

Adopt He-W 571, previously effective 12/29/95 (Document #6158) and expired 12/29/03, to read as follows:

PART He-W 571 DURABLE MEDICAL EQUIPMENT, PROSTHETIC AND ORTHOTIC DEVICES, AND MEDICAL SUPPLIES

He-W 571.01 Definitions.

- (a) “Date of service” means the date that the durable medical equipment, prosthetic or orthotic device, or medical supply is delivered to the recipient.
- (b) “Department” means the New Hampshire department of health and human services.
- (c) “Durable medical equipment (DME)” means a non-disposable device that can withstand repeated use, that is appropriate for in-home use for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury, and that is not useful to a person in the absence of an acute or chronic medically diagnosed health condition, illness, or injury.
- (d) “Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, or the recommendations of physician specialists practicing in relevant clinical areas.
- (e) “Healthy kids-gold” means the program administered by the department under which the assistance authorized by Title XIX of the Social Security Act is made available to eligible individuals under the age of 19.
- (f) “Item” means any DME, prosthetic or orthotic device, or medical supply.
- (g) “Medicaid” means the Title XIX program administered by the department, which makes medical assistance available to eligible individuals who are age 19 or over.
- (h) “Medically necessary” means health care services including DME, prosthetic devices, orthotic devices, or medical supplies that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:
  - (1) Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient’s illness, injury, disease, or its symptoms;
  - (2) Not primarily for the convenience of the recipient or the recipient’s family, caregiver, or health care provider;
  - (3) No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient’s illness, injury, disease, or its symptoms; and

(4) Not experimental, investigative, cosmetic, or duplicative in nature.

(i) “Medical supplies” means consumable or disposable items appropriate for in-home use for relief or treatment of a specific medically diagnosed health condition, illness, or injury.

(j) “Monthly quantity” means the amount of supplies allowed per calendar month.

(k) “Orthotic” means an orthopedic item that is applied externally to the limb or body, to:

- (1) Provide protection;
- (2) Support a weak or deformed portion of the body; or
- (3) Prevent or correct a physical deformity or malfunction.

(l) “Prosthetic device” means a non-dental, artificial appliance or part used to:

- (1) Replace a missing portion of the body; or
- (2) Replace a missing function of the body.

(m) “Recipient” means any individual who is eligible for and receiving medical assistance under programs entitled healthy kids-gold or medicaid.

(n) “Title XIX” means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under programs entitled healthy kids-gold and medicaid.

He-W 571.02 Recipient Eligibility. All Title XIX recipients shall be eligible to receive prosthetic devices, orthotic devices, DME, and medical supplies as prescribed by a physician, physician assistant, or an advanced registered nurse practitioner (ARNP) in accordance with policy and limitations set forth in He-W 571, except that recipients residing in nursing facilities shall not be eligible to receive medical supplies and non-customized DME.

He-W 571.03 Provider Participation. Each participating provider of DME, prosthetic devices, orthotic devices, or medical supplies shall:

- (a) Be a New Hampshire-enrolled Title XIX provider; and
- (b) Request and obtain prior authorization (PA) from the department in accordance with He-W 571.06.

He-W 571.04 Covered Services.

(a) With the exception of those items listed in He-W 571.05, the following DME, prosthetic or orthotic devices, and medical supplies shall be covered as follows:

- (1) The following items shall be covered when prescribed and supported by a letter of medical need (LMN) written by the ordering physician, physician assistant, or ARNP:

- a. Purchase of prosthetic devices;
- b. Purchase of orthotic devices;
- c. Purchase of specialty formulas prescribed for life-sustaining purposes; and
- d. Purchase of specialty formulas and food products prescribed for metabolic diseases in accordance with RSA 415:6-c;

(2) The LMN in (1) above shall contain:

