RULEMAKING NOTICE FORM

Notice Number	**2015-144**	Rule Number	**He-W 571**

1. Agency Name & Address:

NH Dept. of Health & Human Services
Office of Medicaid Business and Policy
129 Pleasant Street
Concord, NH 03301

2. RSA Authority: **RSA 161:4-a, X**
3. Federal Authority:
4. Type of Action:
   - Adoption
   - Amendment
   - Repeal
   - Readoption
   - Readoption w/amendment **X**

5. Short Title: **Durable Medical Equipment, Prosthetic and Orthotic Devices, and Medical Supplies**

6. (a) Summary of what the rule says and of any proposed amendments:

He-W 571 describes the requirements for coverage of durable medical equipment (DME), prosthetic and orthotic devices, and medical supplies under the NH Medicaid program, including covered items, non-covered items, and those items requiring prior authorization. This rule is intended to clarify current coverage and prior authorization practices and to efficiently manage the utilization of high-cost equipment and supplies while ensuring that the clinical need is met by the appropriate item.

This proposal makes substantive changes based upon the experiences of the Department's Program Integrity and Medicaid units, and the changes made to clinical criteria are based upon Medicare criteria, other state Medicaid programs, or private insurers. Changes have also been made to the organization of the rule for increased clarity and readability.

The proposed rule includes the following changes:

- **Definitions were added for terms which were used throughout the rule but were not previously defined, including "life sustaining," "mobility devices," "letter of medical necessity," and "prior authorization agent." The definition for "date of service" reflects requirements elsewhere in the rule, including the new requirement that for fabricated prosthetic and orthotic devices "date of service" means the date the item is fabricated. Definitions were added to distinguish between "providers" who prescribe or order items and "dispensing providers" who furnishing the items.**
- **Coverage for wheelchairs will require that the evaluation must be performed by either an occupational or physical therapist, which has been a requirement listed on a Department form but not previously included in the rule.**
- **Coverage criteria for prosthetic devices will now exclude fingers, thumbs, and toes.**
- **Coverage of incontinence supplies will clarify that coverage includes toileting wipes used for the condition, and includes incontinence secondary to a disease or condition that causes incontinence or caused by tardive dyskinesia.**
- **Coverage for CPAP machines will now include the requirement that the symptoms of sleep apnea must impair performance of activities of daily living.**
- **Clinical coverage criteria for BiPaP machines and for functional electric stimulation will now be included in the rule.**

- **Clinical coverage criteria for recipients under the age of 21 for items including customized strollers, gait trainers, standers, HFCC vests, and pediatric beds will now be included in the rule, and are based upon the private insurance markets' coverage of these items, in order to provide clarity for dispensing providers.**
- **Requirements for maintaining documentation and tying payment to maintaining documentation have been added to the rule. These include documentation that the provider conducted a face-to-face encounter with the recipient no earlier than 60 days before the prior authorization request, stipulation that no payment will be made for items left unattended which are destroyed or made unusable due to actions of the dispensing provider, and that the supply of a substitute wheelchair when the recipient's wheelchair is being repaired is at no cost for two 2 weeks. The requirement that dispensing providers maintain documentation in support of claims for 6 years is not a new requirement because it is part of the provider agreement each provider signs with the Department.**

Most of this rule expires on August 20, 2015, subject to extension pursuant to RSA 541-A:14-a.

6. (b) Brief description of the groups affected:

This rule affects NH Medicaid enrolled providers of DME, prosthetic and orthotic devices, and medical supplies, as well as Medicaid recipients who utilize these items.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

Rule	Federal Reg./RSA
He-W 571.01	42 CFR 440.120
He-W 571.02	42 CFR 440.210; 42 CFR 440.220
He-W 571.03	42 CFR 440.50; 42 CFR 440.60; 42 CFR 440.166; 42 CFR 431.107; RSA 328-D:1
He-W 571.04	RSA 415:6-c; RSA 415:18-n; RSA 415:18-d; RSA 126-A:5,VII;42 CFR 440.230; 42 CFR 440.130(a)
He-W 571.05	42 CFR 440.230(d); 42 CFR 456.3
He-W 571.06	42 CFR 440.230(d); 42 CFR 456.3
He-W 571.07	42 CFR 431.107; 42 CFR 455 Subparts A and B; 42 CFR 447 Subparts A and B; 42 CFR 456 Subparts A and B
He-W 571.08	42 CFR 431.107, 42 CFR 433 Subpart D
He-W 571.09	42 CFR 455 Subparts A and B; 42 CFR 456 Subparts A and B
He-W 571.10	42 CFR 455 Subparts A and B; 42 CFR 456 Subparts A and B, 42 CFR 447.45; RSA 161:4, VI(a); RSA 126-A:3, III(b)

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Michael Holt** Title: **Rules Coordinator**

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TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
http://www.dhhs.nh.gov/oos/aru/comment.htm

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Wednesday, September 30, 2015**

☒Fax ☒E-mail ☐Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Wednesday, September 23, 2015 at 10:00 AM**

Place: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **15:152**, dated **08/14/15**

1. Comparison of the costs of the proposed rule(s) to the existing rule(s):

When compared to existing rules, the proposed rules will increase state expenditures, costs to State citizens, and costs to independently owned businesses that provide durable medical equipment, prosthetics and orthotic devices, and medical supplies.

2. Cite the Federal mandate. Identify the impact of state funds:

No federal mandate, no impact on state funds.

3. Cost and benefits of the proposed rule(s):

A. To State general or State special funds:

The added coverage criteria for incontinence supplies will increase State expenditures by an indeterminable amount in the State Medicaid program. Half of this cost will be to the state and the remaining portion will be paid with federal funds. He-W 571.10 (m) clarifies that dispensing providers shall replace items rendered unusable from destruction or damage due to being left unattended. This may result in savings to the State. There will be no impact on any State special fund.

B. To State citizens and political subdivisions:

There may be additional costs to State citizens who are participants in the Medicaid program as some recipients may not meet the new coverage criteria for a particular item. There will be no impact on political subdivisions.

C. To Independently owned businesses:

There may be additional costs to wheelchair providers who will be required to provide a substitute wheelchair at no cost for two weeks during a wheelchair repair. There will be additional cost to providers due to the new documentation requirements concerning the required face-to-face contact with recipients and prior authorization. He-W 571.10 (m) clarifies that dispensing providers shall replace items rendered unusable from destruction or damage due to being left unattended. This may result in additional costs if a provider leaves an item unattended.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rule modifies an existing program or responsibility, but does not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.

