State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department, Medical Assistance Division, is proposing amendments to 8.324.5 NMAC, *Durable Medical Equipment (DME) and Medical Supplies,* to clarify regulatory language, accuracy with existing rules and respond to current budgetary constraints.

If implemented as proposed, the following changes to Medicaid DME and Medical Supply benefit coverage will affect recipients by:

- Limiting quantities for supplies to eligible recipients to reasonable amounts.

If implemented as proposed, the following changes to Medicaid DME and Medical Supply benefits and reimbursement will affect DME and medical supply providers:

- MAD will follow Medicare rules for limiting or capping reimbursement for rental equipment over time and requiring providers to maintain and repair the equipment following the capped rental period;
- MAD requires suppliers to document that the eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next order; and
- Added reimbursement language to clarify when a provider must bill the invoice cost plus a percentage and also reduces the percentage allowed above the invoice price by 5%.

Other changes in the rule being proposed at this time include the following:

- Replacing outdated word usage, such as Medicaid with MAD, the Medical Assistance Division;
- Providing more instruction on the eligibility of providers and their responsibilities;
- Directing providers to enroll and follow a MAD managed care or MAD fee-for-service instructions for billing and authorization of services; and
- Deleting unnecessary information.

The changes in the durable medical equipment and medical supplies benefits are being proposed because the Department believes the changes are more in line with the benefits typically available from other commercial DME insurers. Also, at this time there is a serious shortfall in state revenues which has resulted in reductions in many state agency budgets. The New Mexico Medicaid program budget is no exception. Program costs are outpacing available revenues. Therefore, the Department has looked at DME and other program benefits to determine changes that can be made while still providing medically appropriate services.

The reduction in payments for these services in the Medicaid fee-for-service program is estimated to be $360,000.

VI. RULES

This proposed rule changes refers to 8.324.5 NMAC of the Medical Assistance Program Policy Manual. This register is available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 . The proposed rule changes are attached to the register. If you do not have Internet access, a copy of the rules may be requested by contacting the Medical Assistance Division at 505-827-3156.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective February 1, 2011.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at 1:30 p.m. on Wednesday, December 15, 2010, in the ASD conference room, Plaza San Miguel, 729 St. Michael's Drive in Santa Fe, NM.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on December 15, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 5 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program [~~is~~] and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act[~~, as amended and by the state human services department pursuant to state statute~~] as amended or by state statute. See Sections 27-2-12 et seq. NMSA 1978 [~~(Repl. Pamp. 1991)~~].
[2/1/95; 8.324.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 7/1/04; A, 2/1/11]

8.324.5.6 OBJECTIVE: [~~The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.~~] The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.324.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 7/1/04; A, 2/1/11]

8.324.5.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~]~~To~~ To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[2/1/95; 8.324.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 7/1/04; A, 2/1/11]

8.324.5.9 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES: [~~The New Mexico medicaid program (medicaid)~~] The New Mexico medical assistance division (MAD) pays for medically necessary services furnished to eligible recipients, including durable medical equipment and medical supplies, as specified at 42 CFR Section 440.70 (c). [~~This part describes eligible providers, covered services, services restrictions, noncovered services, and general reimbursement methodology.~~]
[2/1/95; 8.324.5.9 NMAC - Rn, 8 NMAC 4.MAD.754, 7/1/04; A, 2/1/11]

8.324.5.10 ELIGIBLE PROVIDERS: [~~Upon approval of medical assistance program provider participation agreements by the medical assistance division (MAD), all suppliers of medical supplies and/or durable medical equipment that are licensed to do business may become medicaid providers. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as they receive new materials from MAD.~~] Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.
[2/1/95; 8.324.5.10 NMAC - Rn, 8 NMAC 4.MAD.754.1 & A, 7/1/04; A, 2/1/11]

8.324.5.11 PROVIDER RESPONSIBILITIES: [~~Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and~~

~~determine if medicaid recipients have other health insurance. Providers must maintain records that are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. Providers must notify recipients of covered and non-covered services by medicaid prior to providing services. See 8.301.3 NMAC, *General Noncovered Services* and 8.302.1 NMAC, *General Provider Policies*.~~]

