

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 5 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT,
OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS

8.324.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.324.5.1 NMAC - Rp, 8.324.5.1 NMAC, 1-1-14]

8.324.5.2 SCOPE: The rule applies to the general public.
[8.324.5.2 NMAC - Rp, 8.324.5.2 NMAC, 1-1-14]

8.324.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program 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 or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.324.5.3 NMAC - Rp, 8.324.5.3 NMAC, 1-1-14]

8.324.5.4 DURATION: Permanent.
[8.324.5.4 NMAC - Rp, 8.324.5.4 NMAC, 1-1-14]

8.324.5.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.324.5.5 NMAC - Rp, 8.324.5.5 NMAC, 1-1-14]

8.324.5.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.324.5.6 NMAC - Rp, 8.324.5.6 NMAC, 1-1-14]

8.324.5.7 DEFINITIONS: [RESERVED]

8.324.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.324.5.8 NMAC - Rp, 8.324.5.8 NMAC, 1-1-14]

8.324.5.9 VISION APPLIANCES, HEARING APPLIANCES, DURABLE MEDICAL EQUIPMENT, OXYGEN, MEDICAL SUPPLIES, PROSTHETICS AND ORTHOTICS: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to a medical assistance program (MAP) eligible recipient, including covered vision appliances, hearing aids and related services [42 CFR Section 440.60(a) and Section 440.110(c)], durable medical equipment and medical supplies, [42 CFR Section 440.70 (c)] and covered prosthetic and orthotic services [42 CFR Section 440.120(c)].
[8.324.5.9 NMAC - Rp, 8.324.5.9 NMAC, 1-1-14]

8.324.5.10 ELIGIBLE PROVIDERS: Health care to a MAP eligible recipient 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 (PPA), a licensed practitioner of a facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to a MAP eligible recipient. 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 instruction, utilization review (UR) 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, to comply with the requirements and to update his or her knowledge as new material is provided by MAD. The provider must contact HSD or its authorized agents to request hard copies of any MAD New Mexico administrative code (NMAC) program rules, MAD billing and UR instructions and other pertinent material, and 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 his or her MAD PPA and all applicable statutes, regulations, rules and executive orders. MAD or its selected claims processing contractor

issues payments to a provider using electronic funds transfer (EFT) only. A provider must supply necessary information in order for payment to be made. Upon approval of his or her MAD PPA, the following practitioners and facilities may be enrolled as MAD providers:

A. Vision appliance provider:

- (1) an ophthalmologist licensed to practice medicine in New Mexico, who limits his or her practice to ophthalmology (ophthalmologist) and the groups, corporations, and professional associations they form;
- (2) an optometrist licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;
- (3) an optician qualified to provide eyeglasses, contact lenses, supplies, and other vision-related materials; or
- (4) Indian health service (IHS) or a tribal facility operating under Public Law 93-638.

B. Hearing appliances providers:

- (1) an individual licensed to practice medicine or osteopathy; or
- (2) a hearing aid dealer registered and licensed by the New Mexico regulations and licensing division (RLD) practice boards for speech language pathology, audiology, and hearing aid dispensing.

C. Durable medical equipment (DME), oxygen and medical supplies provider: A DME, oxygen and medical supplies provider must hold a current PPA with MAD.

D. Prosthetics and orthotics provider: A prosthetics or orthotics provider must hold a current PPA with MAD.

[8.324.5.10 NMAC - Rp, 8.324.5.10 NMAC, 1-1-14]

8.324.5.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. A provider who furnishes services to a MAP eligible recipient must comply with all federal, state, local laws, rules, regulations, executive orders and the provisions of his or her PPA. A provider must adhere to the NMAC program rules and program policies that include but are not limited to supplements, billing instructions, and UR directions, as updated. The provider is responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify an individual is eligible for a specific MAD service and verify the recipient's enrollment status at time of service, as well as determining if a copayment is applicable or if services require prior authorization. A provider must determine if a MAP 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 the MAP eligible recipient.

C. Services furnished must be within the scope of practice defined by the provider's licensing board, scope of practice act, or regulatory authority; see 8.302.2 NMAC.

D. Vision appliances providers: A provider must ensure that a prescription for eyeglasses or contact lenses is accurate to the extent that the prescription corrects the MAP eligible recipient's vision to the degree of acuity indicated on his or her vision examination record. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and the MAP eligible recipient is unable to use his or her eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[8.324.5.11 NMAC - Rp, 8.324.5.11 NMAC, 1-1-14]

8.324.5.12 COVERED SERVICES:

A. Vision appliances: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays a provider for the correction of refractive errors that are required by the condition of the MAP eligible recipient. All services must be furnished within the limits of MAD benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and his or her New Mexico regulation and licensing division's (RLD) practice board.