Readopt with amendments He-W 571, effective 8-20-07 (Document #8961), as amended effective 9/21/07 (Document #8983), as amended effective 3-12-08 (Document #9103), as amended effective 1-16-10 (Document #9637), as amended effective 12-18-10 (Document#9836), and as amended effective 7/1/12 (Document #10139), cited and to read as follows:

CHAPTER He-W 500 MEDICAL ASSISTANCE

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) "Item" means any DME, prosthetic or orthotic device, or medical supply.~~

~~(e) "Medicaid" means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.~~

~~(f) "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.~~

~~(g) "Monthly quantity" means the amount of supplies allowed per calendar month.~~

~~(h) "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.~~

~~(i) "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.~~

~~(j) "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.~~

~~(k) "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 the medicaid program.~~

(l) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

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. 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:

(a) 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:

(1) Purchase of prosthetic devices;

(2) Purchase of orthotic devices;

(3) Purchase of specialty formulas prescribed for life-sustaining purposes; and

(4) Purchase of specialty formulas and food products prescribed for metabolic diseases in accordance with RSA 415:6-c;

(b) The LMN in (a) above shall contain:

(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) An estimation of the effect on the recipient if the requested item(s) is not provided;

(4) The medical justification for the item(s) being requested;

(5) The recommended timetable of the prescribed treatment with use of the item(s);

(6) The expected outcome of providing the requested item(s);

(7) The recommended timeframe to achieve the expected outcome;

(8) 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

(9) 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;

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

(d) Purchase of medical supplies, with the exception of disposable incontinence supplies for adults, 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:

(1) The prescription or LMN shall be valid for one year from the date written so long as the medical treatment remains unchanged;

(2) The prescription or LMN shall include:

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. The specific monthly quantity(s) to be dispensed;

d. The specific type of supply(s) to be dispensed; and

e. The frequency of use for the supply(s) being dispensed;

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

(4) The prescription or LMN shall not be written retroactively;

(e) DME and disposable incontinence supplies for adults shall be covered in accordance with He-W 571.06; and

(f) 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.

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) Room vaporizers;~~

~~(7) Room humidifiers;~~

~~(8) Foot pads;~~

~~(9) 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, or New Hampshire or New England commercial insurance coverage criteria, published at the time of coverage determination as described in (o) and (p) below:

(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;

(n) For disposable incontinence supplies, including chux underpads; incontinence briefs, pull-ups, and diapers; and pads/liners:

(1) PA shall be required for those recipients 21 years of age or older;

(2) PA shall be approved:

a. For one year if the recipient's type of incontinence is:

1. Secondary to a disease process or injury to the bladder which results in irreversible loss of control of the urinary bladder and/or rectal sphincter;

2. Secondary to an injury to the brain or spinal cord; or

3. Attributed to a profound cognitive disability, such as severe mental retardation or dementia, that results in an inability to achieve continence through bladder training; and

b. For 6 months if the recipient's type of incontinence is:

1. Secondary to a surgical procedure, such as prostatectomy, resulting in temporary urinary incontinence; or

2. Secondary to an injury to the bladder and/or urinary sphincter, including nerve injury and detrusor muscle instability, resulting in temporary urinary incontinence; and

(3) The following quantity limits shall apply unless the prior authorization request specifies and medically justifies a greater quantity:

a. Chux underpads shall be limited to a total of 3 per day, up to 93 per month, except that if package sizes necessitate dispensing a greater monthly quantity, the monthly quantity shall not exceed 105 per month;

b. Incontinence briefs, pull-ups, and diapers shall be limited to a total of 6 per day, up to 186 per month, except as follows:

1. If package sizes necessitate dispensing a monthly quantity which is greater than 186, the monthly quantity shall not exceed 216 per month; and

2. The provider shall dispense the fewest number of packages that result in a quantity as close as possible to the 186 limit without going under. For example, if a package size is 10 diapers per package, then 19 packages equaling 190 diapers shall be dispensed, not 20 or 21 packages; and

c. Pads and liners used to line undergarments shall be limited to a total of 3 per day, up to 93 per month, except as follows:

1. If package sizes necessitate dispensing a monthly quantity which is greater than 93, the monthly quantity shall not exceed 144 per month; and

2. The provider shall dispense the fewest number of packages that result in a quantity as close as possible to the 93 limit without going under. For example, if a package size is 16 liners per package, then 6 packages equaling 96 liners shall be dispensed, not 17 or 18 or 19 packages;

(o) Current medicare criteria shall be found at;

http://www.cms.gov/medicare-coverage-database/; and

(p) New Hampshire or New England commercial insurance coverage criteria shall be found at:

(1) http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/wi/f5/s1/t4/pw_ad080065.htm&state=wi&rootLevel=0&label=Anthem%20Medical%20Policies;

(2) http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/index.html; or

(3) http://www.aetna.com/cpb/medical/data/cpb_alpha.html.

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) For all DME and disposable incontinence supply requests, a form completed and signed by an authorized provider representative shall be submitted to the department as follows:

(1) A Form 272D, "Durable Medical Equipment (DME) Prior Authorization Request Form," shall be submitted for DME requests; or

(2) A Form 272DIA, "Incontinence Products Prior Authorization Request Form," shall be submitted for disposable incontinence supply requests.

(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, with the exception of disposable incontinence supplies, meets the definition of DME pursuant to He-W 571.01(c);

(2) The item is included as a medicaid covered DME item or a disposable incontinence supply, 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, ordering, or consultative health care professional'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," which includes the following information:

(1) The reason for, and legal basis of, the denial; and

(2) 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) Payment for disposable incontinence supplies, including gloves used for this condition, provided to recipients shall be made only for supplies obtained from the exclusive supplier of incontinence products contracted through the department.

(d) 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.

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

(f) Payment shall be denied or recouped if the provider bills for and is paid for disposable incontinence supplies, including gloves used for such condition, which are not obtained from the exclusive supplier of incontinence products contracted through the department.

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

(h) 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.

(i) 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.

(j) 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

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

He-W 571.01 Definitions.

(a) "Date of service" means:

(1) The date that the item is delivered to or received by the recipient;

(2) For custom wheelchairs, the date the custom wheelchair is ordered;

(3) For custom fabricated prosthetic and orthotic devices, the date of fabrication; or

(4) For frame and seating systems to pediatric and adult wheelchairs, the date of the order.

(b) "Department" means the New Hampshire department of health and human services.

(c) "Durable medical equipment (DME)" means a type of item that is:

(1) Non-disposable and able to withstand repeated use;

(2) Primarily and customarily used to serve a medical purpose for the treatment of an acute or chronic medically diagnosed health condition, illness, or injury; and

(3) Generally not useful to an individual in the absence of an acute or chronic medically diagnosed health condition, illness, or injury.

(d) "Item(s)" means any DME, prosthetic devices, mobility devices, orthotic devices, or medical supplies.

(e) "Dispensing provider" means the company or the company's authorized representative providing the item to the recipient.

(f) "Letter of medical necessity (LMN)" means a letter, signed by the ordering physician, physician assistant, or advance practice registered nurse (APRN), certifying the need for the item being requested.

(g) "Life sustaining" means medical interventions that utilize mechanical or other artificial means to sustain, restore, or supplant a vital function, which serve only or primarily to prolong the moment of death, and where, in the judgment of the attending and consulting physicians, as reflected in the recipient's medical records, death is imminent if such interventions are not utilized.

(h) "Medicaid" means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

(i) "Medical supplies" means a type of consumable or disposable item appropriate for relief or treatment of a specific medically diagnosed health condition, illness, or injury.

(j) "Mobility devices" means a type of item specifically designed for use by individuals with a mobility-related injury, illness, or disability that helps the individual walk or move from place to place, and includes manual and power wheelchairs, strollers, scooters, walkers, gait trainers, crutches, canes, or similar devices.

(k) "Monthly quantity" means the amount of medical supplies allowed per month.