- a. The recipient's name, address, and NH Title XIX identification number;
- b. The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;
- c. An estimation of the effect on the recipient if the requested item(s) is not provided;
- d. The medical justification for the item(s) being requested;
- e. The recommended timetable of the prescribed treatment with use of the item(s);
- f. The expected outcome of providing the requested item(s);
- g. The recommended timeframe to achieve the expected outcome;
- h. A summary of any previous treatment plans, including outcomes, which were used to treat the diagnosed condition for which the requested item(s) is being recommended; and
- i. Assurance that the requested item or covered service is the least restrictive, least costly item or covered service available to meet the recipient's needs;

(3) Repair of prosthetics and orthotics shall be covered;

(4) Purchase of medical supplies shall be covered for continuous use or on an as needed basis, when prescribed, or supported by a LMN written by the ordering physician, physician assistant, or ARNP, and subject to the following:

- a. The prescription or LMN shall be valid for one year from the date written so long as the medical treatment remains unchanged;
- b. The prescription or LMN shall include:
  - 1. The recipient's name, address, and NH Title XIX identification number;
  - 2. The recipient's diagnosis and prognosis, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;

3. The specific monthly quantity(s) to be dispensed;
4. The specific type of supply(s) to be dispensed; and
5. The frequency of use for the supply(s) being dispensed;

c. Supporting documentation shall be maintained to justify monthly quantity(s) and type of supply(s) prescribed; and

d. The prescription or LMN shall not be written retroactively;

(5) DME shall be covered in accordance with He-W 571.06; and

(6) Coverage of DME for nursing facility residents shall be limited to customized devices not included in the nursing facility rate determined in accordance with He-E 806;

(b) For any item not specifically identified in He-W 571.04 through 571.06, for any item identified as non-covered pursuant to He-W 571.05, and for any item for which a prior authorization request has been made and denied pursuant to He-W 571.06 and 571.07, a recipient may submit to the department a written request for coverage as follows:

(1) The written request shall be submitted on Form 272EX, “Request for Independent Clinical Review for Coverage”;

(2) All applicable sections of Form 272EX, including signature and date lines, shall be completed by the recipient and ordering provider, as specified; and

(3) All supporting documentation, as specified on the Form 272EX, shall be provided.

(c) The department shall cover items that are requested in accordance with (b) above, if one of the following criteria is met:

(1) The DME, prosthetic or orthotic device, or medical supply meets Medicare or New Hampshire or New England commercial insurance coverage criteria, found at <http://www.cms.hhs.gov/coverage/default.asp>, [http://www.tricenturion.com/content/lcd\\_current\\_dyn.cfm](http://www.tricenturion.com/content/lcd_current_dyn.cfm), or <http://www.newenglandhealthcare.com/Insurance.html>;

(2) The DME, prosthetic or orthotic device, or medical supply does not meet Medicare or New Hampshire or New England commercial insurance coverage criteria found at the websites listed in (1) above, but the item meets the definition of medically necessary;

(3) The item does not meet the definition of medically necessary, but the department’s independent clinical review finds that there are extenuating circumstances unique to the recipient that would make a denial for coverage clinically contraindicative; or

(4) The item does not meet the definition of medically necessary, but the department’s independent clinical review finds that new scientific evidence exists in the medical literature or

by experts in the field about the efficacy or medical appropriateness of the requested item, and the department determines that the original basis for non-coverage was based on the previous lack of such evidence.

(d) Written confirmation of a department approval for coverage shall be sent to the recipient and the ordering provider, as specified on Form 272EX.

(e) If the requested item is determined to be non-covered by the department, the department shall forward a notice of non-coverage to the recipient and the provider on Form 272nc, “Non-Covered Based Upon Independent Clinical Review” including:

- (1) The reason that the request did not meet the criteria in (c) above; and
- (2) Instructions that a fair hearing may be requested, in accordance with He-C 200, by the recipient within 30 calendar days of the date of the non-coverage notice.

(f) Decisions made by the department in accordance with (c) above shall not be superseded by the treating or consultive health care professional’s prescription, orders, or recommendations.

