Party Liability (DVHA rule 7108) it is important to clarify how the TPL requirements apply to the submission of claims for wheelchairs.

Thank you for consideration of these comments. Please us a copy of the final rule and the response to comments when you have completed that review process.

Michael Benvenuto, Project Director
Elder Law Unit
Vermont Legal Aid, Inc.

Sean Londergan
State Long Term Care Ombudsman
Long Term Care Ombudsman Project
Vermont Legal Aid, Inc.

Ruby Baker
Executive Director
Community of Vermont Elders

VERMONT LEGAL AID, INC.

DISABILITY LAW PROJECT
57 NORTH MAIN STREET SUITE 2
RUTLAND, VERMONT 05701
(802) 775-0021 (VOICE AND TTY)
FAX(802)775-0022
(800) 769-7459

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

By email to: AHS.MedicaidPolicy@vermont.gov

August 13, 2018

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, Vermont 05671-1000

Re: Comments on OCR 18-037; HCAR Rules; 4.209 Durable Medical Equipment; 4.210 Wheelchairs, Mobility Devices, and Seating Systems

We submit these comments on behalf of the Disability Law Project (DLP), as part of the Protection and Advocacy system in Vermont. The DLP receives federal funding to provide advocacy for Vermonters with disabilities seeking access to needed medical care and access to assistive technology, including durable medical equipment, wheelchairs, mobility devices, and seating systems. We regularly represent Vermonters experiencing a range of difficulties accessing these services including, repair and replacement issues, prior approval issues, and coverage denials. The Medicaid services here are critically important to Vermonters with disabilities. We understand that the intent of the HCAR process is to update and consolidate the Medicaid coverage rules, but not to make substantive changes. Our primary concern in commenting on these proposed rules is to ensure that a beneficiary's Medicaid coverage for these services is not limited or restricted by these rule changes.

RuJe 4.209 Durable Medical Equipment

4.209.2 Covered Services

This rule states that "[i]tems of DME that are not pre-approved are subject to prior authorization review." We suggest the addition of the following language in order to be consistent with the federal Medicaid definition of equipment and appliances:

Any beneficiary may request coverage for equipment and appliances not on the pre-approved list by sending a request for coverage to the Director of the Office of Vermont Health Access (DVHA) in accordance with the procedures set out in M7104 of these rules (or any future iteration of M7104).

4.210.2 Covered Services

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:
(1) Participate in one or more MRADLs in or outside of the home,
(2) Access authorized Medicaid transportation to medical services, or
(3) Exit the home within a reasonable timeframe.

The medically necessary criteria should incorporate the concept of "functionally ambulate" from the definition. So, we would suggest adding "(4) Functionally ambulate."

4.210.4 Conditions for Coverage
(a) The requirements in 4.209 Durable Medical Equipment apply to wheelchairs.

This cross reference to the DME rule is potentially confusing because it does not clarify which aspects of the DME rule apply to wheelchairs. An example of a difference is that there is a different definition of medical necessity for DME than for wheelchairs. Does the DME rule on purchasing DME vs renting DME apply to wheelchairs?

4.210.5 Prior Authorization Requirements
(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.

Access to wheelchairs is a long standing problem in Vermont and in other states. These access problems often relate to medical supplier concerns about reimbursement rates, particularly for Medicare and Medicaid dually eligible beneficiaries. In order to address access concerns for wheelchairs, DVHA has adopted an exception to the general requirement that Medicare be billed first on an "assigned" basis for the purchase and repair of wheelchairs and seating systems. *See* Green Mountain Care Provider Manual 11.7. Under the exception process, the provider may submit a prior authorization request to DVHA for provisional authorization, before billing Medicare. A reference to this exception process should be incorporated into this rule in order to clarify this billing practice: "For beneficiaries eligible for Medicare, providers may submit a claim for provisional authorization before submitting the claim to Medicare on an unassigned basis as set out in the provider manual." As the HCAR rules process may be updated to include Third Party Liability (TPL) (DVHA rule 7108) it is important to clarify how the TPL requirements apply to the submission of claims for wheelchairs.

Additionally, the proposed rule removes the limitation on the requirement for prior authorization for rentals of wheelchairs to those rentals for a period in excess of three months. Under the proposed rule, prior authorization is required for *any* rental of a wheelchair or mobility device, no matter the duration of the rental. Such a requirement is overly burdensome for short term rentals and should be removed. We suggest the

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Al Gobeille, Secretary
[phone] 802-241-0440
[fax] 802-241-0450

Date: November 5, 2018

RE: Responses to comments received from the public for the following proposed Health Care Administrative Rules:

- 3.101.1 Telehealth
- 4.209 Durable Medical Equipment
- 4.210 Wheelchairs, Mobility Devices, and Seating Systems
- 4.231 Home Health Agency Services

A summary of comments received and the Agency of Human Services' responses to those comments is included below. Comments were received from: Vermont Legal Aid, Inc., Senior Citizens Law Project; Vermont legal Aid, Inc., Disability Law Project; the VNA's of Vermont; the Vermont Medical Society; and the Vermont Association of Hospitals and Health Systems.

Proposed Rule 3.101.1 Telehealth

3.101.1 Definitions

Comment:
Comment was received that the definition of telemedicine in the proposed rule limits covered services to evaluation, diagnosis, consultation or treatment. A language revision was proposed to eliminate this limitation.

Response:
DVHA believes that the service categories listed in the rule are an exhaustive comprehensive list of what would be covered and therefore is not modifying the proposed rule based on this comment at this time.

