VERMONT

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The Department of Vermont Health Access
Tools related to Augmentative Communication Devices

Last Revision: November 10, 2016*
Revision 3: June 18, 2015
Revision 2: May 8, 2014
Revision 1: June 25, 2013
Original: April 23, 2012

***Please note: Most current content changes will be highlighted in yellow.**

Packet includes the following:

1) Department of Vermont Health Access: All Augmentative Communication Devices Require Prior Authorization
2) Department of Vermont Health Access: Rules Related to Augmentative Communication Devices
3) Department of Vermont Health Access: Guidance for Application Completion
4) Department of Vermont Health Access: Evaluation for an Augmentative Communication Device
5) Department of Vermont Health Access: /Augmentative Communication Device: PRESCRIPTION for iPad/iPod Devices Only
6) Department of Vermont Health Access: Augmentative Communication Device: PRESCRIPTION for Non-iPad/iPod Augmentative Communication Device
7) Department of Vermont Health Access: Procedure for Augmentative Communication Devices
8) Department of Vermont Health Access: Durable Medical Equipment Ownership, Operation, and Maintenance Agreement

1) Department of Vermont Health Access:

All Augmentative Communication Devices Require Prior Authorization

November 2016

When making its determinations, DVHA utilizes nationally recognized evidence-based criteria, internal guidelines which reflect Vermont Medicaid Rule, and the Vermont Medicaid Rules themselves. The Vermont Medicaid Rules pertaining to prior authorization, medical necessity, durable medical equipment (DME) and augmentative communication devices in particular are available on the AHS website at http://humanservices.vermont.gov/on-linerules/dvha .

All covered devices must meet the beneficiary's medical needs (Vermont Medicaid Rule 7103), must match the capability of the device/accessories to the beneficiary's medical needs within the limitations of Vermont Medicaid coverage, and must be the least expensive, medically appropriate device (7102.2).

The documentation provided in the Augmentative Communication Evaluation and Prescription Forms are advisory in nature, to assist medical providers and durable medical equipment providers in providing the documentation necessary to complete a request to Vermont Medicaid for coverage of a communication device. Use of the forms and the information contained on the forms will facilitate the prior authorization process.

Note that augmentative communication devices are also described as speech generating devices and alternative/augmentative communication (AAC) devices.

2) Department of Vermont Health Access: Rules Related to Augmentative Communication Devices

November 2016

Vermont Medicaid Rule 7507: "An augmentative communication device or system transmits or produces messages or symbols in a manner that compensates for the disability of a beneficiary with severe communication impairment. It is a specialized prosthetic device consistent with the federal definition found at 42 CFR 440.120c."

Vermont Medicaid Rule 7507.3 Conditions for Coverage: "Payment will be made for purchase or rental of augmentative communication devices or systems to assist a beneficiary in communication when the impairment prevents writing, telephone use, or talking. Augmentative communication prescriptions must take into account the beneficiary's current and future needs. An augmentative communication device will be approved only if the device/system will be used to meet specific medical objectives or outcomes. The beneficiary's cognitive level of functioning will be taken into consideration when matching the device to the beneficiary…purchase…will be considered only after the beneficiary has demonstrated success in meeting the majority of medical outcomes associated with short-term goals as specified in the medical necessity documentation. Payment will be made for one primary piece of medical equipment; duplicate services/equipment in multiple locations will not be covered. Coverage for replacement equipment will be provided only when the existing device or system no longer effectively addresses the beneficiary's needs. All devices or systems must carry a one year warranty."

Vermont Medicaid Rule 7507.4 Prior Authorization Requirements: "Prior authorization is required for the rental or purchase of all augmentative communication devices or systems. The department reserves the right to request a second opinion or additional evaluations for the purpose of clarifying medical objectives or outcomes."

Vermont Medicaid Rule 7507.5 Non-Covered Services: "…environmental control devices, such as switches, control boxes, or battery interrupters and similar devices that do not primarily address a medical need are not covered. Initial purchase of the device or system will include any training provided by the manufacturer or supplier. Additional training by the manufacturer or supplier is not covered. However, if additional training is necessary for the beneficiary, it may be obtained through speech therapy services."