A. A provider who furnishes services to a medicaid or other health care programs eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.324.5.11 NMAC - Rn, 8 NMAC 4.MAD.754.2 & A, 7/1/04; A, 2/1/11]

8.324.5.12 COVERED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES:

A. [~~Medicaid~~] **Durable medical equipment:** MAD covers durable medical equipment (DME) that [~~meet~~] meets the definition of DME, the medical necessity criteria and the prior authorization requirements. [~~Medicaid~~] MAD covers repairs, maintenance, delivery of durable medical equipment and disposable and non-reusable items essential for use of the equipment, subject to the limitations specified in this section. All items purchased or rented must be ordered by [~~providers who are currently enrolled in medicaid~~] a provider who is currently enrolled with MAD. MAD coverage for DME is limited for an eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, nursing facility, intermediate care facility for the metally retarded and a rehabilitation facility. An eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover multiple services. An eligible recipient is limited to one wheelchair, one hospital bed, one oxygen delivery system or one of any particular type of equipment. A back-up ventilator is covered.

(1) "Durable medical equipment" is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

(2) Equipment used in [~~a~~] an eligible recipient's residence must be used exclusively by the eligible recipient for whom it was approved.

(3) To meet the medical necessity criterion, durable medical equipment must be necessary for the treatment of an illness or injury or to improve the functioning of a body part.

(4) Replacement of equipment is limited [~~to one item every three years for adults,~~] to the same extent as it is limited by medicare policy. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in medical necessity or [~~are~~] as otherwise indicated in policy.

B. [~~Medicaid~~] **Medical supplies:** MAD covers medical supplies that are necessary for an ongoing course of treatment within the limits specified in this section. As distinguished from DME, medical supplies are disposable and non-reusable items. [~~Medicaid also covers oxygen, nutritional products and shipping charges as specified in this section. Medicaid coverage for DME and medical supplies may be limited for recipients in institutional settings when the institutions are expected to provide the necessary items. Institutional settings are hospitals, nursing facilities, intermediate care facilities for the mentally retarded and rehabilitation facilities.~~]

(1) A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.

(2) Medicaid coverage for DME and medical supplies may be limited for recipients in MAD coverage for medical supplies is limited for an eligible recipient in an institutional setting when the institution is to

provide the necessary items. An institutional setting is a hospital, nursing facility, intermediate care facility for the mentally retarded and a rehabilitation facility.

[~~C.~~] D. **Covered services for non-institutionalized recipients:** [~~Medicaid covers certain medical supplies, nutritional products and durable medical equipment provided to eligible non-institutionalized recipients without prior authorization. Medicaid covers the following for non-institutionalized recipients:~~] MAD covers certain medical supplies, nutritional products and durable medical equipment provided to a non-institutionalized eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare policy. When medicare does not specify a limitation, an item is limited to reasonable amounts as defined by medicaid and published in the billing instructions for DME/medical supplies. MAD covers the following for a non-institutionalized eligible recipient:

(1) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyperalimentation or enteral feedings;

(2) diabetic supplies, chemical reagents, including blood, urine and stool testing reagents;

(3) gauze, bandages, dressings, pads, and tape;

(4) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;

(5) parenteral nutritional support products prescribed by a physician on the basis of a specific medical indication for [~~a~~] an eligible recipient who has a defined and specific pathophysiologic process for which nutritional support is considered specifically therapeutic and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet medical needs;

(6) apnea monitors: prior authorization is required if the monitor is needed for six [~~(6)~~] months or longer; and

(7) disposable [~~sterile~~] gloves (sterile or non-sterile) are limited to 200 per month[~~; disposable non-sterile gloves are limited to 200 per month~~].

[~~D.~~] C. **Covered services [~~for institutionalized and non-institutionalized recipients~~] and items:** [~~Medicaid~~] MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized [~~recipients~~] eligible recipient:

(1) trusses and anatomical supports that do not need to be made to measure;

(2) family planning devices;

(3) [~~repairs to DME; medicaid covers repair and replacement parts if recipients own the equipment for which the repair is necessary and the equipment being repaired is a covered medicaid benefit;~~] repairs to DME and replacement parts if an eligible recipient owns the equipment for which the repair is necessary and the equipment being repaired is a covered MAD benefit; some replacement items used in repairs may require prior authorization; [~~repairs to augmentative and alternative communication devices require prior authorization;~~] see Subsection C of 8.324.5.14 NMAC;

(4) repairs to augmentative and alternative communication devices require prior authorization;

[~~(4)~~] (5) monthly rental includes monthly service and repairs; and

[~~(5)~~] (6) replacement batteries and battery packs for augmentative and alternative communication devices owned by the eligible recipient.