(l) "Orthotic devices" means a type of orthopedic item that is applied externally to the limb or body to:

(1) Protect against injury;

(2) Support a weak or deformed portion of the body; or

(3) Prevent or correct a physical deformity or malfunction.

(m) "Prior authorization agent" means an individual or organization contracted by the department, responsible for reviewing, validating, approving, or denying all prior authorization (PA) requests.

(n) "Prosthetic devices" means a non-dental, artificial type of item or part of an item used to:

(1) Replace a missing portion of the body; or

(2) Replace a missing function of the body.

(o) "Provider" means a New Hampshire licensed ordering physician, APRN, physician assistant, or an ordering occupational or physical therapist specializing in rehabilitation medicine.

(p) "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.

(q) "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 the medicaid program.

(r) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

He-W 571.02 Recipient Eligibility.

(a) Except as specified in (b) below, all NH medicaid recipients shall be eligible to receive items in accordance with and subject to the limitations set forth in this part.

(b) Medicaid recipients residing in nursing facilities shall be eligible to receive only customized items not already included in the nursing facility rate, which is determined in accordance with He-E 806.

He-W 571.03 Dispensing Provider Participation. Each dispensing provider shall be enrolled with NH Medicaid.

He-W 571.04 Covered Services.

(a) The purchase of medical supplies, for continuous use or on an as-needed basis, shall be covered when prescribed, except as follows:

(1) Specialty formulas and food products shall only be covered in accordance with (b)(3)a. and b. below;

(2) Enteral formulas and supplies shall only be covered in accordance with (b)(3)c. below;

(3) Disposable incontinence supplies shall only be covered in accordance with (b)(3)d. and (c)(18) below; and

(4) Medical supplies that are listed as non-covered services in He-W 571.06 shall not be covered.

(b) The following items shall be covered when prescribed and supported by an LMN:

(1) The purchase of, or repairs to, prosthetic devices, excluding prosthetic fingers, thumbs, and toes, which are not a covered benefit;

(2) The purchase of, or repairs to, orthotic devices;

(3) The purchase of the following medical supplies:

a. Specialty formulas prescribed for life-sustaining purposes;

b. Specialty formulas and food products prescribed for metabolic diseases described in RSA 415:6-c;

c. Enteral formulas and supplies when oral feeds are contraindicated; and

d. Disposable incontinence products for recipients between 3 and 20 years of age;

(4) The purchase of one standard manual breast pump per pregnancy;

(5) Bed cradle when necessary to prevent contact with the bed covering for conditions such as burns, decubitis, diabetic ulcers, and gout; and

(6) Repairs to a purchased, non-rental, wheelchair when such repairs do not exceed a total of $800 within a given state fiscal year, which begins July 1st and ends June 30th.

(c) All items that are not otherwise indicated as covered in (a)-(b) above, or listed as non-covered in He-W 571.06, shall be covered when prescribed, supported by an LMN, and prior authorized in accordance with He-W 571.05, and as follows:

(1) Infant home apnea monitors shall be covered when at least one of the following criteria is met:

a. Within the past 30 days from the date the completed PA request is submitted to the department's prior authorization agent, the infant has experienced an apparent life-threatening event (ALTE), which is defined as one or more of the following:

1. Apnea;

2. Change in skin color;

3. Marked change in muscle tone, usually marked limpness; or

4. Choking and gagging; or

b. The infant has one or more of the following conditions:

1. Tracheostomy or anatomic abnormalities of the face, tongue, jaw, or airway that make the infant vulnerable to airway compromise;

2. Neurologic or metabolic disorders affecting respiratory control;

3. Chronic lung disease, such as bronchopulmonary dysplasia, and requires supplemental oxygen (O_2), continuous positive airway pressure, or mechanical ventilation;

4. Apnea of prematurity, which means that one of the following has occurred:

(i) The sudden cessation of breathing that lasts for at least 20 seconds;

(ii) The sudden cessation of breathing for any length of time, which is accompanied by bradycardia, which means a heart rate less than 80 beats per minute;

(iii) O_2 desaturation, which means O_2 saturation of less than 90% with cyanosis or pallor in an infant younger then 37 weeks gestation; or

(iv) The presence of marked hypotonia;

5. Bradycardia on caffeine, theophylline, or similar agents;

6. Diagnosis of pertussis, with positive laboratory results;

7. Diagnosis of gastroesophageal reflux disease (GERD) that results in apnea of at least 20 seconds, bradycardia, or O_2 saturation; or

8. Discharged home on a schedule of weaning narcotics;

(2) A PA approved for an infant home apnea monitor shall be issued as follows:

a. The initial approval shall be valid for 3 months;

b. PA requests for additional coverage beyond the initial 3-month period shall be granted until the infant is ALTE-free for 2 months or until the child reaches 12 months of age, whichever comes first; and

c. PA requests for coverage after the infant reaches 12 months of age shall be granted when supported by physician documentation recommending the continuation of monitoring based on the child's condition;

(3) An external insulin pump for the treatment of insulin-dependent diabetes (Type 1) shall be limited to one pump per recipient every 4 years unless technology evolves so that the pump can no longer be used, and shall be approved when the following criteria are met:

a. The recipient has received 3 or more daily insulin injections for at least 6 consecutive months;

b. The recipient has self-monitored his or her own blood sugar at least 4 times per day for the past 2 consecutive months;

c. The recipient and the recipient's family demonstrate the ability to carbohydrate count using insulin-to-carbohydrate ratios as well as insulin correction factors;

d. The recipient has a documented history of recurrent hypoglycemia with wide fluctuations in blood glucose, despite recipient compliance;

e. The recipient has dawn phenomenon with fasting sugars frequently exceeding 200 mg/dl;

f. The recipient has a history of severe glycemic excursions; and

g. An endocrinologist, or a physician with similar skills 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;

(4) The purchase of a wig shall be covered with approval being subject to RSA 415:18-d;

(5) The purchase of any wheelchair or wheelchair accessory, as well as all repairs and modifications made to purchased wheelchairs that exceed the $800 limit set forth in (b)(6) above, shall be covered when the following criteria are met:

a. The need for a wheelchair, accessory, repair, or modification has been evaluated by a physical therapist (PT) or occupational therapist (OT), in consultation with the ordering physician;

b. The recipient has a condition for which there is a disease process, injury, or disability:

1. That would contraindicate weight bearing or ambulation; and

2. Where there is a decrease in neuromuscular function that prevents the recipient from being able to ambulate without assistance;

c. When the PA request is for a power wheelchair, the recipient:

1. Is unable to propel a manual wheelchair because of a disease process, injury, or disability; and

2. Is able to safely and independently operate a power wheelchair;

d. The wheelchair is not solely for the convenience of the recipient, or the recipient's family or caregivers;

e. The recipient does not already have another mobility device that meets the recipient's mobility needs; and

f. When the PA request is to replace an existing wheelchair, the following criteria are met:

1. It is not possible to repair or modify the existing wheelchair or replacement of the existing wheelchair is found to be the least costly alternative;

2. The current wheelchair no longer meets the recipient's mobility needs; and

3. The request is not being made solely as a result of changing technology, age of the current wheelchair, or a desire for a new wheelchair;