Vermont Medicaid Rule 7507.6 Qualified Providers: "Providers must be licensed, registered and/or certified by the state (where applicable) and be enrolled with Vermont Medicaid. Vendors are expected to maintain adequate and continuing service support for Medicaid beneficiaries."

Vermont Medicaid Rule 7505.7 Reimbursement: "The department is the actual owner of all purchased equipment. Such equipment may not be resold…augmentative communication devices may be recovered for reuse or recycling when the original beneficiary no longer needs it."

3) DEPARTMENT OF VERMONT HEALTH ACCESS
EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICE
Guidance for Application Completion

November 2016

OVERVIEW OF APPLICATION

The Medicaid evaluation for augmentative communication devices has 4 main parts. Each part is described briefly below.

Part 1 Beneficiary/ Request Information	
PROCEDURE CODES	The codes for the device and all requested components
DEMOGRAPHICS	Beneficiary's contact and identification
PRESCRIPTION CONTACTS	Medicaid information for physician, vendor, and Speech Language Pathologist (SLP)
INSURANCE	Other insurance, and documentation of denial.
Part 2: Beneficiary's Abilities and Needs	
MEDICAL NECESSITY	Details of beneficiary's diagnoses and conditions that impact their speech.
CURRENT STATUS	Relevant information about the beneficiary's abilities and needs.
Part 3: Device Consideration Process	
OVERVIEW	Brief description of how the device consideration process was conducted
RESULTS	Outcome of device consideration in form of access methods and requested device/app.
DEVICE AND APP PROFILE	Features of each device and app that was trailed.
PERFORMANCE PROFILE	Skills observed before and after trial of selected device/app.
Part 4: Next Steps:	
PLANNING	Treatment goals and plan.
PRESCRIPTION	
AGREEMENT	

Detailed Guide to Completing Form

Part 1: Beneficiary / Beneficiary Information	
Date of Application	Date application is completed and submitted to Medicaid
Requested Procedure Codes	Provide the proper procedure code for the device and all requested components. For iPad/iPod, the device and all components are bundled together under the single code E2510. Coding assistance is available from the vendor for traditional devices.
Beneficiary's Demographics	Provide requested information specific to the beneficiary's name, Medicaid ID, date of birth, and home address.
Prescription Contacts	Provide the name and provider numbers for the beneficiary's physician, the SLP who is prescribing this device, and the DME provider. For iPad/iPod, the DME provider is: Small Dog Electronics. Their provider # is 1019949.
Beneficiary's Insurance	If the beneficiary has any other insurance, you must provide the name of the insurance, the policy number, and you MUST obtain documentation from the insurer that states that the request for a speech device has been denied including an explanation of the reason for the denial.
Part 2: Beneficiary's Abilities and Needs	
Medical Necessity	The questions in this section are designed to establish that the AAC device is being requested due to medical necessity. Medical necessity is a requirement for all Medicaid coverage. Include information about the beneficiary's medical diagnoses that impact their speech and the specific communication diagnosis, with related ICD 10 diagnostic codes. Indicate if all the necessary elements of medical necessity are true for the client. If you cannot say "yes" to all the statements, document an explanation in the text space provided.
Beneficiary's Current Status	
hearing	Record the date of the most recent hearing testing and the results, or document if hearing is not a concern.
vision	Record the date of the most recent visual acuity and cortical vision testing and the results, or document if visual acuity is not a concern.