E. **Covered oxygen and oxygen administration equipment:**

(1) [~~Medicaid~~] MAD covers the following oxygen and oxygen administration systems, within the specified limitations:

(a) oxygen contents, including oxygen gas and liquid oxygen;

(b) oxygen administration equipment purchase, with prior authorization: oxygen administration equipment may be supplied on a rental basis for one [~~(1)~~] month without prior authorization; rental beyond the initial month requires prior authorization.

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems; medicaid approves the most economical oxygen delivery system [~~possible for a specific recipient when considering types of oxygen concentrators~~] available that meets the medical needs of the eligible recipient;

(d) cylinder carts, humidifiers, regulators and flow meters;

(e) purchase of cannulae or masks; and

(f) oxygen tents and croup or pediatric tents.

(2) [~~Medicaid~~] MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If [~~medicaid~~] MAD pays rental charges for systems, tank rental is included in the rental payments. MAD follows the medicare rules for limiting or capping reimbursement for oxygen rental at 36 months, requirements for the provider to maintain and repair the equipment, and to provide ongoing services and disposable supplies after the capped rental.

(3) [~~Nursing homes are administratively responsible for overseeing oxygen supplied to their residents. Nursing homes are encouraged to enter into agreements with oxygen suppliers to provide a well-managed process for provision of oxygen.~~] A nursing home is administratively responsible for overseeing oxygen supplied to the eligible recipient.

F. **Augmentative and alternative communication devices:** [~~Medicaid~~] MAD covers medically necessary electronic or manual augmentative communication devices for [~~medicaid recipients~~] an eligible recipient. Medical necessity is determined by [~~the medical assistance division~~] MAD or its designee(s). Communication devices whose purpose is also educational [~~and/or~~] or vocational are covered only when it has been determined the device meets medical criteria.

(1) [~~A recipient must have the cognitive ability to use the augmentative communication device and meet one of the following criteria:~~

~~(a) the recipient cannot functionally communicate verbally or through gestures due to various medical conditions in which speech is not expected to be restored; or~~

~~(b) the recipient cannot verbally or through gestures participate in his/her own health care decisions (i.e., making decisions regarding medical care or indicating medical needs or communicate informed consent on medical decisions).~~] An eligible recipient must:

(a) have the cognitive ability to use the augmentative communication device; and

(b) be able to functionally communicate verbally or through gestures.

(2) All of the following criteria must be met before an augmentative communication device can be considered for authorization. The communication device must be:

(a) a reasonable and necessary part of the eligible recipient's treatment plan;

(b) consistent with the symptoms, diagnosis or medical condition of the illness or injury under treatment;

(c) not furnished for the convenience of the eligible recipient, the family, the attending practitioner or other practitioner or supplier;

(d) necessary and consistent with generally accepted professional medical standards of care [~~(i.e., not experimental or investigational)~~];

(e) established as safe and effective for the eligible recipient's treatment protocol; [~~and~~]

(f) furnished at the most appropriate level suitable for use in the eligible recipient's home environment;

(g) augmentative and alternative communication devices are authorized every 60 months for an eligible recipient 21 years of age or older and every 36 months for an eligible recipient under 21 years of age, unless earlier authorization is dictated by medical necessity; and

(h) repairs to, and replacement parts for augmentative and alternative communication devices owned by the recipient.

G. **Rental of durable medical equipment:** [~~Medicaid~~] MAD covers the rental of durable medical equipment. [~~All rental payments must be applied toward purchase of the equipment. When the rental charges equal the amount allowed by medicaid for purchase, the equipment becomes the property of the recipient for whom it was approved.~~]

(1) [~~Medicaid~~] MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace equipment during the rental period.

(2) Low cost items, defined as those items for which the medicaid allowed payment is less than [~~one hundred and fifty ($150)~~] $150 dollars, may only be purchased. Purchased DME becomes the property of the [~~medicaid~~] eligible recipient for whom it was approved.