Comment:
Suggestions that DVHA should consider telemonitoring for patients with diagnoses beyond congestive heart failure and also not limit who can provide telemonitoring services.

Response:
DVHA is not looking to expand conditions/risk factors in the proposed rule. The limitation to a congestive heart failure diagnosis is not a new policy. 33 VSA §1901g required Vermont Medicaid to cover home telemonitoring services performed by home health agencies for one or more conditions or risk factors as identified by the Agency on or before July 1, 2014. After reviewing clinical evidence, DVHA selected the congestive heart failure diagnosis as it had the most evidence of effectiveness supported in literature.

3.101.4 Beneficiary Eligibility

Comment:
A recommendation for re-wording 3.101.4(1) to "Have Medicaid as their primary insurance or dual enrollment in Medicaid and Medicare but not meet Medicare's eligibility requirements" from "Have Medicaid as their primary insurance or Medicaid and dually enrolled in Medicare with a non-homebound status".

Response:
DVHA is maintaining the original language for clarity, and therefore is not modifying the proposed rule based on this comment at this time.

3.101.5 Conditions for Coverage

Comment:
Comment was received to remove the standards section 3.101.5(a) as written and cross reference the state statute at 18 VSA § 9361(c).

Response:
DVHA is including the standards language in the rule for clarity, and therefore is not modifying the proposed rule based on this comment at this time.

Comment:
Comment was received that 3.101.5(a)(2)(B) could be clearer by using, "The types of services that will be provided using telemedicine technologies" instead of "The types of transmissions permitted using telemedicine technologies".

Response:
DVHA has amended the language to, "The types of services permitted using telemedicine technologies".

Comment:
Comment received that "Beneficiary agreement that the provider determines whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter" found at 3.101.5(a)(2)(C) is confusing and suggested revising to "A statement that the provider can determine whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter.

Response:
DVHA has amended the rule to reflect the suggested revision.

Comment:
Comment received that the language in section 3.101.5(a)(2)(F) is unclear and suggested amending the language to, "A statement that medical records for all beneficiaries receiving health care services through telemedicine will be maintained consistent with established laws and regulations governing patient health care records".

Response:
DVHA has amended the language to, "A statement that the provider will follow all applicable federal and state legal requirements of medical and health information privacy".

Comment:
The term 'ensure' found at 3.101.5(a)(6) is overly broad and it was suggested to amend the language to, "Address needs for follow-up care or information by, for example, informing beneficiary how to contact provider or designee and/or providing beneficiary or identified care providers timely access to medical records."

Response:
Language has been amended to, "Address needs for continuity of care for beneficiaries (e.g., informing beneficiary how to contact provider or designee and/or providing beneficiary).

Comment:
The language at 3.101.5(a)(7) is unclear and it was recommended to amend to, "Take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations, history of the beneficiary, and prescribing consistent with traditional standards of care".

Response:
Language was amended to, "If prescriptions are contemplated, follow traditional standards of care to ensure beneficiary safety in the absence of a traditional physical examination".

Comment:
Comment was made to add exceptions to informed consent into the rule.

Response:
3.101.5(a)(2)(G) has been added to address circumstances under which consent is not required.

Comment:
Comment was received that AHS should not limit the definition of telemonitoring to home health agencies and nursing staff in its rule.

Response:
As mentioned above, the adoption of this rule is not intended to change existing policies at this time.

3.101.7 Non-Covered Services

Comment: Comment was received that stating Medicaid will not cover services and procedures not covered in a face-to-face setting under Vermont Medicaid is shortsighted given the changing health care landscape and the technological advances of telemedicine and should be omitted.

Response: CMS defines telemedicine for Medicaid as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states can choose to cover under Medicaid. CMS requires that the services delivered via telemedicine are allowable Medicaid covered services.

Proposed Rule 4.231 Home Health Agency Services

Comment:
Comment recommended renaming the rule, "Home Health Services." Home health agencies provide many services that are not subject to rule 4.231. Only acute home health services are subject to the rule.

Response:
In response to the comment, the name of the rule and references to home health agency services have been revised for clarity. Home health services are defined in 4.231.2(a) for the purposes of the rule.

Comment:
A comment requested that the State ensure that a beneficiary's Medicaid coverage for these services is not limited or restricted by these rule changes.

Response:
The rules are amended to align with federal regulations and current coverage and practices under Vermont Medicaid.

Comment:
The intersection of personal care under this home health benefit and the Choices for Care benefit is confusing. Clarification would be beneficial to seniors and providers who may not be aware that seniors can receive personal care in their home when medically necessary, without first being required to apply for long-term care Medicaid.

Response:
Personal care services are included in the rule as a service that may be provided by a home health aide. Any beneficiary enrolled in Vermont Medicaid may receive home health aide services, when medically necessary, as defined by rule. Beneficiaries do not have to apply to, or be eligible for, long-term care Medicaid to receive home health services. The eligibility requirements for Choices for Care Long Term Care Medicaid are specific to that program and defined by those program guidelines and rules.

4.231.2 Covered Services

Comment:
Explicitly state that the rule applies only to acute home health services and does not apply to hospice or to other Medicaid programs.

Response:
Home health services are specified in 4.231.2 for the purposes of the rule. There are too many programs and services to list those to which this rule does not apply. Hospice and other Medicaid programs are defined elsewhere within Vermont Medicaid rules.