(6) Customized strollers shall be covered only for recipients who meet the following criteria:

a. Are non-ambulatory;

b. Meet the criteria for wheelchair approval as set forth in (5) above;

c. Do not already have a wheelchair or customized stroller, and are not expected to be prescribed a wheelchair within 24 months; and

d. Have mobility needs that will not be met by a commercially available stroller with adaptations;

(7) Gait trainers shall be covered only for recipients who:

a. Are able to stand upright with assistance and has some lower-extremity and truck strength to be supported in the gait trainer;

b. Are not able to ambulate independently due to a condition such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities;

c. Do not have lower-extremity contractures that would preclude ambulation, and have adequate range of motion to support mobility;

d. Have alignment of the lower extremities that is such that the foot and ankle can tolerate a standing or upright position as well as reciprocal movement;

e. Do not have complete paralysis of the lower extremities;

f. Have demonstrated improved mobility, ambulation, function, or physiologic symptoms or have maintained status with the use of the selected gait trainer, and are able to follow a home therapy program incorporating the use of the gait trainer, as documented by a clinical program or home trial with the requested gait trainer; and

g. Have a written home therapy plan outlining the use of the requested gait trainer and for whom there is a caretaker who can appropriately supervise use of the gait trainer;

(8) Standers shall be covered only for recipients who:

a. Do not already have a stander or gait trainer;

b. Are unable to stand or ambulate independently due to a condition such as, but not limited to, a neuromuscular or congenital disorder, including acquired skeletal abnormalities;

c. Are at high risk for lower extremity contractures that cannot be appropriately managed by other treatment modalities, such as stretching, active therapy, and home programs;

d. Have an alignment of the lower extremities such that they can tolerate a standing or upright position;

e. Do not have complete paralysis of the lower extremities;

f. Do not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases, or hip and knee flexion contractures of more than 20°;

g. Have demonstrated improved mobility, function, and physiologic symptoms or has maintained status with the use of the requested stander, when other alternatives have failed, and are able to follow a home standing program incorporating the use of the stander, as documented by clinical standing program or home trial with the requested stander;

h. Are unable to stand or ambulate with caregiver assistance or an ambulatory assistive device at sufficient duration or distance to achieve a medical benefit;

i. Have a home therapy plan outlining the use of the requested stander; and

j. Have a request for a stander using code E0642, and are able to self-propel the stander.

(9) Cranial remolding helmets shall be covered when the following criteria are met:

a. The recipient is at least 3 months of age, but not older 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 is documented by one of the following:

1. Skull base asymmetry of 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 of 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;

(10) A continuous positive air pressure (CPAP) machine to treat obstructive sleep apnea (OSA) in recipients up to the age of 21 shall be covered when all of the following criteria are met:

a. Adenotonsillectomy is contraindicated, delayed, or unsuccessful in relieving symptoms of OSA;

b. There is an OSA diagnosis established by polysomnography (PSG) performed by a medicare certified sleep study center, or a children's hospital; and

c. The recipient is 7 years of age or older and weighs 40 pounds or more;

(11) A CPAP machine to treat OSA in a recipient 21 years of age or older shall be covered when all of the following criteria are met:

a. The recipient has a diagnosis of OSA diagnosed established by PSG performed by a medicare certified sleep study center; and

b. At least one of the following clinical criteria has been met:

1. The apnea-hypopnea index (AHI), which assesses the severity of sleep apnea, is moderate to severe, which is defined as 15 or more events per hour; or

2. The AHI is from 5 to 14 events per hour with documentation of symptoms of daytime sleepiness, impaired cognition, mood disorders, or insomnia that impairs the recipient's ability to carry out activities of daily living, and one of the following conditions is met:

(i) A diagnosis of hypertension, ischemic heart disease, or a history of stroke; or

(ii) More than 20 episodes of O_2 desaturation, measuring less than 85%, or any one episode of O_2 desaturation, measuring less than 70%, during a full-night sleep study;

(12) A CPAP machine covered in accordance with (10) or (11) above shall be prior authorized as follows:

a. The initial authorization shall be limited to a 2-month trial rental of the CPAP machine to ensure the recipient uses the machine daily and will receive a sufficient benefit from use of the machine;

b. The recipient's daily use shall be documented by a compliance report indicating that the recipient is gaining sufficient benefit from the CPAP machine, as evidenced by a downloaded recording from the machine showing usage of a daily minimum of 4 hours per night;

c. Following the 2-month trial period, if the recipient demonstrates daily use as described in b. above during the 2-month trial rental period, the requesting dispensing provider may submit a subsequent PA request, which shall include the documentation described in b. above, for the purchase of the CPAP machine;

d. If the recipient does not use the machine as required in b. above during the trial period, but the non-compliance is correctable, such as by adjusting the fit of the mask, the requesting dispensing provider may submit a subsequent PA request for an additional rental period; and

e. Following the trial rental period, if it is demonstrated that the CPAP machine is not providing a sufficient benefit to the recipient, and the failure is not due to non-compliance, abuse, or neglect, the requesting dispensing provider may submit a PA request for a bi-level positive airway pressure (BiPAP) machine;

(13) The department's prior authorization agent shall approve a request for a BiPAP machine when it has been determined, in accordance with (12) above, that a CPAP machine is not effective in treating the recipient's OSA;

(14) Coverage of a BiPAP machine shall be as follows:

a. The initial authorization shall be limited to a 2-month trial rental of the BiPAP machine to ensure the recipient uses the machine daily and will receive a sufficient benefit from use of the machine;

b. The recipient's daily use shall be documented by a compliance report indicating that the recipient is gaining sufficient benefit from the BiPAP machine, as evidenced by a downloaded recording from the machine showing usage of a daily minimum of 4 hours per night; and

c. Following the 2-month trial period, if the recipient demonstrates daily use during the trial rental period as required in b. above, the requesting item provider may submit a subsequent PA request, which shall include the documentation described in b. above, for the purchase of the BiPAP machine;

(15) High-frequency chest compression (HFCC) devices shall be covered when the following criteria are met:

a. The recipient shall be at least 2 years of age at the time the device is being used;

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 that

(i) Is characterized by a daily productive cough that has been confirmed by high resolution, spiral, or a standard CT scan;

(ii) Lasts for at least 6 consecutive months; or

(iii) Results in exacerbation, at least 2 times in a one year period that requires antibiotic therapy; or

3. Chronic neuromuscular disorder affecting the ability to cough or clear respiratory secretions with a prior history of pneumonia or other significant worsening of pulmonary function, which exists when at least 2 of the following criteria are met:

(i) Forced expiration capacity (FEC) of 80% predicted;

(ii) Forced vital capacity (FVC) of less than 50% predicted;

(iii) Small airway score (FEP 25-75%) decrease in one year of 25% or more;

(iv) Pattern of annual or more hospitalizations for acute pulmonary exacerbations; or

(v) Demonstration of reduction of pulmonary function while on steroids for a year;

d. The recipient's physician provides documentation demonstrating that standard treatments have failed to adequately mobilize retained secretions, as indicated by one of the following:

1. Other airway clearance therapies, including chest physical therapy or the use of a flutter device, cannot be performed at least twice daily, or as would be appropriate for the recipient's age, because:

(i) There are no available parental or partner resources to perform chest physical therapy;

(ii) The caregiver is physically or mentally incapable of performing chest physical therapy at the required frequency; or