He-W 571.05 Non-Covered Services. The following items shall not be covered:

(a) Nutritional supplements when not needed to sustain life, except for recipients under the age of 21 who have a failure to thrive diagnosis, which shall be subject to He-W 546.06;

(b) Common, over-the-counter household and medicine chest items, including:

- (1) Band-aids;
- (2) Corn plasters;
- (3) Nursery supplies;
- (4) Thermometers;
- (5) Odor barrier products;
- (6) Personal hygiene items, including disposable diapers and disposable incontinence garments, liners, under pads, and wipes, except for recipients who are at least age 3 and under the age of 21 who meet the requirements set forth at He-W 546.06;
- (7) Room vaporizers;
- (8) Room humidifiers;
- (9) Foot pads;
- (10) Items specified in accordance with He-W 570.05(d);

(c) Environmental modifications and controls, including:

- (1) Wheelchair ramps;
  - (2) Tub rails;
  - (3) Air conditioners;
  - (4) Wheelchair remote controls;
  - (5) Air purifiers;
  - (6) Humidifiers;
  - (7) Vaporizers;
  - (8) Power generators;
  - (9) Aromatherapy;
  - (10) Stairway elevators;
  - (11) Heaters;
  - (12) Fans;
  - (13) Adaptive or computer switch toys; and
  - (14) Ceiling tract lifting devices;
- (d) The following wheelchair accessories and options:
- (1) Air suspension systems;
  - (2) Light packages;
  - (3) Baskets and horns;
  - (4) Attendant control switches;
  - (5) Power seat lift mechanisms;
  - (6) Power assist devices or equipment to modify a manual wheelchair into a power wheelchair;
  - (7) Any wheelchair accessory or option for purposes of allowing the recipient to perform leisure, social, or recreational activities; and
  - (8) Grade aids and anti-roll devices for manual wheelchairs;

- (e) Items typically not used by the general public for a medical purpose, including:
  - (1) Furniture for non-mobility purposes;
  - (2) Back cushions;
  - (3) Massage tables and equipment; and
  - (4) Therapy tables and equipment;
- (f) Titanium framed and sport-type wheelchairs;
- (g) Back-up wheelchairs for recipients who already have a manual wheelchair, power wheelchair, power scooter, or custom stroller;
- (h) Wheelchairs with stair climbing options;
- (i) Wheelchairs with power stander and seat lift options;
- (j) Repairs and adjustments to rented DME;
- (k) Repairs and adjustments to purchased DME within the provider's or manufacturer's warranty;
- (l) Devices that contribute to or enhance fertility or procreation;
- (m) Gait trainers, except for recipients who have a reasonable degree of medical certainty of gaining functional ambulation as documented in the recipient's goal-oriented care plan;
- (n) Strollers, except for recipients who:
  - (1) Are age 6 and older;
  - (2) Are non-ambulatory;
  - (3) Meet the criteria for wheelchair approval in He-W 571.06(f)(2) and (g)(2);
  - (4) Do not already have a wheelchair; and
  - (5) Have mobility needs that will not be met by a commercially available stroller with adaptations;
- (o) Back-up equipment, which does not meet the criteria described in He-W 571.06(h);
- (p) Recreational, therapy, and exercise equipment, including, bicycles and tricycles, mats, tables, and swings;
- (q) Replacement or repair of DME, prosthetic devices, orthotic devices, and medical supplies as a result of:

- (1) Recipient abuse, misuse, or inappropriate use or neglect;
  - (2) Failure to protect the item from the weather;
  - (3) Using the item inappropriately or contrary to its designed and intended use;
  - (4) Making improper repairs to the item, which would void any manufacturer's warranty;
  - (5) Loss of item or supply resulting from reckless or willful disregard of the consequences to the item or supply, by a reasonable person, when basic safeguarding measures could have been instituted;
  - (6) Failure to maintain the item through proper routine maintenance by an authorized dealer;  
or
  - (7) Taking any action that would otherwise void the manufacturer's warranty;
- (r) Items typically used by the general public for preventing injury or ensuring safety, including:
- (1) Customized beds, except for recipients who are at least age 4 and under the age of 21, who meet the requirements set forth at He-W 546.06;
  - (2) Customized car seats, with the exception of those used for recipients who have a neuromotor diagnosis whose needs cannot be met by a commercially available car seat with minor adaptations that do not reduce the effectiveness or safety of the car seat nor make the manufacturer's warranty null and void;
  - (3) Helmets, with the exception of those needed by:
    - a. Recipients with drop seizures; or
    - b. Recipients with severe head-banging disorders;
  - (4) Pneumatic vests and lumbar supports; and
  - (5) Molding helmets except when all of the following criteria are met:
    - a. The recipient is at least 3 months of age but not greater than 18 months of age;
    - b. The recipient has marked asymmetry that has not been substantially improved following conservative therapy of at least 2 months duration with cranial repositioning therapy and/or physical therapy; and
    - c. The asymmetry of the cranial base shall be documented by one of the following:
      1. Skull base asymmetry shall be at least 6 mm right or left discrepancy measured subnasally to the tragus, which is the cartilaginous projection of the auricle at the front of the ear; or

2. Cranial vault asymmetry shall be at least 10 mm right or left discrepancy, measured obliquely from the supraorbital point to the parietooccipital scalp at the midpoint of maximal convexity and from the supraorbital point to the parietooccipital scalp at the midpoint of the flattened area, or a ratio of these 2 measurements is greater than 1.1;

(s) Service animals and related expenses;

(t) Clothing items;

(u) Items, supplies, or devices which are more costly than other available items, supplies, or devices, which could be expected to provide the same, similar, or duplicate outcome;

(v) Upgrades to or replacement of any functioning DME that still meets the recipient's needs, including external insulin infusion pumps, ventilators, and glucose meters; and

(w) Apnea monitors for the prevention of sudden infant death syndrome (SIDS), except when the criteria in He-W 571.06(c)(2) have been met.

He-W 571.06 Prior Authorization Requirements. Prior authorization (PA) shall be required as follows:

(a) Prior authorization (PA) shall be required for the items listed in (b)(1) through (b)(19) below;

(b) Coverage for the following items shall be governed in accordance with current medicare criteria published at the time of coverage determination, found at <http://www.cms.hhs.gov/coverage/default.asp> and [http://www.tricenturion.com/content/lmrp\\_current\\_dyn.cfm](http://www.tricenturion.com/content/lmrp_current_dyn.cfm):

(1) Pressure-reducing surfaces;

(2) Enteral pumps;

(3) Hospital beds and accessories when prescribed;

(4) External infusion pumps, with the exception of insulin pumps, which shall be subject to the criteria set forth in (d)(2) below;

(5) Negative pressure wound therapy pumps;

(6) Pneumatic compression devices;

(7) Recipient lifts;

(8) Transcutaneous electrical nerve stimulators (TENS);

(9) Trapeze bars;

(10) Bi-level positive airway pressure (BiPAP) machines for conditions other than sleep apnea;

- (11) Osteogenesis stimulators;
  - (12) Parenteral nutrition pumps;
  - (13) Suction machines;
  - (14) Inexsufflators;
  - (15) Voice activated home glucose monitors;
  - (16) Speech generating devices and mounting equipment;
  - (17) Seat lift mechanisms;
  - (18) Continuous passive motion machines; and
  - (19) Oxygen compressors and humidification devices;
- (c) For apnea monitors:
- (1) PA shall be required;
  - (2) PA shall be approved for infants when at least one of the following 2 criteria is met:
    - a. The infant is premature, born prior to 38 weeks gestation, and has a history of apnea, which is defined as when breathing stops for 20 seconds or longer, and is accompanied by:
      - 1. Bradycardia; or
      - 2. Oxygen desaturation; or
    - b. The infant has experienced an apparent life-threatening event, which is defined as some combination of the following:
      - 1. Apnea;
      - 2. Change in skin color;
      - 3. Marked change in muscle tone; or
      - 4. Choking and gagging; and
  - (3) The PA approved in (c)(2) above shall be valid until the infant has experienced no apnea episodes for 6 weeks;
- (d) For external insulin pumps for the treatment of insulin-dependent diabetes (Type 1):

