

**TESTIMONY OF THE  
NEW ENGLAND MEDICAL EQUIPMENT DEALERS ASSOCIATION  
RELATIVE TO PART HE-W 571, DURABLE MEDICAL EQUIPMENT, PROSTHETIC  
AND ORTHOTIC DEVICES AND MEDICAL SUPPLIES  
OCTOBER 27, 2006**

My name is Karyn Estrella, Executive Director of the New England Medical Equipment Dealers Association (NEMED). We appreciate this opportunity to comment on the proposed rule for durable medical equipment, prosthetic and orthotic devices and medical supplies.

NEMED is a regional trade association representing respiratory, rehab/assistive technology, durable medical equipment and home infusion therapy providers in the six New England states. Our members in New Hampshire provide products and services to approximately 85% of the Medicaid beneficiaries in the State.

We recommend the following changes to the proposed rule:

He-W 571.01(g) – The monthly quantity needs to be defined. Currently, providers are not aware of all codes that have a maximum quantity. They typically find out after a product has been delivered, billed and denied or in the event of an audit. HHS should publish a list of HCPCS codes with quantity limits.

He-W 571.04(b)(2)(a) – As mentioned above, HHS should publish a list of HCPCS codes with quantity limits that is available to DME providers and the SURS unit. If the quantity prescribed by the physician does not exceed the limit set by HHS, providers' monies should not be recouped. The SURS unit should abide by the published DME rules regarding quantity limits.

He-W 571.05 (a)(3)(b) – It is unclear if this includes grab bars. This should be clarified in the final rule.

He-W571.05 – Customized Beds – We recommend removing this product from the non-covered list. We recommend that these products be reviewed and considered on an individual case-by-case basis which is the current practice.

He-W 571.06 (a) – We recommend removing PA requirement for the following equipment, particularly short-term rentals: Beds, wheelchairs, trapeze, patient lift, wheeled walker w/seat, heavy duty walker, extra wide commode, apnea monitors, pulse oximeters, suction machine, ultrasonic nebulizer, APP, CPAP, BIPAP, humidifiers (passive and heated), enteral pump, IV pole, Group I & II support surfaces, continuous passive motion machines (CPMs) and replacement parts for standard DME where the client owns equipment. (see attached)

He-W 571.07 (d)(5) – We recommend removing bath and toileting items from the list of items that require Form 272EQ. A Letter of Medical Necessity from the physician and/or therapist's report, along with Form 272D, should be sufficient for these products.

He-W 571.07 (j)(2) – Can the provider assist the recipient with the fair hearing request if asked? This should be clarified in the final rule.

He-W 571.11 (c)(2) – This should be eliminated because it is a cumbersome process for both the State and providers. Providers should be reimbursed based on a fee schedule established by HHS or their usual and customary charge, whichever is less.

He-W 571.11 (e) - We recommend the addition of the following language, “For frame and seating growths to pediatric and adult wheelchairs only, payment shall be denied if the recipient is not eligible on the date of the order for the manual wheelchair growth”.

He-W 571.11 (h)(3) – Wheelchair reimbursement is not adequate to cover two (2) additional inspections by a skilled, certified technician. We recommend that separate reimbursement be established.

He-W 571.11 (i) – If an appropriate substitute wheelchair can be provided and is needed for longer than one (1) week for repair, the provider should be reimbursed at the established rental rate for the wheelchair. It should be noted that most of the rehab client population would not be able to be provided with an appropriate substitute wheelchair due to complexity of the seating system and individual needs.

Once adopted, HHS should clarify where these rules will supersede previously published policies/remittance advice memos and include a reference to previously published policies that are currently in place. Additionally, once the final rule has been adopted, we recommend sending every DME provider a packet which includes the following: the new DME rules, fee schedule and all current medical criteria policies that currently exist. This will protect the State and providers in an audit.

Thank you again for this opportunity to provide comment on this proposed rule. I am happy to answer any questions you may have.

Respectfully submitted,

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