[~~(3) Oxygen concentrators, ventilators, stationary and portable liquid oxygen systems are not subject to the mandatory provisions of applying the rental payments toward purchase. See Subsection E of 8.324.5.12 NMAC, *covered oxygen and oxygen administration equipment*.~~]

(3) MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.

H. **Delivery of equipment and shipping charges:** [~~Medicaid~~] MAD covers the delivery of DME only when the equipment is initially purchased or rented and the round trip delivery is over [~~seventy-five (75)~~] 75 miles. [~~Providers may bill delivery charges as separate additional charges only when the providers customarily charge a separate amount for delivery to non-medicaid patients~~] A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to those clients who are not recipients of MAD services. [~~Medicaid~~] MAD does not pay delivery charges for equipment purchased by medicare,

for which [~~medicaid~~] MAD is responsible only for the coinsurance and deductible. [~~Medicaid~~] MAD covers shipping charges for DME and medical supplies when it is cost effective or practical to ship items rather than have [~~recipients~~] an eligible recipient travel to pick up items. Shipping charges are defined as the actual cost of shipping items from [~~providers~~] a provider to [~~recipients~~] an eligible recipient by a means other than that of provider delivery. [~~Medicaid~~] MAD does not pay shipping charges for items purchased by medicare for which [~~medicaid~~] MAD is only responsible for the coinsurance and deductible.

[~~I. **Rental and purchase of used equipment:** MAD covers the rental and purchase of used equipment. The equipment must be identified and billed as used equipment. The equipment must have a statement of condition or warranty, and a stated policy covering liability.~~]

[~~J.~~] I. **Wheelchairs and seating systems [~~for institutionalized recipients~~]:**

(1) [~~Medicaid covers customized wheelchairs and seating systems made for specific recipients, including recipients who are institutionalized.~~] MAD covers customized wheelchairs and seating systems made for a specific eligible recipient, including an eligible recipient who is institutionalized. Written prior authorization is required. MAD or its designee cannot give verbal authorizations for customized wheelchairs/seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific eligible recipient and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. There must be a customization of the frame for the wheelchair base or seating system to be considered customized.

(2) Repairs to a wheelchair owned by [~~a~~] an eligible recipient residing in an institution may be covered.

(3) Customized or motorized wheelchairs required by an [~~institutional recipient~~] eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, and will be reviewed on a case-by-case basis.

[2/1/95; 3/1/99; 8.324.5.12 NMAC - Rn, 8 NMAC 4.MAD.754.3 & A, 7/1/04; A, 12/1/04; A, 11/1/05; A, 2/1/11]

8.324.5.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All [~~Medicaid~~] MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review.* [~~Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.~~] The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's written instructions for authorization of services.

A. **Services [~~for non-institutionalized recipients~~] that require prior authorization:** [~~Medicaid~~] MAD covers certain medical supplies, nutritional products and durable medical equipment provided to [~~eligible recipients~~] an eligible recipient with prior authorization. Written requests for items not included in the categories listed above or for a quantity greater than that covered by [~~medicaid~~] MAD may be submitted by the eligible recipient's physician, with a prior authorization request, to MAD for consideration of medical necessity. Please refer to criteria in 8.301.3 NMAC, *General Noncovered Services* [~~MAD-602.6~~] for durable medical equipment or medical supplies that are not covered. Services for which prior authorization was obtained remain subject to review at any point in the payment process. Certain procedures or services may require prior authorization for MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment. See Subsection A of 8.311.2.16 NMAC, *emergency room services.* Prior authorization does not guarantee that an individual is eligible for medicaid. A provider must verify that the individual is eligible for medicaid at the time services are furnished and determine if the recipient has other health insurance. [~~Medicaid~~] MAD covers the following benefits with prior authorization for non-institutionalized eligible recipients:

(1) enteral nutritional supplements and products provided to [~~recipients~~] an eligible recipient who must be tube fed oral nutritional supplements when administered enterally are included;

(2) oral nutritional support products prescribed by a physician:

(a) on the basis of a specific medical indication for [~~a recipient~~] an eligible recipient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet the medical needs;