(1) PA shall be required;

(2) PA shall be approved when all of the following criteria are met:

- a. The recipient is involved in a comprehensive diabetes education program;
- b. The recipient has received 3 or more daily insulin injections for at least 6 consecutive months;
- c. The recipient has self-monitored their own blood sugar at least 4 times per day for the past 2 months;
- d. The recipient and recipient's family demonstrate the ability to carbohydrate count using insulin-to-carbohydrate ratios as well as insulin correction factors;
- e. The recipient has a history of recurrent hypoglycemia with wide fluctuations in blood glucose, in spite of recipient compliance;
- f. The recipient has dawn phenomenon with fasting sugars frequently exceeding 200 mg/dl;
- g. The recipient has a history of severe glycemic excursions;
- h. The ordering health care provider has provided supporting medical documentation with requests for external insulin pumps; and
- i. An endocrinologist, or physician with similar skill and training as the endocrinologist in the management of external insulin pumps, prescribes the pump and is involved with the medical care of the recipient; and

(3) PA for the purchase of an external insulin pump approved in (d)(2) above shall be limited to one pump per recipient every 4 years;

(e) PA shall be required for wigs, which shall be covered subject to RSA 415:18-d;

(f) For manual wheelchairs, accessories, and modifications:

(1) PA shall be required; and

(2) PA shall be approved in accordance with the following criteria:

a. The recipient's primary health care provider shall prescribe the manual wheelchair and prepare the following documentation for submittal with the PA request:

1. Written diagnosis including a brief medical history justifying the need for the manual wheelchair;
2. An estimate of the length of time the manual wheelchair will be required; and

3. Form 272M, “Mobility Evaluation Form,” submitted by the selected wheelchair vendor;
- b. The recipient shall have a disease process or injury:
    1. That would contraindicate weight bearing or ambulation; and
    2. In which there is a decrease in neuromuscular function that prevents independent ambulation, with or without a walker or cane;
  - c. The item is not solely for the convenience of the recipient, recipient’s family member, recipient’s caregiver, or provider;
  - d. The manual wheelchair shall provide sufficient growth potential in seat depth, seat width, and weight capacity to provide at least 5 years of service for the recipient;
  - e. The recipient shall not already have a stroller or other mobility device; and
  - f. Replacement of manual wheelchairs shall only be permitted when the existing wheelchair cannot be repaired or modified, and replacement shall be limited to no more than once every 5 years;
- (g) For power wheelchairs, power operated vehicles, accessories, and modifications:
- (1) PA shall be required; and
  - (2) PA shall be approved in accordance with the following criteria:
    - a. The power wheelchair shall have been prescribed by a primary health care practitioner with a specialty related to the condition for which the wheelchair is being prescribed;
    - b. The recipient shall:
      1. Have a condition in which there is a disease process or injury where there is decreased neuromuscular function that prevents independent ambulation, with or without a walker or cane;
      2. Have a condition in which there is a disease process or injury that would contraindicate weight bearing or ambulation;
      3. Be unable to propel a manual wheelchair because of a disease process, injury, or disability;
      4. Be able to safely and independently operate a power wheelchair; and
      5. Not already have a stroller or other mobility device;

c. Replacement of power wheelchairs shall only be permitted when the existing power wheelchair cannot be repaired or modified, and replacement shall be limited to no more than once every 5 years; and

d. PA shall be required for repairs to non-rental power wheelchairs if the repairs total \$800 or more;

(h) Coverage of back-up equipment shall be limited to those situations where the recipient's health would be endangered without such equipment, as determined by the department in accordance with He-W 571;

(i) For continuous positive airway pressure (CPAP) machines.:

(1) PA shall be required; and

(2) PA shall be approved in accordance with the following:

a. The recipient shall have a diagnosis of obstructive sleep apnea (OSA) diagnosed and documented by an attended, facility-based polysomnogram;

b. The polysomnographic study shall be performed at a medicare certified sleep study center;

c. One of the following 2 clinical criteria shall be met:

1. The apnea-hypopnea index (AHI), which is the average number of episodes of apnea and hypopnea per hour of sleep based on a minimum of 2 hours of sleep, is greater than or equal to 15 events per hour; or

2. The AHI is from 5 to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, and insomnia; and

(i) Hypertension, ischemic heart disease, or a history of stroke; or

(ii) More than 20 episodes of oxygen desaturation less than 85%, or any one episode of oxygen desaturation of less than 70%, during a full-night sleep study;

d. If the criteria specified in (2)a. through (2)c. above are met, then a 2-month trial rental of CPAP shall be authorized prior to the purchase of the CPAP machine, to ensure recipient compliance;

e. The recipient compliance described in (2)d. above shall be documented by:

1. A polysomnogram conducted in accordance with (2)a. and (2)b. above; and

2. A compliance report documenting that the recipient is gaining sufficient benefit from the CPAP machine, as evidenced by a downloaded recording from the machine showing usage of a minimum of 4 hours per night;

f. The documentation in (2)e. above shall be submitted by the requesting DME provider to the department, along with a PA request for a CPAP purchase following the 2-month trial period; and

g. The department shall only pay for the purchase or any future rental of the CPAP machine if the compliance report in (2)e.2. above reveals that the recipient is gaining sufficient benefit from the CPAP machine and if the recipient is compliant;

(j) PA shall be required and approved for BiPAP machines only when the department has determined that the CPAP machine was not effective in treating the recipient's OSA;

(k) PA shall be required for any DME billed with any miscellaneous procedure code;

(l) For high-frequency chest compression (HFCC) devices:

(1) PA shall be required;

(2) PA shall be approved for a 2-month trial rental period in accordance with the following:

a. The recipient shall be at least 2 years old;

b. The recipient shall have a documented need of airway clearance;

c. The recipient shall have one of the following documented diagnoses:

1. Cystic fibrosis;

2. Chronic bronchiectasis; or

3. Chronic neuromuscular disorder and prior history of pneumonia or other significant worsening of pulmonary function; and

d. The recipient shall have documented failure of other methods, or inability to use other airway clearance therapies, including chest physical therapy, or no available parental or partner resource to perform chest physical therapy;

(3) Recipient and family compliance and sufficient benefit from usage during the 2-month trial rental period shall be documented by:

a. A report completed by a pulmonologist documenting the recipient's comfort, tolerance, and willingness to use the device;

b. A report completed by a pulmonologist demonstrating that the recipient has sufficiently benefited from the use of the HFCC as evidenced by clinical indications, including:

1. Improvement in forced expiratory volume (FEV1); or
  2. A reduction in the number of hospitalizations;
  - c. A statement signed by the pulmonologist, which may be part of the report in (3)b. above, that the recipient has sufficiently benefited from the use of the HFCC and that the pulmonologist recommends continued usage of the HFCC; and
  - d. A usage meter report generated by the DME provider documenting usage at least 67% of the prescribed time;
- (4) The documentation in (3) above shall be submitted by the requesting DME provider to the department, along with a request for PA of future rental, following the 2-month trial rental period; and
- (5) The department shall determine the allowability of, and the duration of, authorization for future periods of time, not to exceed one year, based upon clinical evidence of compliance and benefit as demonstrated in (3) above; and
- (m) For oximeters:
- (1) PA shall be required; and
  - (2) PA shall be approved when one of the following criteria are met:
    - a. The recipient is being assessed by his or her primary care practitioner or pulmonary specialist, to determine if supplemental oxygen is required;
    - b. The recipient has been on supplemental oxygen and an oximeter is requested to determine if he or she can be weaned from the supplemental oxygen; or
    - c. The recipient is receiving supplemental oxygen and is experiencing widely fluctuating oxygen saturation levels and an oximeter is required to assist in determining the cause, frequency, and duration of the fluctuation to properly determine the oxygen flow rate.