(1) Exam: MAD covers routine eye exams. Coverage for a MAP eligible recipient over 22 years of age is limited to one routine eye exam in a 36-month period. Exam coverage for a MAP eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period. If a MAP eligible recipient has transitioned

from the early, periodic screening, diagnosis and treatment (EPSDT) program at age 21, the date of service for his or her last exam starts the 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma will be covered for required follow-up and treatment. The medical condition must be clearly documented on his or her visual examination record and indicated by diagnosis on the claim form.

(2) Corrective lenses: MAD covers one set of corrective lenses for a MAP eligible recipient 21 years of age and older not more frequently than once in a 36-month period. For a MAP eligible recipient under 21 years of age, one set of corrective lenses is covered no more frequently than once every 12 months. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service for his or her last corrective lenses starts the 36-month period. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the MAP eligible recipient's visual examination record and indicated by a diagnosis on the claim.

(a) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

- (i) -1.00 myopia (nearsightedness);
- (ii) + 1.00 for hyperopia (farsightedness);
- (iii) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;
- (iv) ± 1.00 for presbyopia (farsightedness of aging); or
- (v) diplopia (double vision) - prism lenses.

(b) When a MAP eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Paragraph (2) above, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

- (i) a MAP eligible recipient over 21 years of age with cataracts;
- (ii) an ophthalmologist or optometrist recommends a change due to a medical condition; or
- (iii) a MAP eligible recipient is under 21 years of age.

(3) Bifocal lenses: MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

(4) Tinted lenses: MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the comments section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

- (a) aniridia;
- (b) albinism, ocular;
- (c) traumatic defect in iris;
- (d) iris coloboma, congenital;
- (e) chronic keratitis;
- (f) sjogren's syndrome;
- (g) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;
- (h) rod monochromaly;
- (i) pseudophakia; or
- (j) other diagnoses confirmed by ophthalmologist or optometrist that is documented in the

MAP eligible recipient's visual examination form.

(5) Polycarbonate lenses: MAD covers polycarbonate lenses for:

(a) a MAP eligible recipient for medical conditions which require prescriptions for high power lenses;

- (b) a MAP eligible recipient with monocular vision;
- (c) a MAP eligible recipient who works in a high-activity physical job;
- (d) a MAP eligible recipient under 21 years of age; or
- (e) a MAP eligible recipient 21 years and older that has a developmental or intellectual

disability.

(6) Balance lenses: MAD covers balance lenses for a MAP eligible recipient under 21 years of age without a prior authorization in the following situations:

- (a) lenses used to balance an aphakic eyeglass lens; or

(b) a MAP eligible recipient under 21 years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

(7) Frames: MAD covers frames for corrective lenses. Coverage for a MAP eligible recipient 21 years of age and older is limited to one frame in a 36-month period. If a MAP eligible recipient has transitioned from the EPSDT program at age 21, the date of service of his or her last frames starts the 36-month period. Coverage for a MAP eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

(a) an ophthalmologist or optometrist has documented a medical condition that requires replacement; or

(b) other situations that will be reviewed on a case-by-case basis.

(8) Contact lenses: MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient 21 years of age and older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. If a MAP eligible recipient is transition from the EPSDT program at age 21, the date of service for his or her last contact lenses starts as the 24-month period. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the MAP eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(a) the MAP eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian or at least 3.00 diopters of anisometropia; or

(b) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

(9) Replacement: Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the MAP eligible recipient, may be replaced. Two items must be documented in the provider's request for the replacement in addition to being found in the MAP eligible recipient's visual examination record: The MAP eligible recipient's eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion; and an explanation of the loss, deterioration or breakage is provided. The following are the criteria that an MAP eligible recipient must be meet for the replacement of his or her eyeglasses or contact lenses:

(a) the MAP eligible recipient is under 21 years of age; or

(b) the MAP eligible recipient is 21 years of age and older and has a developmental or intellectual disability.

(10) Prisms: Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the MAP eligible recipient's visual examination record.

(11) Lens tempering: MAD covers lens tempering only on new glass lenses.

(12) Lens edging: MAD covers lens edging and lens insertion.

(13) Minor repairs: MAD covers minor repairs to eyeglasses.