FINE MOTOR	Briefly describe the person's fine motor abilities and challenges specifically related to accessing and using a speech-generating device. Consider hand use, grading of movement, strength, accuracy of point, typing, etc. When appropriate, discuss alternate access methods (e.g. switch, alternate body part for direct access) and any necessary personnel supports, equipment, and adapted materials.	
GROSS MOTOR	Briefly describe the person's gross motor abilities and challenges related to seating, positioning, and mobility, including any necessary personnel supports, equipment, and adapted materials. Include information specifically related to accessing and using a speech-generating device such as the ability to transport and access the device from different positions.	
COGNITION	Briefly describe what is known about the person's cognitive abilities and challenges, such as memory, attention, and learning. Include any necessary personnel and material supports.	
LITERACY	Describe the beneficiary's current reading and writing skills. Include any technology or other supports the person uses.	
BEHAVIOR	Document any behavior issues that may affect the beneficiary's use of a speech generating device.	
NEUROLOGICAL	Document any neurological issues, such as tonal changes or seizure activity, that may affect the beneficiary's use of a speech generating device.	
MEDICATIONS	List the beneficiary's medications that may affect their ability to use a speech generating device.	
CARDIOVASCULAR/ PULMONARY	Document any cardiovascular or pulmonary issues that may affect the beneficiary's use of a speech generating device. For example, a cardiac condition that causes fatigue, or a pulmonary condition that affects breath support.	
COMMUNICATION	RECEPTIVE	Describe what the beneficiary comprehends, understands.
	EXPRESSIVE MODES	Describe the beneficiary's current modes of communication, such as unaided forms (e.g. actions, gestures, signs, speech) and aided forms (paper-based supports, high-tech supports). Do not include the use of the device being requested in this section.
	FUNCTIONS	Indicate which communicative functions the beneficiary currently expresses, in any form (not including the AAC device being trialed).

	Mean Length of Utterance (MLU)	Average number of words per utterance (any combination of forms) as determined by language sample.
	Intelligibility	Percent of speech that is understood by partners. Include familiar and unfamiliar partners, familiar and unfamiliar content.
Personal	Include any information about the beneficiary – their personality, preferences, etc. – that is important to consider in the device process.	
Past history	Document the past history of SLP treatment.	
Other medical equipment	Document the equipment used by the beneficiary that may impact their use of the speech generating device. For example, a person using a wheelchair may need a mounting system.	
Involvement of OT/PT	Document the other therapy disciplines that assisted in the evaluation process. For example, an OT may have been involved in determining the precise location for the most efficient use of a wheelchair-mounted device.	
Positioning needs	Document if specific positioning needs are required to ensure that the device will work for the beneficiary. For example, a person using a wheelchair, with limited motor endurance, may need a particular arm support to use the speech generating device.	
Transportation	Document the modes of transportation used by the beneficiary. For example, a school bus or public transportation.	
ADL status	Document the amount of assistance needed to perform activities of daily living such as feeding, grooming, dressing, and hygiene.	
Technology	Document all previous types of technology related to speech generation that have been used by this beneficiary, when it was used, and why it is no longer appropriate.	
Currently available technology	Specify what is currently available to the beneficiary. For example, an ipad may be available at school, and has been used successfully, but is not available for home/community use.	
Psychosocial	Provide information related to the beneficiary's life that may impact the use of the speech generating device. For example, if the person needs to walk for long distances, a carry case with a strap may be needed.	

PART 3: DEVICE CONSIDERATION PROCESS	
CONSIDERATION	The term "consideration" is used to refer to the larger process of identifying an appropriate AAC device.
TRIAL	The term "trial" is used to refer to the more specific process of using an AAC device with the client and recoding the results.
Overview	
START/END DATES	Identify when the device consideration process began and when it ended. Also document when the trial of the requested device started and when it ended. A successful one month trial inclusive of both the home and community settings is required.
TEAM ROLES	Identify all team members who were involved in the device consideration process. Document if an external AAC specialist participated in the process.
LOCATIONS	Document the contexts used as part of the device trial process. Note that the home MUST be included as one of the contexts.
DEVICES AND APPS	List the names of the devices and applications (apps) or programs, if non-iPad devices were considered that were considered in this process.
PROCESS	Briefly describe the sequence of activities conducted as part of the device consideration process.
RESULTS	• Identify the specific device and app that was selected as a result of the consideration process. • Indicate and describe the access method that was identified as the most appropriate.
DEVICE AND APP PROFILE	
A device/app profile should be completed for <u>each</u> device/app that was used in a trial with the client. Devices/apps that were considered (but not actually tried) do not need to a profile.	
DEVICE/APP	Indicate the name of the device/app. Also, indicate which page set or vocabulary you have selected.
TARGETS	Specify the number of messages per page (indicate range if it varies) and the number of messages in the overall app. It is helpful to include a screen shot of the main page to help the reviewer know what the display looks like.
CONTENT	Indicate the types of messages that are available within the device/app. The client does not need to be using all of these at this time – these categories represent robust system elements that would be there as a potential for use.