(iii) There are 2 or more individuals with cystic fibrosis, chronic bronchiectasis, or chronic neuromuscular disorder in the same household; or

2. There is a significant deterioration of the recipient's clinical conditions, as described in c.3. above; and

e. The recipient is under the care of a pulmonologist;

(16) A HFCC device covered in accordance with (15) above shall be prior authorized as follows:

a. The initial authorization shall be limited to a 2-month trial rental of the HFCC device to ensure the recipient uses the device daily and will receive a sufficient benefit from use of the device;

b. The recipient's daily use and sufficient benefit from usage during the 2-month trial rental period shall be documented by:

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

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

(i) Improvement in forced expiratory volume (FEV1); or

(ii) A reduction in the number of hospitalizations per year;

3. A statement signed by the pulmonologist, which may be part of the report in 2. above, stating that the recipient has sufficiently benefited from the use of the HFCC device, and that the pulmonologist recommends continued usage of the HFCC device; and

4. A usage meter report generated by the dispensing provider documenting usage at least 67% of the prescribed time;

c. Following the 2-month trial rental period specified in a. above, the requesting dispensing provider may submit a prior authorization request for an additional rental period, not to exceed one year, by submitting a prior authorization request along with documentation demonstrating the recipient's use as described in b. above;

d. A request for an additional rental period or to purchase the device through a rent-to-own arrangement, submitted in accordance with c. above, shall be approved by the department's prior authorization agent when the clinical evidence of the recipient's use and sufficient benefit supports continued use of the HFCC device; and

e. Approvals shall be limited to only one HFCC device and one vest per size per family;

(17) Oximeters shall be covered when the recipient has been assessed by his or her physician or pulmonary specialist to determine if supplemental O_2 is required, and either:

a. The recipient has been on supplemental O_2 and an oximeter is requested to determine if he or she can be weaned from the supplemental O_2; or

b. The recipient is receiving supplemental O_2 and is experiencing widely fluctuating O_2 saturation levels and an oximeter is required to assist in determining the cause, frequency, and duration of the fluctuation to properly determine the O_2 flow rate;

(18) Disposable incontinence supplies, including chux underpads, incontinence briefs, pull-ups, diapers, pads/liners, and gloves and toileting wipes used for this condition, for recipients 21 years of age or older shall be covered in accordance with the following:

a. The PA shall be approved for a period of one year if the recipient's type of incontinence is:

1. Secondary to a disease process or injury to the bladder, which results in irreversible loss of control of the urinary bladder and/or rectal sphincter;

2. Secondary to an injury to the brain or spinal cord; or

3. Secondary to a disease or condition that causes incontinence; or

3. Attributed to a profound cognitive disability or progressive neurological disorder, such as severe intellectual disability, dementia, or tardive dyskinesia, that results in an inability to achieve continence through bladder training;

b. The PA shall be approved for a period of 6-months if the recipient's type of incontinence is:

1. Secondary to a surgical procedure, such as prostatectomy, resulting in temporary urinary incontinence; or

2. Secondary to an injury to the bladder and/or urinary sphincter, including nerve injury and detrusor muscle instability, resulting in temporary urinary incontinence; and

c. The following quantity limits shall apply, unless the prior authorization request specifies and medically justifies a greater quantity:

1. Disposable chux underpads shall be limited to a total of 3 per day, up to 93 per month, except that if package sizes necessitate dispensing a greater monthly quantity, the monthly quantity shall not exceed 105 per month;

2. Incontinence briefs, pull-ups, and diapers shall be limited to a total of 6 per day, up to 186 per month, except as follows:

(i) If package sizes necessitate dispensing a monthly quantity which is greater than 186, the monthly quantity shall not exceed 216 per month; and

(ii) The dispensing provider shall dispense the fewest number of packages that result in a quantity as close as possible to the 186 limit without going under. For example, if a package size is 10 diapers per package, then 19 packages equaling 190 diapers shall be dispensed, not 20 or 21 packages; and

3. Pads and liners used to line undergarments shall be limited to a total of 3 per day, up to 93 per month, except as follows:

(i) If package sizes necessitate dispensing a monthly quantity which is greater than 93, the monthly quantity shall not exceed 144 per month; and

(ii) The dispensing provider shall dispense the fewest number of packages that result in a quantity as close as possible to the 93 limit without going under. For example, if a package size is 16 liners per package, then 6 packages equaling 96 liners shall be dispensed, not 17 or 18 or 19 packages;

(19) Functional electric stimulation (FES), which is used to enable a recipient with spinal cord injury to ambulate, shall be covered when the recipient meets all of the following criteria:

a. Has intact lower motor units (L1 and below), both muscle and peripheral nerve;

b. Can bear weight on upper and lower extremities to maintain an upright posture independently;

c. Demonstrates brisk muscle contraction to neuromuscular electrical stimulation and has sensory perception of electrical stimulation sufficient for muscle contraction;

d. Is motivated and has the cognitive ability to use such devices for walking;

e. Can transfer independently and stand for at least 3 continuous minutes;

f. Possesses hand and finger function to manipulate the controls;

g. Is at least 6-months post-recovery of spinal cord injury and restorative surgery;

h. Does not have hip or knee degenerative disease and has no history of long bone fracture secondary to osteoporosis, and

i. Has successfully completed a training program, which consists of at least 32 physical therapy sessions with the device over a 3-month period;

(20) Pediatric specialty beds shall be covered for infants and children up to the age of 12, as follows:

a. The recipient shall have one or more of the following diagnoses:

1. Traumatic brain injury;

2. Moderate or severe cerebral palsy;

3. Seizure disorder with daily seizure activity, characterized by loss of consciousness or lack of awareness to surroundings;

4. Pervasive developmental disorder;

5. Psychiatric, neurological, or metabolic diagnosis with documented risk of self-injury; or

6. Severe behavioral disorder;

b. The recipient has cognitive and communication impairment;

c. There is documentation of medical necessity that includes at least one of the following:

1. Daily seizure activity as described in a.3. above;

2. Uncontrolled perpetual involuntary movement related to a medical diagnosis; or

3. Self-injurious behavior, such as head banging, where a helmet was tried and was not successful;

d. There is evidence of a safety risk that includes at least one of the following:

1. The recipient demonstrates unsafe mobility that will put the recipient at risk for serious injury, not just a possibility of injury, such as climbing out of bed;

2. The recipient has balance problems or vertigo; or

3. The recipient has history of injury that has occurred prior to the request;

e. There is documented use of more cost effective alternatives for which the outcomes were unsuccessful, such as:

1. Positional aids and side rails with padding around the regular bed;

2. Alternative bedding, such as moving the mattress to the floor with surrounding padding;

3. Management of seizure disorder;

4. Pharmacotherapy;

5. Helmet for head protection;

6. Behavioral therapy;

7. Environmental assessment and removal of safety hazards and use of appropriate child protective devices, such as on the door knob or use of a baby gate to prevent the child from leaving the room; or

8. Use of portable monitoring devices, such as a baby monitor to listen in on the child's activities; and

f. The LMN shall include the following:

1. The recipient's medical, psychiatric, neurological, metabolic, and behavioral diagnosis;

2. The recipient's needs that are a result of the diagnosis that shows the medical need for the specialty bed;

3. The specific name, type, and bed model that addresses each of the recipient's needs with specific requirements such as full safety rails, height required for safety, or the necessity of articulation to raise the head or feet of the child to feed, medicate, or provide mobility;