4.231.3 Qualified Providers

Comment:
Section 4.231.3(c)(1) appears to conflict with the provision under 4.231.3(d) that allows the attending acute or post-acute physician to perform the face-to-face visit. Changing the term "conduct" to "document" would be consistent with the requirements of the federal regulation, and would incorporate the "post-acute" exception as to which physician is required to perform the face-to-face.

Response:
In response to the comment, 4.231.4(c)(1) was amended to specify that a qualified provider must conduct a face-to-face encounter with the beneficiary. The qualified providers listed in 4.231.3 of the rule include the acute or post-acute physician in addition to the non-physician practitioners who may conduct the encounter.

4.231.4 Conditions for Coverage

Comment:
Incorporate section 4.231.4(a) Conditions for Coverage General Conditions into section 4.231.2 Covered Services. This change will better align the Medicaid policy with Medicare guidance available at https://www.medicare.gov/coverage/home-health-services.html.

Response:
In response to comments the requirement for services to be according to a plan of care on a part-time or intermittent basis was moved to the definition of home health services in 4.231.1(b). The additional conditions for coverage clarify provisions that apply to the covered services. These conditions will not be moved as these are not covered services rather conditions associated with those services. This format is consistent throughout the Health Care Administrative Rules.

Comment:
Personal care by an aide must be supervised by a skilled nurse or therapist. The intent of section 4.231.4(a)(2) should be read in light of the supervision requirement: personal care by a home health aide is not contingent on receiving skilled nursing in addition to supervision.

Response:
The purpose of the rule at 4.231.4(a)(2) is to clarify that a beneficiary may receive home health services without also needing nursing or therapy services. This language mirrors the federal Medicaid regulation at 440.70(b) and is included in the rule for clarity. Supervision of a home health aide is a requirement under the conditions of participation for home health. Also, the rule at 4.231.4 (e)(4) specifies the supervisory visit requirements. Therefore, AHS is not modifying the proposed rule based on this comment at this time.

Comment:
4.231.4(a)(3) states that the beneficiary's condition shall be either an episode of acute illness or injury, or a chronic condition requiring part time or intermittent home health care. Comment requests that this be removed because it reflects an outdated concept that conditions are either "acute" or "chronic".

If a description of the beneficiary is needed the comment suggested the rule could be revised to include "the beneficiary's overall condition, without regard to whether the condition is acute, chronic, terminal, or expected to extend over a long period of time, shall be considered in evaluating the need for part-time or intermittent home health care to maintain the beneficiary's current condition or prevent or slow further deterioration".

Response:
The rule was revised to remove references to "acute" and "chronic" conditions as recommended by the comment. The definition for home health services was revised to clarify that services are available to persons who need them when provided according to a plan of care on a part time or intermittent basis.

Comment:
This rule change adds "part-time" to the general conditions of coverage. The requirement is "part-time **or** intermittent". Therefore, under the proposed rule, a beneficiary may require, and would be entitled to coverage under Medicaid for daily skilled nursing, as long as the skilled nursing care being provided remained below the level considered to be "full-time" care.

Response:

The commenter is correct. The rule specifies that services shall provide part-time **or** intermittent care. This includes daily skilled nursing that is less than full time.

Comment:
The basis for a plan of care to include a long-range forecast of likely changes in the patient's condition is not clear. The language may be interpreted as requiring a change to the patient's condition as a condition of coverage. Indicating that changes in condition are required for coverage conflicts with the core principle of the *Jimmo* litigation: that coverage for skilled nursing and therapy services can be reasonable and necessary to "maintain" the beneficiary's condition without changes. It may be more accurate to revise this concept to "(C) the patient's long-term prognosis as a result of the treatment".

Response:
The rule was amended to "(C) long term prognosis as a result of the services," as requested. The plan of care requirement at 4.231.4(b)(1)(C) aligns with the home health conditions of participation for care planning which calls for the inclusion of the prognosis and outcome associated with treatment.

Comment:
Comment questioned the four-month limit on therapy services at 4.231.4(h). Medicaid coverage includes maintenance therapy services. Maintenance therapy services may be reasonable and necessary on an ongoing basis (meaning such services can extend for longer than a four-month period), in order to preserve strength and capabilities or to slow or prevent decline in functioning. The rule should be amended to add "...treatment of the patient's condition, or to establish or continue a maintenance therapy program" at 4.231.4(h)(1)(4)

Response:
Vermont Medicaid allows the provision of therapy services beyond four months with prior authorization as defined by the rule. The rule allows reasonable and necessary therapy services under standards of medical practice for the treatment of the patient's condition. Maintenance therapy is an accepted standard of practice to treat the patient's condition when medically necessary. Therefore, the rule will not be revised to list maintenance therapy.

Comment:
4.231.4(b)(3) appears to limit the documentation of verbal physician orders to "registered nurses." In practice, verbal orders are documented by therapists, nurses and LPNs.

Response:
The rule at 4.231.4(b)(3) was revised to specify additional practitioners who may accept and document a physician's oral orders in accordance with the conditions of participation for a home health agency.

Comment:
4.231.4(f) references routine supplies but doesn't define the term or provide examples. New Hampshire defines routine supplies as "those supplies used incidentally in the course of a visit and include gloves, alcohol wipes, blood drawing supplies, adhesive and paper tape, and non-sterile dressings."