(14) Dispensing fee: MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames at the same time. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not approved by MAD to prescribe and fit contact lenses.

(15) Eye prosthesis: MAD covers eye prostheses (artificial eyes); see Subsection D below.

B. Hearing appliances:

(1) Within specified limitations, MAD covers the following services when furnished by primary care provider (PCP), licensed audiologists or by licensed hearing aid dealers:

(a) hearing aid purchase, rental repairs, hearing aid repair and handling, replacements, and the loan of equipment while repairs or replacements are made:

(i) binaural hearing aid fitting will be covered for a MAP eligible recipient with bilateral hearing loss who is attending an educational institution, seeking employment, is employed, or for a MAP eligible recipient with a current history of binaural fitting; or

(ii) binaural hearing aid fitting will be considered on a case-by-case basis for a MAP eligible recipient determined to be legally blind;

(b) hearing aid accessories and supplies, including the batteries required after the initial supply furnished at the time the hearing aid is dispensed; and

(c) hearing aid insurance against loss and breakage for up to four years for all purchased hearing aids; hearing aid insurance is required when the aid is dispensed; four years of hearing aid insurance is required for: (i) a MAP eligible recipient under 21 years of age; (ii) a MAP eligible recipient residing in a nursing facility (NF); or (iii) a MAP eligible recipient who has a developmental or intellectual disability;

(d) replacement of hearing aids is limited to the provisions of the MAP eligible recipient's hearing aid insurance; the provider is responsible for obtaining insurance for every hearing aid purchased for a MAP eligible recipient.

C. **DME, oxygen and medical supplies:** MAD covers DME that meets the MAD definition of DME, the medical necessity criteria, and MAD prior authorization requirements. MAD covers the repair, maintenance, delivery of durable medical equipment, and the disposable and non-reusable items essential for the use of the equipment, subject to the limitations specified in this rule. All items purchased or rented must be ordered by a provider who has an approved MAD PPA. Coverage for DME is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, intermediate care facility for individuals with intellectual disabilities (ICF-IID), and a rehabilitation facility. A MAP eligible recipient who is receiving services from a home and community-based waiver is not considered an institutionalized eligible recipient. MAD does not cover duplicates of items, for example, a MAP 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) DME is defined by MAD as: (a) equipment that can withstand repeated use; (b) primarily and customarily used to serve a medical purpose; (c) not useful to an eligible recipient in the absence of an illness or injury; and (d) appropriate for use at home.

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

(3) To meet the medical necessity criterion, DME must be necessary for the MAP eligible recipient's treatment of an illness, injury, or to improve the functioning of a specific body part.

(4) Replacement of equipment is limited to the same extent as it is limited by medicare regulation. When medicare does not specify a limitation, equipment is limited to one item every three years unless there are changes in the MAP eligible recipient's medical necessity or as otherwise indicated in this rule.

(5) 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.

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

(b) MAD coverage for DME and medical supplies is limited for a MAP eligible recipient in an institutional setting when the institution is to provide the necessary items. An institutional setting is a hospital, NF, ICF-IID, and a rehabilitation facility.

(6) Covered services and items: MAD covers the following items without prior authorization for both an institutionalized and non-institutionalized MAP eligible recipient:

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

(b) family planning devices;

(c) repairs to DME and replacement parts if a MAP 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; see Section 13 of this rule;

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

(e) monthly rental includes monthly service and repairs; and

(f) replacement batteries and battery packs for augmentative and alternative communication devices owned by the MAP eligible recipient.

(7) Covered services for a non-institutionalized MAP eligible recipient: MAD covers certain medical supplies, nutritional products and DME provided to a non-institutionalized MAP eligible recipient without prior authorization. Monthly allowed quantities of items are limited to the same extent as limited by medicare regulation. When medicare does not specify a limitation, an item is limited to a reasonable amount as defined by MAD and published in its DME and medical supplies billing instructions which are available on the HSD/MAD website. MAD covers the following for a non-institutionalized MAP eligible recipient:

(a) needles, syringes and intravenous (IV) equipment including pumps for administration of drugs, hyper-alimentation or enteral feedings;

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

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

(d) catheters, colostomy, ileostomy and urostomy supplies and urinary drainage supplies;
(e) parenteral nutritional support products prescribed by a PCP on the basis of a specific medical indication for a MAP 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 the MAP eligible recipient's medical needs;

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

(g) disposable gloves (sterile or non-sterile) are limited to 200 per month.