4. Documentation as to how the recipient's current bed or crib or modifications to the bedroom fail to address the clinical need and which states whether the recipient has the capacity to climb;

5. Current and previous treatment modalities, including an explanation why these modalities were not successful;

6. Assessment of cognitive function including developmental age equivalent for motor function, cognitive function, and habilitation potential; and

7. Detailed history of safety issues including incidence and resulting injury;

(21) Coverage of other items that are not specifically listed elsewhere in this rule, such as those listed below, shall be based on the National Coverage Determinations (NCD) criteria published in the Medicare Coverage Database (MCD) at the time of the coverage determination, as found at http://www.cms.gov/medicare-coverage-database/. Such items include:

a. Pressure-reducing surfaces;

b. Enteral feeding pumps;

c. Hospital beds and accessories;

d. External infusion pumps, with the exception of insulin pumps, which shall be subject to the criteria set forth in He-W 571.04(c)(3) above;

e. Negative pressure wound therapy pumps;

f. Pneumatic compression devices;

g. Hoyer type lifts and other patient lift transfer systems;

h. Transcutaneous electrical nerve stimulators (TENS);

i. Trapeze bars;

j. Osteogenesis stimulators;

k. Parenteral nutrition pumps;

l. Suction machines;

m. Airway clearance devices, such as inexsufflators;

n. Voice activated home glucose monitors;

o. Seat lift mechanisms that are not part of a wheelchair;

p. Continuous passive motion machines; and

q. Oxygen compressors and humidification devices;

(22) For items that are not specifically listed elsewhere in this rule and are also not listed in the MCD, the department shall review the recipient's medical information and shall cover the item when the department determines that coverage of the item:

a. Is 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 as determined by a review of the coverage criteria set forth in the New Hampshire or New England commercial insurance coverage as listed in He-W 530.05(b)(32)b.;

b. Is not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

c. Is no more costly than other items or services that would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipients' illness, injury, disease, or its symptoms;

d. Is not experimental, investigative, cosmetic, or duplicative in nature;

e. Does not place the recipient in greater risk of mortality or morbidity than an equally effective alternative treatment; and

f. Is allowable under Medicaid and does not otherwise conflict with the New Hampshire Medicaid State Plan;

(d) All items billed with any Healthcare Common Procedure Coding System (HCPCS) miscellaneous procedure code shall be covered when prescribed, supported by an LMN, and prior authorized in accordance with He-W 571.05, and as follows:

(1) Customized car seats shall be covered for recipients who have a neuromotor diagnosis and 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; and

(2) Protective helmets for recipients with drop seizures or severe head-banding disorders.

He-W 571.05 Prescription, LMN, and Prior Authorization Requirements.

(a) The prescription required in He-W 571.04(a)-(c) above shall be written by the provider and include the following:

(1) The recipient's name, address, date of birth, and NH medicaid identification number (MIN);

(2) The specific monthly quantity(s) to be dispensed, not to exceed the limits set forth in this rule;

(3) The specific type of item(s) to be dispensed;

(4) The frequency of use for the medical supply(s) being dispensed; and

(5) The dated signature or electronic signature of the provider.

(b) The LMN required in He-W 571.04(b)-(c) above shall be written by the provider and include the following:

(1) The recipient's name, address, date of birth, and NH MIN;

(2) A narrative description of the recipient's medically diagnosed health condition, illness, or injury, including an indication of whether the diagnosis is a pre-existing condition or a presenting condition;

(3) The recipient's prognosis;

(4) An estimation of the effect on the recipient if the requested item(s) is not provided;

(5) The medical justification for the item(s) being requested, including its contribution to the treatment of the recipient's illness or injury or to the improvement of the recipient's physical condition;

(6) The anticipated length of time the item(s) is expected to be needed;

(7) The expected outcome of providing the requested item(s);

(8) The recommended timeframe to achieve the expected outcome;

(9) 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;

(10) A statement, with supporting documentation, assuring that the requested item(s) is the least restrictive, least costly item available to meet the recipient's needs;

(11) Supporting documentation that demonstrates the medical need for the item(s); and

(12) The dated signature, or electronic signature, of the provider.

(c) The prescription and LMN described in (a) and (b) above shall:

(1) Not be written retroactively; and

(2) Be valid for one year from the date written so long as the medical treatment remains unchanged.

(d) All PA requests shall be sent to the department's prior authorization agent(s) for review and approval, and include the following documentation:

(1) A copy of the prescription, as described in (a) above;

(2) An LMN containing all of the information specified in (b) above; and

(3) A completed PA form specific to the item being requested, as follows:

a. For all items, a completed Form 272D, "Item/Medical Supply Prior Authorization Request" form (July 2015), signed and dated by an authorized representative of the NH medicaid enrolled dispensing provider;

b. For all disposable incontinence supplies, a completed Form 272DIA, "Incontinence Products Prior Authorization Request Form," (July 2015) completed by an authorized representative of the NH medicaid enrolled dispensing provider;

c. In addition to submitting the forms required by a. above, requests for all wheelchairs, scooters, and customized strollers must also include a completed Form 272M, "Mobility Evaluation Form" (July 2013), and which shall include the following:

1. A dated signature and printed name of the provider completing the evaluation;

2. A dated signature and printed name of the recipient or the recipient's parent or legal guardian, if applicable;

3. A dated signature and printed name of an authorized representative of the NH medicaid enrolled dispensing provider; and

4. A copy of the manufacturer's invoice or quote, which includes the Manufacturer's Suggested Retail Price (MSRP) and acquisition cost;

d. In addition to the requirements specified in (3)c. above, PA request for the purchase of accessories for a wheelchair shall also include the following documentation from the ordering physician:

1. Documentation that the ordering physician has assessed the recipient for the accessory within 60 days of making the PA request;

2. A written diagnosis, including a brief medical history justifying the need for the accessory; and

3. When applicable, an estimate of the length of time the accessory will be required; and

e. In addition to submitting the form required by a. above, requests for all standers, gait trainers, and bath and toileting items shall also include a completed Form 272EQ, "Medical Equipment Request Evaluation Form Non-Wheelchair" (July 2013), and include the following:

1. A dated signature and printed name of the provider completing the evaluation;

2. A dated signature and printed name of the recipient or the recipient's parent or legal guardian, if applicable;

3. A dated signature and printed name of an authorized representative of the NH Medicaid enrolled dispensing provider; and

4. A copy of the manufacturer's invoice or quote, which includes the MSRP and acquisition cost.

(e) A dispensing provider may submit Form 272REV "Incontinence Products Prior Authorization Revision Request Form" (July 2013) in order to provide products which better suit a recipient's needs when such changes are to:

(1) Product size that will result in a new T-code or modifier;

(2) Product absorbency that will result in a new T-code or modifier; or

(3) Product style that will result in a new T-code or modifier.