Response:
Coverage of specific supplies and their codes can be found in the Medicaid fee schedule which is publicly available on the DVHA website. A definition of routine medical supplies will not be included within the home health services rule as these items are too numerous to list and are subject to change. Additional information regarding the coverage of medical supplies can be found in Rule 7504 Medical Supplies and the Medicaid provider manual in section 11.15.12.

Proposed Rule 4.209 Durable Medical Equipment

4.209.2 Covered Services

Comment:
This rule states that "items of DME that are not pre-approved are subject to prior authorization review." Commenter suggested the addition of the following language in order to be consistent with the federal Medicaid definition of equipment and appliances:

Any beneficiary may request coverage for equipment and appliances not on the pre-approved list by sending a request for coverage to the Director of the Office of Vermont Health Access (DVHA) in accordance with the procedures set out in M7104 of these rules (or any future iteration of M7104),

Response:
Items of durable medical equipment that are not on the pre-approved list are subject to prior authorization review as specified at 4.209.2(a). This allows requests in accordance with the Federal Medicaid regulations at 42CFR §440.70 (3)(v), which prohibits states from having an exhaustive list of items of durable medical equipment. Items that do not meet the definition of durable medical equipment may be requested as specified in Medicaid Rule 7104 Requesting Coverage Exceptions.

4.209.4 Conditions for Coverage

Comment:
Section 4.209.4(a) should be revised to clarify that the post-acute physician can perform the face-to-face encounter and the ordering physician can document that encounter when ordering the DME.

Response:
Section 4.209.4(a) was amended to specify that a qualified provider must conduct a face-to-face encounter with the beneficiary. The qualified providers are listed in 4.209.3 of the rule and include the acute or post-acute physician in addition to the non-physician practitioners who may conduct the encounter.

Proposed Rule 4.210 Wheelchairs, Mobility Devices, and Seating Systems

Comment:
Comment requested that the State ensure that a beneficiary's Medicaid coverage for wheelchairs, mobility devices, and seating systems is not limited or restricted by these rule changes.

Response:
The rules are amended to align with federal regulations and current coverage and practices under Vermont Medicaid.

4.210.1 Definitions

Comment:
Comment questioned the purpose of having a definition for when the beneficiary is "unable to functionally ambulate". The criteria is too restrictive by requiring that the individual be "unable" to walk "with or without" an assistive device. Many beneficiaries have significant mobility impairments

and would require a wheelchair, but may not completely lack any ability to ambulate with a walker as an example. The definition should incorporate a similar concept from the medical necessity criteria ("significantly impairs"): "...enable mobility for beneficiaries ~~unable~~ with a significant impairment of the ability to functionally ambulate."

Response:
The definition at 4.210.1(a) defines wheelchairs and mobility devices and specifies that wheelchairs and mobility devices enable mobility for beneficiaries who are unable to functionally ambulate. To functionally ambulate means the ability to walk with or without the aid of a device, therefore allowing coverage as medically necessary for an individual who may have some ability to walk. The rule was amended as requested by the comment to include, "with a significant impairment of the ability to functionally ambulate" as this has the same meaning.

4.210.2 Covered Services

Comment:
The medically necessary criteria at 4.210.2(b) should incorporate the concept of "functionally ambulate" from the definition. So add "(4) Functionally ambulate."

Response:
In order for a wheelchair or mobility device to be medically necessary a beneficiary must meet at least one of the criteria in 4.210.2(b). A limitation in the ability to functionally ambulate as a single criterion may not meet the definition of medical necessity and therefore will not be added to the list.

4.210.4 **Conditions for Coverage**

Comment:
The cross reference to the DME rule at 4.210.4(a) is potentially confusing because it does not clarify which aspects of the DME rule apply to wheelchairs. An example of a difference is that there is a different definition of medical necessity for DME than for wheelchairs. Does the DME rule on purchasing DME vs renting DME apply to wheelchairs?

Response:
Wheelchairs and mobility devices are items of durable medical equipment and defined as such in the rule at 4.210.1(a). The definitions and coverage requirements in proposed rule 4.209 Durable Medical Equipment also apply to wheelchairs and mobility devices. The coverage and conditions for wheelchairs provide additional detail specific to wheelchairs, mobility devices, and seating systems. These criteria do not conflict with the terms and conditions in the DME rule.

The Wheelchairs, Mobility Devices and Seating systems rule at 4.210.2(c)(1) defines the criteria for rental of wheelchairs and mobility devices. These criteria include the capped rental requirements as specified in the DME rule. All conditions for rental items for DME also apply to wheelchairs.

4.210.5 **Prior Authorization Requirements**

Comment:
DVHA has adopted an exception to the general requirement that Medicare be billed first on an "assigned" basis for the purchase and repair of wheelchairs and seating systems as specified in the

Green Mountain Care Provider Manual section 11.7. Under this exception a prior authorization request may be submitted to DVHA for provisional authorization, before billing Medicare. A reference to this process should be incorporated into this rule.

Response:
Medicare recently adopted an advance determination of Medicare coverage review process for wheelchairs, which is mandatory for certain items including power wheelchairs. This will allow Medicare review prior to delivery for certain items. A durable medical equipment supplier may submit prior authorization to Medicaid for provisional review, however, if the item is denied by Medicare, DVHA requires the denial information prior to making payment. As the Medicare regulations continue to evolve, the language regarding provisional authorization will remain in the provider manual and will not be incorporated into the rule.