FEATURES	Indicate the features, settings, or options that are available within this device/app. Again, they do not need to be used by the beneficiary, but it is important that the team know what is possible. A screen shot may be included if that is helpful.
TRAINING	Indicate how the team obtained information about this device/app and its features to be able to make an informed decision about its potential. Include AAC specialist training, webinars, vendor support etc.
TRIAL	Describe the device trial process. Information should include: contexts, activities, frequency of trials/data collection, partners, instruction, and client performance. Data sheets may be attached if they clearly display the necessary information.
OUTCOME	Identify what was decided as a result of the trial of the device/app – whether it was selected as the appropriate device/app and if not, why.
BASELINE AND ENDLINE PERFORMANCE PROFILE	
This form should be completed for <u>each</u> device/app trialed. Devices/apps that were considered (but not actually tried) do not need to a profile.	
RATING SCALE	Indicate how well/often the beneficiary demonstrates the target behavior: 0 = never 1 = sometimes or inconsistently demonstrates the behavior 2 = consistently, usually, often demonstrates the behavior
OBSERVABLE BEHAVIORS	Use this list of behaviors to help identify appropriate device trial outcomes. Consider which behaviors are demonstrated consistently (current level of functioning), which are inconsistent (aim to become more consistent) and which are not observed (provide opportunities for learning and showing these behaviors). This list is NOT a list of prerequisites or a hierarchy – it is one way of recording trial outcomes.
PLANNING	
SHORT TERM OUTCOMES	Identify goals that appear to be attainable within the next year.
LONG TERM OUTCOMES	Identify goals that appear to be attainable with multiple years of instruction and use.
TRAINING SUPPORT	Identify the plan to educate and support communication partners, particularly home partners.
RESPONSIBLE PARTIES	Indicate who – at home and other primary context (e.g. school, work) - will assume responsibility for keeping the device safe from

	damage, theft, or loss and device maintenance. Provide contact information.

PRESCRIPTION
Choose the correct prescription form and complete it entirely. Do not leave blank spaces or the request may be delayed or denied.

REQUESTED DEVICE AND PERIPHERALS
Identify the device and app that was selected as a result of the consideration and trial process. Also indicate all of the peripherals/equipment necessary to access and use the device across contexts.

AGREEMENT
The Ownership, Operation, and Maintenance form must be signed by all responsible parties and included in every request to Vermont Medicaid.

4) DEPARTMENT OF VERMONT HEALTH ACCESS
EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICE
This form must be completed in its entirety to enable review.

November 2016

PART 1: BENEFICIARY/REQUEST INFORMATION

Date of Application:	Month:	Day:	Year:
Requested Procedure Codes:	☐E2500	☐E2506	☐E2511
	☐E2502	☐E2508	☐E2512
	☐E2504	☐E2510	☐E2599

BENEFICIARY'S DEMOGRAPHICS

Name: Medicaid Unique ID:

Date of Birth: month: day: year:

Home Address: house /apt #

street:

city/town:

state: VT zip:

PRESCRIPTION CONTACTS

Primary MD Name: MD Medicaid Provider #:

Prescribing SLP Name SLP Medicaid Provider #:

DME Provider Name: (if an ipad/ipod: Small Dog Electronics

DME Medicaid Provider#: (if an ipad/ipod: 1019949)

BENEFICIARY'S INSURANCE

Does the beneficiary have any insurance other than Medicaid?

☐ no - skip to next section ☐ yes - complete this section

Insurance Name Insurance Policy #:

☐ Attach the denial letter or denial policy from the Primary Insurance: REQUIRED

PART 2: BENEFICIARY'S ABILITIES AND NEEDS

MEDICAL NECESSITY

Beneficiary's medical diagnoses and conditions that contribute or relate to their communication impairment (include icd-10 diagnosis codes and dates of onset):Click or tap here to enter text.

Beneficiary's precise communication diagnosis (e.g. apraxia, dysarthria):
Click or tap here to enter text.