(f) Requests for PA shall be approved by the department's prior authorization agent if the agent determines the following:

(1) With the exception of disposable incontinence supplies, the item meets the definition of item, DME, prosthetic devices, medical supplies, or orthotic devices as defined in He-W 571.01;

(2) The medical documentation was completed and submitted in accordance with (d) above;

(3) The PA request demonstrates that the item is consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms as determined by a review of the coverage criteria set forth in He-W 571.04 above; and

(4) The item is cost effective, as determined by a finding that:

a. There is no other less costly item, as identified by the department's prior authorization agent(s), that would effectively meet the recipient's needs; or

b. Less expensive, appropriate alternatives are not covered or generally not available.

(g) A dispensing provider shall request and obtain prior authorization from the department's prior authorization agent before providing the item(s).

(h) A provider shall conduct a face-to-face encounter with the recipient no earlier than 60 days prior to submitting a prior authorization request..

(i) Requests for a PA shall be denied by the department's prior authorization agent if the prior authorization agent determines that the requirements set forth in (f) above have not been met.

(j) Decisions made by the department's prior authorization agent in accordance with this section shall not be superseded by the treating, ordering, or consultative health care provider's prescription, orders, or recommendations.

(k) If the department's prior authorization agent approves the PA request, the state's fiscal agent shall send written confirmation of the approval to the dispensing provider.

(l) If the department's prior authorization agent denies the PA request or partially denies it, the state's fiscal agent shall forward a notice of denial to the recipient and the provider, that includes the following information:

(1) The reason for, and legal basis of, the denial; and

(2) Information that a fair hearing on the denial may be requested within 30 days of the date on the notice of the denial, in accordance with He-C 200.

(m) The dispensing provider shall be responsible for determining that the recipient is eligible for NH medicaid on the date of service, or for custom wheelchairs, on the date the custom wheelchair is ordered.

He-W 571.06 Non-Covered Services. The following items shall not be covered:

(a) Items that do not meet the coverage criteria set forth in He-W 571.04;

(b) Specialty formulas when not needed for life-sustaining purposes, or as the sole source of nutrition, except as allowed under He-W 546;

(c) Common, over-the-counter, household and medicine-chest items that can be purchased without a prescription, including, but not limited to:

(1) Corn plasters and foot pads;

(2) Nursery supplies;

(3) Hand cleaners or sanitizers, such as Hygenall or Purell;

(4) Personal hygiene items including body lotions, toothbrushes, electric shavers, razors, and other hair removal devices and services;

(5) Thermometers;

(6) Odor barrier products;

(7) Toileting wipes, except as allowed by He-W 571.04(c)(18) above;

(8) First aid kits and supplies, including adhesive bandages and scissors;

(9) Mechanical heated water circulating pads and pumps, including hydrocollator heating units;

(10) Non-legend medications specified in accordance with He-W 570.05(d); and

(11) Nutritional supplements or formula as follows:

a. Dietary or food supplements;

b. Lactose-free foods or products that aid in lactose digestion;

c. Gluten-free products;

d. Low carbohydrate diets;

e. Weight-loss foods, formulas and related products intended to aid in weight loss;

f. Normal grocery items including over-the counter infant formulas;

g. Baby food and banked breast milk;

h. Grocery items that can be prepared in a blender and used with an enteral feeding system;

i. High protein powders and mixes;

j. Medical food products that:

1. Are prescribed without a diagnosis requiring such foods;

2. Used for convenience purposes;

3. Have no proven therapeutic benefit without an underlying disease, condition, or disorder;

4. Used as a substitute for acceptable standard dietary interventions; or

5. Are used exclusively for nutritional supplementation; and

k. Enteral nutrition when the recipient has food allergies or dental problems, but has the ability to meet his or her nutritional requirements through an alternative store-bought food source;

(d) Environmental modifications and controls, including:

(1) Wheelchair ramps;

(2) Tub rails;

(3) Space heaters and heat lamps;

(4) Air conditioners and fans;

(5) Air purifiers, including HEPA and vacuum filters;

(6) Vaporizers, humidifiers, and dehumidifiers;

(7) Aromatherapy;

(8) Stairway lifts and elevators;

(9) Lifting devices including electric patient lifts and hydraulics and ceiling tract lifting devices;

(10) Power generators; and

(11) Adaptive or computer switch toys;

(e) Items typically not used by the general public for a medical purpose, including:

(1) Furniture for non-mobility purposes including, but not limited to:

a. Corner seats;

b. Positioning chairs;

c. High chairs or other feeding type chairs;

d. All beds, except hospital beds as allowed by He-W 571.04(c)(20)c., and the pediatric specialty beds as allowed in He-W 571.04(c)(20) above;

e. Toddler beds, bassinets, portable cribs, or playpens; and

f. Massage and therapy tables and related equipment;

(2) Lumbar support cushions;

(3) Bedding, including electric or weighted blankets;

(4) Clothing items, including sportswear such as neoprene shorts;

(5) Hot Tubs, whirlpool equipment, aqua massagers, and sauna baths;

(6) Recreational, therapeutic, or exercise equipment including, but not limited to, bicycles, treadmills, weights, tables, mats, and swings; and

(7) Video, computer games, or computer applications intended for the purpose of exercise, recreation, education, or instruction;

(f) Items that contribute to or enhance fertility or procreation;

(g) Items typically used by the general public for preventing injury or ensuring safety, including:

(1) Car seats, except as allowed by He-W 571.04(d)(1);

(2) Helmets, including protective helmets used for sports and recreation, except as allowed by He-W 571.04(d)(2); and

(3) Pneumatic vests and lumbar supports;

(h) Disposable incontinence supplies for:

(1) Recipients younger than 3 years of age, except as allowed by He-W 546; and

(2) Recipients 21 years of age or older who do not meet the criteria set forth in He-W 571.04(c)(18);

(i) Bed wetting alarms;

(j) Sleep positioning wraps;

(k) Computer controlled and programmable lateral rotation therapy bed systems;

(l) Chewelry, and similar non-toxic jewelry, intended to be chewed;

(m) Magnets, crystals, gemstones, and similar non-evidenced based, experimental, or investigational healing items ;

(n) Glucowatches;

(o) Auto-feeders;

(p) Automated medication reminder systems;

(q) Cast bags, such as Aquashield;

(r) Electric resuscitators and portable defibrillators;

(s) Bi-directional static progressive stretch devices, including, but not limited to, Joint Active Systems (JAS) splints;

(t) Service or therapy animals and related expenses;

(u) Apnea monitors, except when the criteria in He-W 571.04(c)(2) have been met;

(v) Prosthetic fingers, thumbs, and toes;

(w) Commercially available strollers;

(x) Wheelchairs requested within 24 months of the purchase of a customized stroller;

(y) The following accessories and options for wheelchairs, customized strollers, or other mobility devices:

(1) Wheelchair remote controls and attendant control switches;

(2) Power assist devices or equipment to modify a manual wheelchair into a power wheelchair;

(3) Air suspension systems;

(4) Power standers and seat lift mechanisms;

(5) Grade aids and anti-roll devices for manual wheelchairs;

(6) Wheelchairs with stair climbing options;

(7) Titanium framed and sport-type wheelchairs;

(8) Custom wheels for off-road use or for sport and recreational purposes;

(9) Any wheelchair accessory or option for purposes of allowing the recipient to perform leisure, social, or recreational activities;

(10) Lights, horns, mirror, baskets, pouches, backpacks, and similar accessories; and