(b) when medically necessary due to inborn errors of metabolism; [~~or~~]

(c) medically necessary to correct or ameliorate physical illnesses or conditions in [~~children~~] an eligible recipient under the age of [~~twenty-one~~] 21; or

(d) coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance;

(3) either disposable diapers or underpads prescribed for [~~recipients~~] an eligible recipient age three and older who [~~suffer~~] suffers from neurological or neuromuscular disorders or who [~~have~~] has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;

(4) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for specialized wheelchairs;

(5) protective devices, such as helmets and pads;

(6) bathtub rails and other rails for use in the bathroom;

(7) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;

(8) passive motion exercise equipment;

(9) decubitus care equipment;

(10) equipment to apply heat or cold;

(11) hospital beds and full length side rails;

(12) compressor air power sources for equipment that is not self-contained or cylinder driven;

(13) home suction pumps and lymph edema pumps;

(14) hydraulic patient lifts;

(15) ultraviolet cabinets;

(16) traction equipment;

(17) prone standers and walkers;

(18) trapeze bars or other patient helpers that are attached to bed or freestanding;

(19) home hemodialysis and/or peritoneal dialysis systems, replacement supplies [~~and/or~~] or accessories;

(20) wheelchairs and functional attachments to wheelchairs: wheelchairs are authorized every [~~five (5) years~~] 60 months; for [~~recipient~~] an eligible recipient under [~~twenty-one (21)~~] 21 years of age, wheelchairs can be authorized every [~~(3) years~~] 36 months; earlier authorization is possible when dictated by medical necessity;

(21) wheelchair trays;

(22) whirlpool baths designed for home use;

(23) intermittent or continuous positive pressure breathing equipment; and

(24) manual or electronic augmentative and alternative communication devices;

[~~(25) augmentative and alternative communication devices are authorized every five (5) years for adults an eligible recipient 21 years of age or older and every three (3) years for recipients under twenty-one (21) years of age, unless earlier authorization is dictated by medical necessity.~~

~~B. **Services for institutionalized and non-institutionalized recipients that require prior authorization:** Medicaid covers the following items with prior authorization for both institutionalized and non-institutionalized recipients:~~

~~(1)~~] 25 trusses and anatomical supports that require fitting or adjusting by trained individuals, including JOBST hose;

[~~(2)~~] 26 custom-fitted compression stockings; and

[~~(3)~~] 27 artificial larynx prosthesis;

[~~(4) repairs to, and replacement parts for, augmentative and alternative communication devices owned by the recipient.~~

~~C. **Additional review:** Services for which prior authorization was obtained remain subject to review at any point in the payment process.~~

~~. **Eligibility determination:** Prior authorization does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.~~

~~E.~~] B. **Reconsideration:** [~~Providers who disagree~~] A provider who disagrees with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[~~F. **Reasons for prior authorization denial:** Requests for prior authorization are denied for any of the following reasons~~

~~(1) prescribing providers have not examined recipients within two (2) months or have insufficient knowledge of the recipient's condition to enable them to prescribe or recertify the need for DME~~

~~(2) prescriptions do not document recent physician involvement in the estimate of duration of need or the recipient's condition; or~~

~~(3) requests are not signed by attending physicians: signature stamps or signatures by employees are not acceptable.~~]

[2/1/95; 3/1/99; 6/15/99; 8.324.5.13 NMAC - Rn, 8 NMAC 4.MAD.754.4 & A, 7/1/04; A, 11/1/05; A, 2/1/11]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

[~~A. **Non-covered multiple services:** Medicaid does not cover multiple services. Recipients are limited to one wheelchair, one hospital bed, one oxygen delivery system or one of any particular type of equipment. A back-up ventilator is covered.~~

~~B.~~] A. **Special requirements for purchase of wheelchairs:** [~~Before billing for a customized wheelchair, providers who deliver the wheelchair and seating system to a recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the recipient for whom it was authorized.~~] Before billing for a customized wheelchair, the provider who delivers the wheelchair and seating system to an eligible recipient must make a final evaluation to ensure that the wheelchair and seating system meets the medical, social and environmental needs of the eligible recipient for whom it was authorized.

(1) [~~Providers assume~~] The provider assumes responsibility for correcting defects or deficiencies in wheelchair and seating systems that make them unsatisfactory for use by [~~recipients~~] the eligible recipient.