Check all statements below that are true and demonstrate medical necessity:

- ☐ Beneficiary requires speech-language pathology treatment.
- ☐ Beneficiary is unable to meet their daily communication needs using natural communication methods.
- ☐ Speech-generating device is recognized in current peer reviewed medical literature as an appropriate treatment for the beneficiary's communication impairment diagnosis.
- ☐ Beneficiary's receptive language appears to be at a higher level than their expressive language abilities.
- ☐ Beneficiary's ability to report medical needs, communicate with medical personnel, and share important personal health information is impacted by speech impairment.

BENEFICIARY'S CURRENT STATUS

Sensory	Hearing: Click or tap here to enter text. Vision: Click or tap here to enter text. Eye Control:Click or tap here to enter text.
Motor	Fine motor: Click or tap here to enter text. Ability to point:Click or tap here to enter text. Ability to type:Click or tap here to enter text. Hand Dominance:Click or tap here to enter text. Gross motor: Click or tap here to enter text. Mobility status:Click or tap here to enter text. Trunk control:Click or tap here to enter text. Head Control:Click or tap here to enter text. Posture:Click or tap here to enter text.
Cognition and Literacy	Cognition:Click or tap here to enter text. Attention: Click or tap here to enter text. Memory: Click or tap here to enter text.

Behavior	Problem Solving:Click or tap here to enter text. Understanding of cause/effect: Click or tap here to enter text. Learning:Click or tap here to enter text. Literacy: Click or tap here to enter text. Click or tap here to enter text.
Neurological	Seizure activity:Click or tap here to enter text. Tone: Click or tap here to enter text.
Medications	Click or tap here to enter text.
Cardiovascular /Pulmonary	Click or tap here to enter text.
Communica-tion	Receptive: Click or tap here to enter text. Expressive:Click or tap here to enter text. Method of Expression: (check all that apply) ☐Natural Speech ☐ Sign ☐Facial expression ☐Point ☐ Eye gaze ☐Gesture ☐Other Functions: ☐request items/ action ☐request assistance ☐comment, describe ☐interject / social ☐direct others ☐ask questions / request info ☐affirm / agree ☐social etiquette Mean Length of Utterance: Click or tap here to enter text. % Intelligibility: Click or tap here to enter text.
Personal:	Click or tap here to enter text. History related to communication including previous SLP treatment:

Past History:	Click or tap here to enter text.
Other medical equipment:	(example: Wheelchair, hearing aid, visual assistance device):Click or tap here to enter text.
Involvement of OT/PT (if applicable:	Click or tap here to enter text.
Positioning needs	Click or tap here to enter text.
Transportation	Click or tap here to enter text.
ADL status:	☐Independent ☐Requires minimal assistance ☐Requires moderate assistance ☐Require maximal assistance
Previously used technology and reason why the previous technology is no longer appropriate:	Click or tap here to enter text.
Currently available technology: Home:	Click or tap here to enter text.
School:	Click or tap here to enter text.
Psychosocial:	Click or tap here to enter text.

PART 3: DEVICE CONSIDERATION PROCESS

OVERVIEW	
Start/ end dates	Device consideration dates: Click or tap here to enter text. Trial dates: (Must be at least 1 full month including home trials): Click or tap here to enter text.
Team roles	Click or tap here to enter text.
Locations	Click or tap here to enter text.
Devices and Apps	Click or tap here to enter text.
Process	Click or tap here to enter text.

RESULTS			
Device/App	Selected device Selected Hardware	Selected App	
Access	Access Method	☐ direct select	☐ scanning
	Describe		

iDEVICE VERSUS DEDICATED OR OPEN SPEECH GENERATING DEVICE				
Consideration of assistive technology requires identification of the most cost-effective tool to meet the individual's needs. The information below must be provided if the team has, as a result of the device consideration process, determined that a speech generating device other than an iDevice is required for the individual.				
Rationale	☐	motor/physical access	☐	sensory (vision, hearing) access

	☐	durability	☐	other
Explanation	Please provide specific, compelling evidence that demonstrates that the individual could not use an iDevice and instead requires an alternate speech-generating device.			