He-W 571.07 Submittal of Prior Authorization Requests.

- (a) All PA requests set forth in accordance with He-W 571.06 shall be sent to the department.
- (b) The PA requests in (a) above shall include:
  - (1) A signed prescription; and
  - (2) A narrative description of the recipient's medically diagnosed health condition, illness, or injury, signed by the requesting provider, stating the need for the specific item or service requested, which explains and documents the medical purpose.

(c) For all DME, with the exception of power wheelchairs and specialty stroller prescriptions, the signature on the prescription described in (b)(1) above shall be by a physician, physician assistant, or ARNP.

(d) For power wheelchairs and specialty stroller prescriptions, the signature on the prescription described in (b)(1) above shall be by a physician who specializes in the condition for which the wheelchair or specialty stroller is being prescribed.

(e) Form 272D “Durable Medical Equipment (DME) Prior Authorization Request Form” shall be submitted to the department with all DME requests, completed and signed by an authorized provider representative.

(f) In addition to submitting Form 272D in accordance with (e) above, Form 272M, the “Mobility Evaluation Form,” shall also be submitted to the department with all wheelchair, scooter, and specialty stroller requests, including:

- (1) A dated signature of the physician, licensed therapist or rehabilitation specialist completing the evaluation;
- (2) A dated signature, address, and printed name of the parent or legal guardian, if applicable; and
- (3) A dated signature and printed name of the DME vendor acknowledging the inclusiveness of services included in the NH Title XIX payment for the DME.

(g) In addition to submitting Form 272D in accordance with (e) above, Form 272EQ, the “Medical Equipment Request Evaluation Form” shall also be submitted to the department for the following non-mobility equipment requests:

- (1) Standers;
- (2) Gait trainers;
- (3) Feeding seats; and
- (4) Bath and toileting items.

(h) Form 272EQ shall include:

- (1) A dated signature of the NH licensed physical therapist, occupational therapist, or physician completing the evaluation;
- (2) The name of the individuals present during the evaluation, and their relationship to the recipient;
- (3) The recipient’s dated signature indicating acceptance of the recommended DME, or non-acceptance of the recommendations with the reasoning explained; and

- (4) A dated signature and printed name of the DME supplier, acknowledging the inclusiveness of services included in the NH Title XIX payment for the DME.
- (i) Requests for PAs shall be approved by the department if the department determines the following:
- (1) The item meets the definition of DME pursuant to He-W 571.01(c);
  - (2) The item is included as a medicaid-covered DME item, in accordance with He-W 571.04;
  - (3) The medical documentation submitted is in accordance with He-W 571.07;
  - (4) The coverage criteria established by medicare, He-W 571.04, or He-W 571.06 is met;
  - (5) The cost of the item is cost effective, as determined by a finding that:
    - a. There is no other less costly item, as identified by the department, that would effectively meet the recipient's needs; or
    - b. Less expensive, appropriate alternatives are not covered or generally not available;and
  - (6) The recipient's dated acknowledgment and signature accepting the recommended wheelchair and options, or not accepting the recommendations with reasoning explained.
- (j) Decisions made by the department in accordance with (i) above and He-W 571.06 shall not be superseded by the treating practitioner's prescription, orders, or recommendations.
- (k) If the department approves the PA request, the state's fiscal agent shall send written confirmation of the approval to the provider.
- (l) The provider shall be responsible for determining that the recipient is Title XIX eligible on the date of service, or for custom wheelchairs, on the date the custom wheelchair is ordered.
- (m) If the department denies the PA request, the department shall forward a notice of denial to the recipient and the ordering provider on the department Form 272a, "Medical Assistance Program Denial for Prior Authorized Services" including the following:
- (1) The reason for, and legal basis of, the denial;
  - (2) Information that a request for an independent clinical review on the denial may be requested in accordance with He-W 571.04(b) within 30 calendar days of the date on the notice of the denial; and
  - (3) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

He-W 571.08 Documentation.