(2) [~~Providers are~~] The provider is responsible for consulting physical therapists, occupational therapists, special education instructors, teachers, parents or guardians, as necessary, to ensure that the wheelchair meets the eligible recipient's needs.

(3) Evaluations by a physical therapist [~~and/or~~] or occupational therapist are required when ordering customized wheelchairs and seating systems. These therapists should be familiar with the brands and categories of wheelchairs and appropriate seating systems and work with the eligible recipient and those consultants listed in Paragraph (2) of Subsection B of 8.324.5.14 NMAC to assure that the selected system matches physical seating needs. The physical [~~and/or~~] or occupational therapist may not be a wheelchair vendor or under the employment of a wheelchair vendor or wheelchair manufacturer.

[~~(3)~~] (4) [~~Medicaid~~] MAD does not pay for special modifications or replacement of customized wheelchairs after the wheelchairs are furnished to [~~recipients~~] the eligible recipient.

[~~(4)~~] (5) When the equipment is delivered to the eligible recipient and the eligible recipient accepts the order, the provider will submit the claim for reimbursement.

[~~C.~~] B. **Special requirements for purchase of augmentative and alternative communication devices:**

(1) The purchase of augmentative communication devices requires prior authorization. In addition to being prescribed by a physician, the communication device must also be recommended by a speech-language pathologist, who has completed a systematic and comprehensive evaluation. The speech pathologist may not be a vendor of augmentative communication systems nor have a financial relationship with a vendor.

(2) A trial rental period of up to 60 calendar days is required for all electronic devices to ensure that the chosen device is the most appropriate device to meet the eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the eligible recipient's ability to use the communication device must be provided showing that the eligible recipient's ability to use the device is improving and that the eligible recipient is motivated to continue to use this device.

(3) [~~Medicaid~~] MAD does not pay for supplies for augmentative and alternative communication devices, such as, but not limited to, paper, printer ribbons and computer discs.

(4) Prior authorization is required for equipment repairs.

(5) A provider or medical supplier that routinely supplies an item to an eligible recipient must document that the order for additional supplies was requested by the recipient or their personal representative and the provider or supplier must confirm that the eligible recipient does not have in excess of a 15 calendar day supply of the item before releasing the next supply order to the eligible recipient. A provider must keep documentation in their files available for audit that show compliance with this requirement.

[2/1/95; 3/1/99; 8.324.5.14 NMAC - Rn, 8 NMAC 4.MAD.754.5 & A, 7/1/04; A, 2/1/11]

8.324.5.15 NONCOVERED SERVICES: [~~Medicaid~~] MAD does not cover certain durable medical equipment and medical supplies. See 8.301.3 NMAC, *General Noncovered Services* [~~MAD-602~~], for an overview of the criteria used to assess whether equipment and supplies are not covered.

2/1/95; 3/1/99; 8.324.5.15 NMAC - Rn, 8 NMAC 4.MAD.754.6 &A, 7/1/04; A, 2/1/11]

8.324.5.16 REIMBURSEMENT: [~~Durable medical equipment or medical supply providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.~~

~~A. Reimbursement for purchase or rental of DME and for nutritional products is made at the lesser of the provider's billed charges, the medicare fee schedule, or the MAD maximum allowed amount.~~

~~(1) The provider's billed charge must be the lesser of the usual and customary charge for the item or service, or the actual acquisition cost plus a percentage as described below:~~

~~(a) for items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than one thousand dollars ($1,000), the provider must bill the actual acquisition cost plus twenty-five percent (25%).~~

~~(b) for items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is one thousand dollars ($1,000) or greater, the provider must bill the actual acquisition cost plus fifteen percent (15%).~~

~~(2) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service.~~

~~(3) Medicare fees are implemented when MAD is advised by medicare of changes in the fee schedule. MAD implements medicare fees retroactively.~~

~~(4) If there is not a medicare fee schedule for the item, the MAD maximum allowed amount is the provider's actual acquisition cost plus the applicable percentage as described in Paragraph (1) of Subsection A of 8.324.5.16 NMAC.~~