DEVICE AND APP PROFILE

Device 1 profile:		
App 1 profile:	Name	
	Page Set	
Targets	Per page	
	Total	
Content	☐ individual words	☐ phrases, sentences
	☐ alphabet/keyboard	☐ social terms, interjections
	☐ regulatory/control vocabulary	☐ verbs/actions
	☐ question words	☐ adjectives, adverbs
	☐ pronouns/people	☐ nouns
Features	display	
	buttons	
	speech	
	message window	
	rate enhancement	
	other	
Training		
Trial		
Outcome		

Device 2 profile (if applicable):	n/a: ☐
App 2 profile (if applicable):	n/a: ☐ Name

	Page Set			
Targets	Per page			
	Total			
Content	☐	individual words	☐	phrases, sentences
	☐	alphabet/keyboard	☐	social terms, interjections
	☐	regulatory/control vocabulary	☐	verbs/actions
	☐	question words	☐	adjectives, adverbs
	☐	pronouns/people	☐	nouns
Features	display			
	buttons			
	speech			
	message window			
	rate enhancement			
	other			
Training				
Trial				
Outcome				

BASELINE AND END LINE PERFORMANCE PROFILE

Rating Scale:
0 = never
1 = sometimes, inconsistently
2 = consistently

Start Trial			Observable Behavior	End Trial		
0	1	2	Device Awareness / Acceptance	0	1	2
☐	☐	☐	allow device in personal space	☐	☐	☐
☐	☐	☐	looks towards device	☐	☐	☐
☐	☐	☐	attends to partner using device	☐	☐	☐
☐	☐	☐	attends to device display	☐	☐	☐
0	1	2	Early – Emergent Independent Access	0	1	2
☐	☐	☐	reaches for display	☐	☐	☐
☐	☐	☐	explores display	☐	☐	☐

☐	☐	☐	reaches for display at appropriate time in interaction	☐	☐	☐
☐	☐	☐	reaches for/towards specific target	☐	☐	☐
☐	☐	☐	navigates to word not on current screen	☐	☐	☐
☐	☐	☐	remembers navigation to familiar message (not in same session)	☐	☐	☐
0	1	2	Advance Independent Access	0	1	2
☐	☐	☐	sequence targets to produce word (same page)	☐	☐	☐
☐	☐	☐	sequence targets to produce phrase/sentence (same page)	☐	☐	☐
☐	☐	☐	locates word within categories	☐	☐	☐
☐	☐	☐	produces 2 word phrase	☐	☐	☐
☐	☐	☐	produces 3 word phrase	☐	☐	☐
☐	☐	☐	produces 4/4+ word phrases	☐	☐	☐
☐	☐	☐	repairs errors in navigation	☐	☐	☐
☐	☐	☐	uses word endings	☐	☐	☐
0	1	2	App Operations	0	1	2
☐	☐	☐	activates message window	☐	☐	☐
☐	☐	☐	uses navigation buttons such as “home”, “back”	☐	☐	☐
☐	☐	☐	uses “clear” (display, word) function	☐	☐	☐
0	1	2	Text-Based Skills	0	1	2
☐	☐	☐	types using keyboard	☐	☐	☐
☐	☐	☐	uses word prediction	☐	☐	☐

PLANNING

TRIAL OUTCOMES	
EXPECTED SHORT TERM OUTCOMES	
EXPECTED LONG TERM OUTCOMES	
TRAINING SUPPORT	Must include robust assistance for home/community users:

PARTIES RESPONSIBLE FOR DEVICE SECURITY AND MAINTENANCE	Click or tap here to enter text. Plan to keep device safe from damage, theft or loss: Click or tap here to enter text.		
	home	name	contact
	school	name	contact
	work	name	contact

If the request is for a replacement device due to loss or theft, attach police report

5) DEPARTMENT OF VERMONT HEALTH ACCESS AUGMENTATIVE COMMUNICATION DEVICE: PRESCRIPTION FOR IPAD/IPOD DEVICES ONLY

November 2016

Beneficiary Name:

Beneficiary Address:

Beneficiary Email:

If none check here☐

Medicaid Unique ID:

Existing iTunes acct: **Y** ☐ **N** ☐

Beneficiary Apple ID:

Beneficiary Apple iTunes password:

ICD-10 Diagnosis Code:

SLP Ship or Pick up

All devices must be delivered to, or picked up by, the Speech Language Pathologist. Please select delivery format below:

☐ Pick up: ☐ Manchester NH
☐ Waitsfield VT
or ☐ So Burlington VT

☐ Ship to: SLP Name:
Address:

Phone Number:

For State of VT use only

PA#:

REQUESTED DEVICE AND PERIPHERALS				
AAC Device	Type	Specifications	Medical Necessity Rationale	Procedure Code
Device:				

Components	Specific Name	Vendor	Medical Necessity Rationale	Procedure Code
app name				
protective case				
stand				
speakers				
switch				
switch				
key guard				
mounting arm				
stylus				
other				
other				
other				

I acknowledge that this device is medically necessary and is provided for use as the sole dedicated speech-generating device for this beneficiary. The purpose of the device provided is for independent communication and the device must be used as determined by the prescribing speech language pathologist to ensure the safety and maximum benefit of the beneficiary. All parties signed below deem this prescription accurate and medically appropriate:

Title	Required Information
Beneficiary or legal guardian	Printed Name:
	Contact Information:
	Signature:
	Date:
Primary care physician	Printed Name:
	Contact Information:
	Signature:
	Date:
Speech Language Pathologist	Printed Name:
	Contact Information:

Signature:

Professional Designation (SLP-CCC):

Date:

6) Department of Vermont Health Access:
Speech Generating and Alternative/Augmentative Communication Device:
PRESCRIPTION for E2510-12 (Not for use with iPad/iPod devices)
November 2016

Beneficiary Name:

Medicaid #:

ICD-10 Diagnosis Code:

AAC Device	Type
Device:	

Components	Specific Name	Specifications	Medical Necessity Rationale	Procedure Code
app name				
protective case				
stand				
speakers				
switch		Vendor	Medical Necessity Rationale	Procedure Code
switch				
key guard				
mounting arm				
stylus				
other				
other				
other				

I acknowledge that this device is medically necessary and is provided for use as the sole dedicated communication device for this beneficiary. The purpose of the device provided is for independent communication and the device must be used as determined by the prescribing speech language pathologist to ensure the safety and maximum benefit of the beneficiary. All parties signed below deem this prescription accurate and medically appropriate:

Title	Required Information
Beneficiary or legal guardian	Printed Name:
	Contact Information:
	Signature:
	Date:
Primary care physician	Printed Name:
	Contact Information:
	Signature:
	Date:
Speech Language Pathologist	Printed Name:
	Contact Information:
	Signature:
	Professional Designation (SLP-CCC):
	Date:

7)Department of Vermont Health Access:
Procedure for iPad/iPod Augmentative communication devices

Last Revision: November 10, 2016
Revision 5: June 18, 2015
Revision 4: May 8, 2014
Revision 3: June 25, 2013
Revision 2: March 13, 2013
Revision 1: January 9, 2013
Original: April 23, 2012

- SLP determines that a need exists and begins the evaluation process. If SLP is not a Vermont Medicaid enrolled provider, collaboration must occur with an enrolled provider who has participated in the evaluation and prescribing process, who is familiar with the beneficiary and who is knowledgeable regarding speech generating devices. The enrolled provider must prescribe the device.
- SLP accesses a trial device.
- SLP supervises a **full** 30 day trial with intensive data collection, including home trial.
- SLP completes Evaluation & Prescription form, and the Ownership form.
- SLP sends the above documentation to Vermont Medicaid: fax to 802-879-5963.
- The Prior Authorization (PA) record is set up, using the prescribing SLP and the MD, NP, or PA-C as providers of record.
- Clinical review is performed. If information is missing, a Notice of Decision (NOD) requesting this information will be sent to the SLP, the MD, NP, or PA-C and the beneficiary.
- Upon approval, Notices of Decision (NODs) are sent by Vermont Medicaid's fiscal agent HPE, with a change to Small Dog Electronics as supplying provider, to the MD, NP, or PA-C, Small Dog Electronics, and the beneficiary.
- All components are bundled together under the E2510 code and are listed individually in the text of the NOD.
- DVHA reviewer sends the script to Small Dog Electronics.
- DVHA reviewer notifies the SLP of the decision and sends a recycling sticker to be placed on the device.
- Small Dog Electronics sends pricing information to the Clinical Unit. The information is added to the PA.
- Small Dog Electronics sends claim information including pricing to HPE for reimbursement.
- The device is sent to the SLP, or is picked up at Small Dog Electronics, by the SLP.