Comment:
The proposed rule removes the limitation on the requirement for prior authorization for rentals of wheelchairs to those rentals for a period in excess of three months. Under the proposed rule, prior authorization is required for *any* rental of a wheelchair or mobility device, no matter the duration of the rental. Such a requirement is overly burdensome for short term rentals and should be removed. The comment suggested that the language of the existing rule be retained, and that prior authorization be required only for wheelchair rentals lasting longer than three months.

Response:
All wheelchairs, including rental wheelchairs, require prior authorization. The rule is being amended to reflect current practice that has been in effect for several years. Prior authorization assures that beneficiaries receive medically appropriate equipment. DVHA continues to receive orders for incorrect and ill-fitting wheelchairs for short term rentals, necessitating the need for prior authorization. There is no delay for wheelchairs or other equipment needed on an urgent or immediate basis, as specified by the immediate need exception described in the provider manual at section 7.2.2.

Comment:
Why was the prior authorization requirement removed for "the initial purchase of a standard manual wheelchair with sling seat."? (M7506.4)?

Response:
The rental and purchase of all wheelchairs requires prior authorization. Therefore, it is not necessary to list that prior authorization is required for a wheelchair with a sling seat. Prior authorization for the rental of a wheelchair assures that beneficiaries receive a wheelchair that is medically appropriate.

4.210.6 Non-Covered Services

Comment:
Why was "cushions that are not integral to a seating system" added at 4.210.6 as a non-covered service and would this exclusion apply to gel cushions?

Response:
This language is included in the rule to clarify that cushions that are not integral to a wheelchair are not covered. Cushions are covered when they are a component of a wheelchair seating system. Coverage may include a gel cushion when it is medically necessary.

Clean
Tact

4.210 Wheelchairs, Mobility Devices, and Seating Systems

4.210.1 Definitions

(a) **"Wheelchairs and Mobility Devices"** means items of durable medical equipment (DME) that enable mobility for beneficiaries with a significant impairment in the ability to functionally ambulate. A mobility device, including a power operated vehicle, is an item that serves the same purpose as a wheelchair.

(b) **"Functional Ambulation"** means the ability to walk with or without the aid of a device such as a cane, crutch, or walker for medically necessary purposes as defined in 4.210.2(b).

(c) **Mobility-Related Activities of Daily Living (MRADL)"** means activities such as toileting, feeding, dressing, grooming, and bathing.

(d) **"A Mobility Limitation that significantly impairs a beneficiary's ability to participate in one or more MRADL"** means a limitation that:

(1) Prevents the beneficiary from accomplishing an MRADL entirely, or
(2) Places the beneficiary at heightened risk of morbidity or mortality when attempting to perform an MRADL, or
(3) Prevents the beneficiary from completing an MRADL within a reasonable time frame.

(e) **"Customize"** means making significant alterations or modifications to a component that are not anticipated in the manufacturer's design, or require fabrication of another component or hardware in order to adapt the equipment to a beneficiary or to the wheelchair.

4.210.2 Covered Services

(a) Wheelchairs, mobility devices, seating systems, and related services are covered when medically necessary.

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:

(1) Participate in one or more MRADLs in or outside of the home,
(2) Access authorized Medicaid transportation to medical services, or
(3) Exit the home within a reasonable timeframe.

(c) Rental of Wheelchairs and Mobility Devices

(1) Payment will be made for rental of one device under the following circumstances:

(A) While waiting for purchase or repair of a custom chair, when there is no other available option,
(B) For short-term acute medical conditions,
(C) During a trial period, or
(D) As part of Medicaid reimbursement requirements for items of DME subject to capped rental.

(d) Non-Customized Manual Wheelchairs

(1) Payment will be made for non-customized manual wheelchairs for beneficiaries who have documented long-

term medical needs.

(e) Custom Wheelchairs and Mobility Devices

(1) Payment will be made for a customized manual wheelchair, a power wheelchair, a power-operated vehicle, or other mobility device when a beneficiary's MRADLs cannot be accomplished by the provision of a non-customized manual chair.

(f) Second Wheelchair or Mobility Device

(1) Payment is limited to one primary piece of equipment, except when a beneficiary with a power wheelchair needs a manual wheelchair when medically necessary.

(g) Replacement Wheelchair or Mobility Device

(1) Payment will be made for replacement wheelchairs or mobility devices for:

(A) Beneficiaries with specific documented growth needs,
(B) Beneficiaries with a change in medical status that necessitates replacement,
(C) For loss, or
(D) Replacement when, as a result of normal wear and tear, the wheelchair or device no longer safely addresses the medical needs of the beneficiary and can no longer be repaired.

(h) Seating Systems

(1) Covered items are manufactured seating systems, and seating systems that have been custom-fabricated or customized by the DME provider, for use in a wheelchair. A seating system must contain a seat and/or back with one other positioning component.

(2) Reimbursement for up to five hours of labor associated with custom fabrication of a seating system or customizing a seating system will be made to the DME provider.

(i) Repair to damaged or worn equipment is covered when the equipment is not under warranty.

4.210.3 **Qualified Providers and Vendors**

(a) Providers must be licensed, working within the scope of his or her practice and enrolled in Vermont Medicaid.

(b) Vendors must be Medicaid enrolled providers of Durable Medical Equipment.

4.210.4 **Conditions for Coverage**

(a) The requirements in rule 4.209 Durable Medical Equipment apply to wheelchairs.

(b) Payment will be made for seating systems, and/or any required accessories, for beneficiaries residing in a long term-care facility when the system is so uniquely constructed or substantially modified to the individual that it would not be useful to other residents.