- (a) The provider shall maintain supporting records in accordance with He-W 520.

(b) The provider shall maintain all letters of medical need described in He-W 571.04.

(c) Documentation of adjustments to and inspections of equipment shall be maintained in the provider's records.

(d) The provider shall maintain documentation showing the date and proof of delivery of all items, supplies, and equipment to the recipient, or date of order for custom wheelchairs.

He-W 571.09 Third Party Liability. All third party obligations shall be exhausted before claims shall be submitted to the department or its fiscal agent in accordance with 42 CFR 433.139.

He-W 571.10 Utilization Review and Control. The department shall monitor utilization of DME, prosthetic devices, orthotic devices, and medical supplies, in accordance with 42 CFR 455 and 42 CFR 456.

He-W 571.11 Payment for Equipment, Devices, and Supplies.

(a) The department shall determine rates for all DME, prosthetic devices, orthotic devices, and medical supplies in accordance with RSA 161:4, VI(a).

(b) The DME, prosthetic device, orthotic device, and medical supply providers shall submit claims for payment to the department's fiscal agent.

(c) Billing of and payment for prosthetics, orthotics, DME, medical supplies, and repair parts shall be made at the lesser of:

(1) The provider's usual and customary charge to the public, as defined in RSA 126-A:3, III(b);

(2) The lowest amount the provider accepts from any other third party payor; or

(3) The rate established by the department.

(d) Payment for labor costs for repairs shall be at a rate established by the department.

(e) Payment shall be denied if the recipient is not eligible on the date of service, with the exception of (f) below.

(f) For the following items only, payment shall be denied if the recipient is not eligible on the date of the order:

(1) Customized wheelchairs;

(2) Custom fabricated prosthetics;

(3) Custom fabricated orthotics; and

(4) Frame and seating growths to pediatric and adult wheelchairs.

(g) No DME item, prosthetic device, orthotic device, medical supply, or service shall be paid prior to delivery of the DME item, prosthetic device, orthotic device, medical supply, or service to the recipient.

(h) In accordance with the payment rates established in (a) above, the rate for wheelchairs shall include the following required provider services:

- (1) Delivery and assembly of the wheelchair;
- (2) Training to the recipient and recipient's family and other care giver(s) in the use of the equipment, maintenance care, and equipment diagnostics; and
- (3) Wheelchair adjustments at the end of the first 30 days

(i) Providers shall supply a comparable substitute wheelchair for 2 weeks during the repair of the original wheelchair. For repairs that require more than 2 weeks to complete, the provider shall seek PA for a rental fee.

## Appendix

<b>Section</b>	<b>Title</b>	<b>Federal Reg./RSA</b>
He-W 571.01	Definitions	42 CFR 440.120
He-W 571.02	Recipient Eligibility	42 CFR 440.210; 42 CFR 440.220
He-W 571.03	Provider Participation	42 CFR 440.50; 42 CFR 440.60; 42 CFR 440.166; RSA 328-D:1
He-W 571.04	Covered Services	RSA 415:6-C; RSA 415:18-n; 42 CFR 440.230; 42 CFR 440.130(a)
He-W 571.05	Non-Covered Services	42 CFR 440.230(d)
He-W 571.06	Prior Authorization	42 CFR 440.230(d); 42 CFR 456.3; 42 CFR 431.07
He-W 571.07	Submittal of Prior Authorization Requests	42 CFR 440.230(d); 42 CFR 431.107; RSA 126-A:5, VII
He-W 571.08	Documentation	42 CFR 431.107
He-W 571.09	Third Party Liability	42 CFR 433.139
He-W 571.10	Utilization and Control	42 CFR 455; 42 CFR 456
He-W 571.11	Payment for Equipment, Devices, and Supplies	42 CFR 447.15