(11) Back-up or spare wheelchairs for recipients who already have a wheelchair, power scooter, or customized stroller;

(z) Any back-up or spare equipment, with the exception of ventilators;

(aa) Replacement, repair, or modifications of an item when the need for which is the result of:

(1) Recipient abuse, misuse, or neglect;

(2) Failure to protect the item from the elements;

(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 the item 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 written warranty or is contrary to the manufacturer's recommendations for care, use, and maintenance;

(ab) Repairs, modifications or adjustments to any rented item, including wheelchairs;

(ac) Repairs to recipient owned items, when the recipient does not meet the criteria for coverage of the item, or when such repairs, modifications, or adjustments are:

(1) Within the dispensing provider's or manufacturer's warranty; or

(2) Within one year of the purchase of the item or accessory, unless written documentation from the provider demonstrates a significant change in the recipient's medical condition that meets the coverage criteria for the item and the repair or modification is warranted;

(ad) Upgrades to or replacement of any functioning item that still meets the recipient's needs, but is being requested solely as a result of changing technology;

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

(af) Any items that are primarily intended for use at a school, are part of a child's care plan at school, and could be obtained through the "Medicaid to Schools" program in accordance with He-M 1301, and the child and the child's school participate in the "Medicaid to Schools" program; and

(ag) Any items that are experimental, investigational, or non-FDA approved.

He-W 571.07 Requirements for Maintaining Documentation.

(a) The dispensing provider shall maintain supporting records in accordance with He-W 520 and this part, and failure to maintain records in accordance with He-W 520 and this part shall entitle the department to recoupment of state or federal medicaid payments made as permitted by 42 CFR 455, 42 CFR 447, and 42 CFR 456.

(b) In addition to the requirement set forth in (a) above, the dispensing provider shall maintain the following documentation for a minimum of 6 years or until the resolution of any legal action(s) commenced within the 6 year period, whichever is longer:

(1) All letters of medical necessity (LMN) described in He-W 571.05(b);

(2) Documentation of adjustments made to and inspections of items or related accessories;

(3) Documentation showing:

a. The date and proof of delivery of all items to the recipient;

b. For custom wheelchairs and customized strollers, the date of the order; and

c. For custom prosthetic and orthotic devices, the date of fabrication;

(4) Documentation of a face-to-face encounter between the recipient and the recipient's provider no earlier than 60 days of the PA request as described in He-W 571.05(h) above; and

(5) All other supporting documentation needed to justify monthly quantity(s) and type of supply(s) dispensed.

He-W 571.08 Third Party Liability.

(a) All third party obligations shall be exhausted before medicaid shall be billed, in accordance with 42 CFR 433.

(b) Dispensing providers shall request information from the recipient regarding other insurance coverage.

(c) If other insurance coverage is available, dispensing providers shall contact the insurer to verify benefits initially and at least annually thereafter or when the insurance carrier changes.

(d) Dispensing providers shall maintain a record of any other insurance verifications in the recipient's medical record.

He-W 571.09 Utilization Review and Control. The department's provider program integrity unit shall monitor utilization of items to identify, prevent, and correct potential occurrences of fraud, waste, and abuse, in accordance with 42 CFR 455, 42 CFR 456, and He-W 520.

He-W 571.10 Payment for Items.

(a) The department shall establish rates for all items in accordance with RSA 161:4, VI(a).

(b) All dispensing providers shall submit clean claim(s) which means a claim that can be processed without obtaining additional information from the dispensing provider or from a third party, and a clean claim includes a claim with errors originating in the state's claims system. A clean claim does not include a claim from a dispensing provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

(c) All dispensing providers shall submit clean claims for payment to the department's fiscal agent, and the Department shall be entitled to recoupment of state and federal medicaid payments as permitted in 42 CFR 455, 42 CFR 456, and 42 CFR 447.

(d) All dispensing providers shall maintain supporting records supporting submitted claims in accordance with He-W 520 and He-W 571.07.

(e) Payment shall not be made for items that require prior authorization when prior authorization was not received and approved before the items were provided, in accordance with He-W 571.05. Retroactive prior authorization requests shall be denied.

(f) Payment for disposable incontinence supplies, including gloves and toileting wipes used for this condition, provided to recipients shall be made only for supplies obtained from the exclusive supplier of incontinence supplies contracted through the department.

(g) Billing of and payment for items and repair parts shall be made at the lesser of:

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

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

(3) The rate established by the department in accordance with RSA 161:4, VI(a).

(h) Payment for labor costs for repairs shall be at a rate established by the department in accordance with RSA 161:4, VI(a).

(i) Payment shall be denied or recouped if the dispensing provider bills for and is paid for disposable incontinence supplies, including gloves and toileting wipes used for such condition, which are not obtained from the exclusive supplier of incontinence supplies contracted through the department.

(j) Except as allowed by (k) below, payment shall be denied if the recipient is not eligible on the date of service, even when a prior authorization request has been approved.

(k) For the following items only, payment shall be denied if the recipient is not eligible as follows:

(1) On the date of order for custom wheelchairs;

(2) On the date of fabrication for custom fabricated prosthetic and orthotic devices; or

(3) On the date of order for frame and seating systems to pediatric and adult wheelchairs.

(l) No item shall be paid for prior to delivery to the recipient and dispensing providers shall maintain documentation in accordance with He-W 571.07 and 571.10 which demonstrates that the items were delivered to the recipient.

(m) No payment shall be made for items left unattended which results in the item's destruction or damage to the item so that it is unusable. The dispensing provider shall replace the such unusable item at no cost to the recipient or department.

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

(1) Delivery and assembly of the wheelchair;

(2) Training to the recipient and recipient's family and other caregiver(s) in the use of the equipment, maintenance care, and equipment diagnostics; and

(3) Wheelchair adjustments at the end of the first 30 days.

(o) Dispensing providers shall supply a comparable substitute wheelchair at no additional cost for 2 weeks during the repair of the original wheelchair. For repairs that require more than 2 weeks to complete, the dispensing provider shall request PA for a rental fee.

APPENDIX

RULE	IMPLEMENTING FEDERAL OR STATE AUTHORITY
He-W 571.01	42 CFR 440.120
He-W 571.02	42 CFR 440.210; 42 CFR 440.220
He-W 571.03	42 CFR 440.50; 42 CFR 440.60; 42 CFR 440.166; 42 CFR 431.107; RSA 328-D:1
He-W 571.04	RSA 415:6-c; RSA 415:18-n; RSA 415:18-d; RSA 126-A:5,VII;42 CFR 440.230; 42 CFR 440.130(a)
He-W 571.05	42 CFR 440.230(d); 42 CFR 456.3
He-W 571.06	42 CFR 440.230(d); 42 CFR 456.3
He-W 571.07	42 CFR 431.107; 42 CFR 455 Subparts A and B; 42 CFR 447 Subparts A and B; 42 CFR 456 Subparts A and B
He-W 571.08	42 CFR 431.107, 42 CFR 433 Subpart D
He-W 571.09	42 CFR 455 Subparts A and B; 42 CFR 456 Subparts A and B
He-W 571.10	42 CFR 455 Subparts A and B; 42 CFR 456 Subparts A and B, 42 CFR 447.45; RSA 161:4, VI(a); RSA 126-A:3, III(b)