(c) When Vermont Medicaid has purchased a seating system for an individual residing in a long-term care facility and that individual moves to a new living arrangement, Vermont Medicaid will purchase from the facility, at the net book value, the components of the wheelchair purchased by the facility.

(d) When a beneficiary who resides in a long-term care facility moves to a new living arrangement and requires a wheelchair that is not available in the new residence, Vermont Medicaid will authorize coverage for a new wheelchair, or purchase, at the net book value, the wheelchair provided by the facility from which the individual moved.

4.210.5 Prior Authorization Requirements

(a) Prior authorization is required for the purchase, rental, or replacement of wheelchairs and mobility devices.
(b) Prior authorization is required for wheelchair repairs costing more than $500. Equipment guarantees and warranties must be utilized before billing Medicaid.

(c) Prior authorization is required for the labor cost of repairs where parts are under warranty.

4.210.6 Non-Covered Services

(a) A wheelchair or mobility device is not covered when used as transportation that otherwise could be accomplished in a vehicle.

(b) Payment will not be made for:

(1) Custom-colored wheelchairs or accessories,
(2) Cushions that are not an integral component of the wheelchair,
(3) Costs associated with repair or adjustments to the original wheelchair and related items under implied or expressed warranties, other than labor costs where parts are under warranty, or
(4) DME supplier's costs associated with fitting and/or evaluation of a seating system. These costs are included in the initial reimbursement for the item.

The Vermont Statutes Online

Title 3 : Executive

Chapter 025 : Administrative Procedure

Subchapter 001 : General Provisions

(Cite as: 3 V.S.A. § 801)

§ 801. Short title and definitions

(a) This chapter may be cited as the "Vermont Administrative Procedure Act."

(b) As used in this chapter:

(1) "Agency" means a State board, commission, department, agency, or other entity or officer of State government, other than the Legislature, the courts, the Commander in Chief, and the Military Department, authorized by law to make rules or to determine contested cases.

(2) "Contested case" means a proceeding, including but not restricted to rate-making and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing.

(3) "License" includes the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

(4) "Licensing" includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(5) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(6) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(7) "Practice" means a substantive or procedural requirement of an agency, affecting one or more persons who are not employees of the agency, that is used by the agency in the discharge of its powers and duties. The term includes all such requirements, regardless of whether they are stated in writing.

(8) "Procedure" means a practice that has been adopted in writing, either at the election of the agency or as the result of a request under subsection 831(b) of this title. The term includes any practice of any agency that has been adopted in writing, whether or not labeled as a procedure, except for each of the following:

(A) a rule adopted under sections 836-844 of this title;

(B) a written document issued in a contested case that imposes substantive or procedural requirements on the parties to the case;

(C) a statement that concerns only:

(i) the internal management of an agency and does not affect private rights or procedures available to the public;

(ii) the internal management of facilities that are secured for the safety of the public and the individuals residing within them; or

(iii) guidance regarding the safety or security of the staff of an agency or its designated service providers or of individuals being provided services by the agency or such a provider;

(D) an intergovernmental or interagency memorandum, directive, or communication that does not affect private rights or procedures available to the public;

(E) an opinion of the Attorney General; or

(F) a statement that establishes criteria or guidelines to be used by the staff of an agency in performing audits, investigations, or inspections, in settling commercial disputes or negotiating commercial arrangements, or in the defense, prosecution, or settlement of cases, if disclosure of the criteria or guidelines would compromise an investigation or the health and safety of an employee or member of the public, enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons that are in an adverse position to the State.

(9) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy and that has been adopted in the manner provided by sections 836-844 of this title.

(10) "Incorporation by reference" means the use of language in the text of a regulation that expressly refers to a document other than the regulation itself.

(11) "Adopting authority" means, for agencies that are attached to the Agencies of Administration, of Commerce and Community Development, of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components, the commissioners of those departments; and for other agencies, the chief officer of the agency. However, for the procedural rules of boards with quasi-judicial powers, for the Transportation Board, for the Vermont Veterans' Memorial Cemetery Advisory Board, and for the

Fish and Wildlife Board, the chair or executive secretary of the board shall be the adopting authority. The Secretary of State shall be the adopting authority for the Office of Professional Regulation.

(12) "Small business" means a business employing no more than 20 full-time employees.

(13)(A) "Arbitrary," when applied to an agency rule or action, means that one or more of the following apply:

(i) There is no factual basis for the decision made by the agency.

(ii) The decision made by the agency is not rationally connected to the factual basis asserted for the decision.

(iii) The decision made by the agency would not make sense to a reasonable person.

(B) The General Assembly intends that this definition be applied in accordance with the Vermont Supreme Court's application of "arbitrary" in, Beyers v. Water Resources Board, 2006 VT 65, and In re Town of Sheburn, 154 Vt. 596 (1990).

(14) "Guidance document" means a written record that has not been adopted in accordance with sections 836-844 of this title and that is issued by an agency to assist the public by providing an agency's current approach to or interpretation of law or describing how and when an agency will exercise discretionary functions. The term does not include the documents described in subdivisions (8)(A) through (F) of this section.