Procedure for all other speech generating and alternative/augmentative communication devices:

- SLP, who does NOT need to be a Vermont Medicaid enrolled provider, determines that a need exists and begins the evaluation process.
- SLP accesses a trial device from the durable medical equipment (DME) provider.
- SLP supervises the **full** 30 day trial with intensive data collection, including home trial.
- SLP completes Evaluation and Prescription form.
- SLP sends Evaluation and Prescription form to DME provider.
- DME provider completes the Ownership form with the beneficiary.

- DME provider compiles the Evaluation and Prescription form, manufacturer information on the device, and the Ownership form and faxes to the Department of Vermont Health Access (DVHA) at 802-879-5963.
- The Prior Authorization (PA) record is set up, using the DME provider and MD, NP, or PA-C as providers of record.
- Clinical review is performed. If information is missing, a Notice of Decision (NOD) requesting this information will be sent to the DME provider, the MD, NP, or PA-C and the beneficiary. It is the responsibility of the DME provider to contact the SLP if additional clinical information is required.
- Upon approval, NODs are sent by HPE to the DME provider, the MD, NP, or PA-C and the beneficiary.
- The DME provider submits a claim to HPE for reimbursement.

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This document has been classified as public information.

8) Department of Vermont Health Access:
Durable Medical Equipment Ownership, Operation, and Maintenance Agreement for Augmentative Communication Devices

Last Revision: November 10, 2016
Revision 3: June 18, 2015
Revision 2: May 8, 2014
Revision 1: June 25, 2013
Original: April 23, 2012

Directions: Provider and beneficiary/legal guardian must sign this sheet during the prescription/authorization/delivery process and provide it to the beneficiary for signature during that time. **For iPad/iPod devices, the form must be signed by the SLP.** For wheelchairs, continue to use the Wheelchair Addendum form. The provider must keep this form on file and provide a copy to the beneficiary for their records. If Vermont Medicaid is providing primary coverage for the device, a Vermont Medicaid sticker must be affixed to the device upon delivery of the equipment. Do not apply a sticker or sign this form if the device will be covered by a primary insurance.

Your checkmark or initials and signature at the bottom of the form indicate agreement with each statement.

Provider Acknowledgement (Please check each statement):

_____ I have researched, and have not found, any less costly devices that would be appropriate to the beneficiary's medical needs at this time. Any components from the individual's current equipment that can be utilized will be placed on the new device.
_____ I have instructed the beneficiary/caregivers on the safe use of the device.
_____ I have explained to the beneficiary that, should the device no longer fit or no longer be needed, it is the property of Vermont Medicaid and should be returned to Vermont Medicaid; please call the number on the sticker placed on the equipment by the vendor.
_____ I have explained to the beneficiary that the expectation is that this device will last for at least 5 years, and should be treated so that it will last for this amount of time. If there is a change in the beneficiary's condition, consideration will be given to replacing the device.
_____ I have explained to the beneficiary that, should any defects in the device develop, the beneficiary should report the defects to the vendor.
_____ I have explained to the beneficiary that, should the device be lost or stolen, a police report must be submitted with any request for replacement of the device.

Beneficiary/Legal Guardian Acknowledgement (please check each statement):

_____ I accept the specific device and/or components that have been requested on my behalf by the prescribing medical professional.
_____ I have had an opportunity to try the device or a simulation so that I know it will work for me/my child and fit properly in my home.
_____ I understand how to properly care for and maintain the device so that it can last for 5 years.
_____ I understand how to properly operate the device.
_____ To return the device, I understand that I should call the number on the sticker that has been placed on the device.
_____ I understand that if the device is lost or stolen, a police report must be submitted with any request for a replacement of this device.

Provider's signature:_____ Date: _____

Beneficiary/legal guardian signature:_____