~~(5) All rental payments must be applied towards purchase, with the exception of ventilators, oxygen concentrators and liquid oxygen units. Providers must keep a running total of rental charges identifying the total of all rental charges for each piece of equipment.~~

~~(6) "Set-up fees" are considered to be included in the payment for the equipment or supplies and are not reimbursed as separate charges.~~]

A. **Reimbursement for purchase or rental**: Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for DME and medical supplies and nutritional products is made at the lesser of:

(1) the provider's billed charges or the MAD fee schedule; or

(2) when applicable; alternatively, when there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows:

(a) durable medical equipment, medical supplies and nutritional products;

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000 dollars, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent;

(b) custom specialized wheelchairs and their customized related accessories: payment is limited to the provider's actual acquisition cost plus 15 percent.

B. Rental payments must be applied towards the purchase with the exception of ventilators. Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Reimbursement for rental of DME is made at the lesser of:

(1) the provider's billed charges; or

(2) the MAD fee schedule, when applicable; payment for the month of rental is limited to the provider's acquisition invoice cost plus a percentage, as follows:

(a) a provider must keep a running total of rental payments for each piece of equipment; a provider must consider the items sold and the item becomes the property of the eligible recipient when 13 rental payments have been made for the item, or earlier when the rental payments total the lesser of the provider's usual and customary charge for the purchase of the item or the MAD fee schedule for the purchase of the item; or for an item for which a fee schedule purchase price has not been established by MAD when the provider has received rental payments equal to one of the following:

(i) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is less than $1,000 dollars, payment is limited to the provider's actual acquisition cost plus 20 percent;

(ii) items for which the provider's actual acquisition cost, reflecting all discounts and rebates, is $1,000 or greater, payment is limited to the provider's actual acquisition cost plus 10 percent.

(3) MAD follows medicare rules regarding capped rental. For rental months one through three, the full fee schedule rental fee is allowed. For rental months four through 13, the rental fee schedule rental fee is reduced by 25 percent. No additional rental payments are made following the month 13 or to the most current schedule determined by medicare. The provider may only bill for routine maintenance and for repairs, and oxygen contents, to the extent as allowed by medicare.

(4) oxygen is paid using the medicare billing, capped rental period, and payment rules;

(5) a provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD upon request;

(6) 'set-up fees" are considered to be included in the payment for the equipment or supplies and are not reimbursed as separate charges.

[~~B. **Reimbursement for medical supplies and home infusion drugs:** Reimbursement to providers is made at the lesser of the following:~~

~~(1) The provider's billed charge;~~

~~(a) the provider's billed charge is their usual and customary charge for services.~~

~~(b) "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific service or item, or~~

~~(2) The maximum established by MAD, which is the department's estimated acquisition cost of the item plus twenty-five percent (25%). The department's estimated acquisition cost will be calculated using the average wholesale price less 10.5 percent (10.5%).~~

~~(3) Home infusion drugs are reimbursed at the lesser of the provider's billed charge or the MAD fee schedule.~~

~~(a) Home infusion providers will be reimbursed a dispensing fee for each package or intravenous admisture prepared and dispensed to the recipient.~~

~~(b) Reimbursement will be made at the lesser of the provider's usual and customary charge or the MAD fee schedule.~~]

C. **Reimbursement for home infusion drugs:** Unless otherwise specified in this section, the provider's billed charges must be the usual and customary charge for the item or service. The term "usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific item or service. Home infusion drugs are reimbursed as follow at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee;

(3) for home infusion drugs for which a fee schedule price has not been established by MAD, or for which the description associated with the appropriate billing code is too broad to establish a reasonable payment level, payment is limited to the provider's acquisition cost plus 20 percent. A provider must retain a copy of their acquisition invoice showing the provider's purchase of an item and make it available to MAD upon request.

[~~C.~~] D. **Reimbursement for delivery and shipping charges:** Delivery charges are reimbursed at the MAD maximum amount per mile. Shipping charges are reimbursed at actual cost if the method used is the least expensive method of shipping. [~~Medicaid~~] MAD does not pay for charges for shipping items from suppliers to the providers.

[2/1/95; 12/30/95; 3/1/01; 8.324.5.16 NMAC - Rn, 8 NMAC 4.MAD.754.7 & A, 7/1/04; A, 2/1/11]