(15) "Index" means a searchable list of entries that contains subjects and titles with page numbers, hyperlinks, or other connections that link each entry to the text or document to which it refers. (Added 1967, No. 360 (Adj. Sess.), § 1, eff. July 1, 1969; amended 1981, No. 82, § 1; 1983, No. 158 (Adj. Sess.), eff. April 13, 1984; 1985, No. 56, § 1; 1985, No. 269 (Adj. Sess.), § 4; 1987, No. 76, § 18; 1989, No. 69, § 2, eff. May 27, 1989; 1989, No. 250 (Adj. Sess.), § 88; 2001, No. 149 (Adj. Sess.), § 46, eff. June 27, 2002; 2017, No. 113 (Adj. Sess.), § 3; 2017, No. 156 (Adj. Sess.), § 2.)

Annotated Text

Wheelchairs, Mobility Devices, and Seating Systems

4.210 ~~7506~~ Wheelchairs, Mobility Devices, and Seating Systems ~~(04/01/1999, 98-11F)~~

4.210.1 Definitions

(a) **"Wheelchairs and Mobility Devices"** means ~~Wheelchairs and mobility devices are~~ items of durable medical equipment (DME) that enable mobility for ~~those~~ beneficiaries with a significant impairment in the ability ~~unable~~ to ~~ambulate by other means~~functionally ambulate. A mobility device, including a power operated vehicle, is an item that serves the same purpose as a wheelchair, ~~but may be an appropriate alternative for a beneficiary otherwise requiring a wheelchair.~~

(b) **"Functional Ambulation"** means the ability to walk with or without the aid of a device such as a cane, crutch, or walker for medically necessary purposes as defined in 4.210.2(b)~~a~~)(1).

(c) **"Mobility-Related Activities of Daily Living (MRADL)"** means activities such as toileting, feeding, dressing, grooming, and bathing.~~:~~

(d) **"A Mobility Limitation that significantly impairs a beneficiary's ability to participate in one or more MRADL"** means a limitation that:

(1) Prevents the beneficiary from accomplishing an MRADL entirely, or
(2) Places the beneficiary at heightened risk of morbidity or mortality when attempting to perform an MRADL, or
(3) Prevents the beneficiary from completing an MRADL within a reasonable time frame.

~~(b)~~(e) **"Customize"** ~~customizing is defined as~~ means making significant alterations or modifications to a component that are not anticipated in the manufacturer's design, or require fabrication of another component or hardware in order to adapt the equipment to a beneficiary or to the wheelchair.

~~A seating system must contain a seat and/or back with one other positioning component. It is assembled on a mobility base (frame/wheels) to promote neutral alignment and/or accommodate a fixed postural deformity in order to improve function. These definitions of a wheelchair and a mobility device are consistent with the federal definition found at 42 CFR §440.70(b)(3).7506.1 Eligibility for Care (04/01/1999, 98-11F)~~

~~Coverage for wheelchairs, mobility devices, and seating systems is provided for beneficiaries of any age.~~
~~7506.2~~ 4.210.2 Covered Services ~~(04/01/1999, 98-11F)~~~~7506.1~~

(a) Wheelchairs, mobility devices, seating systems, and related services are covered when medically necessary.

(b) Wheelchairs and mobility devices are considered medically necessary when a beneficiary has a mobility limitation that significantly impairs his/her ability to:

(1) Participate in one or more MRADLs in or outside of the home,
(2) Access authorized Medicaid transportation to medical services, or
(3) Exit the home within a reasonable timeframe. ~~that have been pre-approved for coverage are limited to:~~

~~(a)~~(c) Rental of Wheelchairs and Mobility Devices

(1) Payment will be made for rental of one device under the following circumstances~~a wheelchair~~:
~~(a)~~
(A) W~~w~~hile waiting for purchase or /repair of a custom chair, when there is no other available option~~;~~, ~~or~~

(A)(B) (b) For documented appropriate short-term acute medical conditions,
(C) During a trial period, or
(D) As part of Medicaid reimbursement requirements for items of DME subject to capped rental.
Documentation is required to show that the beneficiary would have substantial chair or bed confinement without a wheelchair.

(d) Purchase of Non-Customized Manual Wheelchairs:

(1) Payment will be made for standard non-customized manual wheelchairs for beneficiaries who have documented long-term medical needs. and are capable of upper body function sufficient to self-propel.

(e) Purchase of Custom Wheelchairs, and Mobility Devices:

(C)(1) Battery-Operated Wheelchairs, Three-Wheeled Power Vehicles, and Other Mobility Devices.
Payment will be made for a customized manual wheelchair, a battery operatedpower wheelchair, a three-wheeled power-operated vehicle, or other mobility device when a beneficiary's MRADLs needs cannot be reasonably metaccomplished by the provision of a standard non-customized manual chair.

(f) Purchase of a Second Wheelchair or Mobility Device:

(3)(1) Payment is limited to one primary piece of equipment, except when a beneficiary with a withpower an electric wheelchair needs a needs a manual wheelchair when medically necessary to meet a therapeutic objective. Prior authorization is required.

(g) Purchase of Replacement Wheelchair or Mobility Device:

(1) Payment will be made for replacement wheelchairs or mobility devices for:

(A) Beneficiaries with specific documented growth needs,;
(B) for bBeneficiaries with a change in medical status that necessitates replacement, of equipment;
(A)(C) Ffor loss,; or
(B)(D) for Rreplacement of current equipment when, as a result of normal wear and tear, the wheelchairit or device no longer safely addresses the medical needs of the beneficiary and can no longer be repaired.

(h) Seating Systems

(4)(1) Covered items are manufactured seating systems, seating and seating systems that consist entirely of components that have been custom-fabricated or customized by the DME provider, and seating systems that consist of both manufactured components and components custom-fabricated by the DME provider for use in a wheelchair. A seating system must contain a seat and/or back with one other positioning component.

(5)(2) Labor Reimbursement for up to five hours of labor associated with custom fabrication of a seating system or customizing a seating system will be made to the DMEDME provider, up to the limit of five hours.

(b)(i) Repairs Repair to damaged or worn out equipment is covered when the equipment is not under warranty.

4.210.3 Qualified Providers and Vendors

(a) Providers must be licensed, working within the scope of his or her practice and enrolled in Vermont Medicaid.

(b) Vendors must be Medicaid enrolled providers of Durable Medical Equipment.

4.210.4 ~~7506.3~~Conditions for Coverage ~~(04/01/1999, 98-11F)~~

(a) The requirements in rule 4.209 ~~7505 regarding durable medical equipment~~Durable Medical Equipment apply to wheelchairs.

(b) Payment will be made for aseating systems, and/or any required accessories, for ~~an individual~~ beneficiaries residing in a long term-care facility when the system is ~~prescribed by a registered physical or occupational therapist trained in rehabilitative equipment and the system is~~ so uniquely constructed or substantially modified to the individual that it would not be useful to other ~~nursing home~~ residents.

(c) When ~~the department~~ Vermont Medicaid has purchased a seating system for an individual residing in a long-term care facility and that individual moves to a new living arrangement, Vermont Medicaid ~~the department~~ will purchase from the facility, at the net book value, the components of the wheelchair purchased by the facility.

(d) When ~~an individual~~a beneficiary who resides in a long-term care facility moves to a new living arrangement and and requires a wheelchair that is not available in the new residence, Vermont Medicaid ~~the department~~ will authorize coverage for a new wheelchair, or purchase, at the net book value, the wheelchair provided by the facility from which the individual moved.

~~(e) The department is the owner of all purchased equipment. Such equipment may not be resold. At the discretion of the commissioner or the commissioner's designee, durable medical equipment may be recovered for reuse or recycling when the original beneficiary no longer needs it. When serviceable equipment is no longer needed or appropriate for a beneficiary, the beneficiary must notify the department.~~

4.210.5 ~~7506.4~~ Prior Authorization Requirements ~~(04/01/1999, 98-11F)~~

~~Prior authorization is required for rental of a wheelchair beyond three month~~

(a) Prior authorization is required for the purchase, -rental, or replacement of ~~all~~ wheelchairs and mobility devices, ~~except the initial purchase of a standard manual wheelchair with sling seat.~~

~~(a)~~

(b) ~~Prior authorization is required for wheelchair replacement. When an individual who resides in a long-term care facility moves to a new living arrangement and requires a wheelchair that is not available in the new residence, the department will authorize coverage for a new wheelchair or purchase, at the net book value, the wheelchair provided by the facility from which the individua~~Prior authorization is required for wheelchair repairs costing more than $~~300~~500. ~~Requests for prior authorization should include the date of purchase and specification of anticipated parts and labor costs. Repair invoices must include an itemized list of components, costs, and labor charges.~~ Equipment guarantees and warranties~~y, and any available third party liability~~ must be utilized before billing Medicaid.

~~(a)~~

(c) Prior authorization is required for the labor cost of repairs where parts are under warranty.

~~7506.5~~ 4.210.6 Non-Covered Services ~~(04/01/1999, 98-11F)~~

(a) A wheelchair or mobility device is not covered when used as transportation that otherwise could be accomplished in a vehicle. ~~With the exception of equipment or services authorized for coverage via rules 7104,~~

~~equipment or services not included under rule 7506.2 and equipment or services that do not meet criteria specified in rules 7506.2–7506.4, where applicable, are not covered.~~

~~(a)~~
~~In addition, no payment will be made for rental of a wheelchair when a less expensive equipment/service is available and appropriate for the beneficiary's medical needs (for example, crutches for a fractured ankle when the beneficiary has upper body function).~~

(b) Payment will not be made for:

~~(1) back-up equipment,~~
~~(2)~~(1) Ceustom-colored wheelchairs or accessories,
~~(3) custom seating systems for mobility devices other than wheelchairs,~~
~~(4)~~(2) Cushions that are not an integral component of the wheelchair to athe ~~seating system are not cover~~,
~~(5)~~(3) Ceosts associated with repair or adjustments to the original wheelchair and related items ~~within 60 days of purchase or under other~~ implied or expressed warrantiesy, other than labor costs where parts are under warranty, or
~~(4) Payment will not be made to DME suppliers for~~ DME supplier's costs associated with fitting and/or /evaluation of a seating system. These costs are included in the initial reimbursement for the item.

~~7506.6 Qualified Providers (04/01/1999, 98-11F)~~

~~DME providers must be licensed, registered and/or certified by the state (where applicable) and be enrolled with Vermont Medicaid.~~

~~DME providers are expected to maintain adequate and continuing service support for Medicaid beneficiaries.~~

~~7506.7 Reimbursement~~(04/01/1999, 98-11F)~~Reimbursement for durable medical equipment is described in the Provider Manual.~~

~~The department is the owner of all purchased equipment. Such equipment may not be resold. At the discretion of the commissioner or the commissioners designee, durable medical equipment may be recovered for reuse or recycling when the original beneficiary no longer needs it. When serviceable equipment is no longer needed or appropriate for a beneficiary, the beneficiary should notify the department and request permission to dispose of the equipment.~~