(8) Covered oxygen and oxygen administration equipment: MAD covers the following oxygen and oxygen administration systems, within these 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 month without prior authorization; rental beyond the initial month requires a prior authorization;

(c) oxygen concentrators, liquid oxygen systems and compressed gaseous oxygen tank systems. MAD approves the most economical oxygen delivery system available that meets the medical needs of the MAP 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.

(g) MAD does not cover oxygen tank rental (demurrage) charges as separate charges when renting gaseous tank oxygen systems. If MAD pays rental charges for a system, tank rental is included in the rental payments. MAD follows the medicare rules for: (i) limiting or capping reimbursement for oxygen rental at 36 months; (ii) requirements for the provider to maintain and repair the equipment; and (iii) to providing ongoing services and disposable supplies after the capped rental;

(h) a NF is administratively responsible for overseeing oxygen supplied to the MAP eligible recipient resident.

(9) Augmentative and alternative communication devices: MAD covers medically necessary electronic or manual augmentative communication devices for a MAP eligible recipient. Medical necessity is determined by MAD or its designee. Communication devices whose purpose is also educational or vocational are covered only when it has been determined the device meets medical criteria. A MAP eligible recipient must have the cognitive ability to use the augmentative communication device, and not be able to functionally communicate verbally or through gestures.

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

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

(ii) consistent with the MAP eligible recipient's symptoms, diagnosis or medical condition of the illness or injury under treatment;

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

(iv) necessary and consistent with generally accepted professional medical standards of care;

(v) established as safe and effective for the MAP eligible recipient's treatment protocol;

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

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

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

(10) Rental of DME: MAD covers the rental of DME.

(a) MAD does not cover routine maintenance and repairs for rental equipment as it is the provider's responsibility to repair or replace the MAP eligible recipient's equipment during the rental period.

(b) Low cost items, defined as those items for which the MAD allowed payment is less than \$150, may only be purchased. For these items, the purchased DME becomes the property of the MAP eligible recipient for whom it was approved.

(c) 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.

(11) Delivery of equipment and shipping charges: MAD covers the delivery of a DME item only when the equipment is initially purchased or rented and the round trip delivery is over 75 miles. A provider may bill delivery charges as a separate additional charge when the provider customarily charges a separate amount for delivery to its clients who are not a MAP eligible recipient of the service. MAD does not pay delivery charges for equipment purchased by medicare, for which MAD is responsible only for the coinsurance and deductible. MAD covers the shipping charges for DME and medical supplies when it is more cost effective or practical to ship items to the MAP eligible recipient rather than have him or her travel to pick up items. Shipping charges are defined as the actual cost of shipping an item from a provider to a MAP eligible recipient by a means other than that of provider delivery. MAD does not pay shipping charges for an item purchased by medicare for which MAD is only responsible for the coinsurance and deductible.

(12) Wheelchairs and seating systems:

(a) MAD covers customized wheelchairs and seating systems made for a specific MAP eligible recipient, including a MAP eligible recipient who is institutionalized. Written prior authorization is required by MAD or its designee. MAD or its designee cannot give verbal authorizations for customized wheelchairs and seating systems. A customized wheelchair and seating system is defined as one that has been uniquely constructed or substantially modified for a specific MAP 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.

(b) Repairs to a wheelchair owned by a MAP eligible recipient residing in an institution are covered.

(c) A customized or motorized wheelchair required by a MAP eligible recipient who is institutionalized to pursue educational or employment activity outside the institution may be covered, but must be reviewed on a case-by-case basis by MAD or its designee.

D. Prosthetics and orthotics supplies: MAD covers medically necessary prosthetics and orthotics supplied by a MAD provider to a MAP eligible recipient only when specified requirements or conditions are satisfied. Prosthetic devices are replacements or substitutes for a body part or organ, such as an artificial limb or eye prosthesis. Orthotic devices support or brace the body, such as trusses, compression custom-fabricated stockings and braces. MAD covers prosthetics and orthotics only when all the following conditions are met:

(1) the device has been ordered by the MAP eligible recipient's PCP or other appropriate practitioner and is medically necessary for MAP eligible recipient's mobility, support or physical functioning;

(2) the need for the device is not satisfied by the existing device the MAP eligible recipient currently has;

(3) the device is covered by MAD and all prior approval requirements have been satisfied;

(4) coverage of compression stockings for a MAP eligible recipient 21 years and older is limited to stockings that are custom-fabricated to meet his or her medical needs;

(5) coverage of orthopedic shoes for a MAP eligible recipient 21 years and older is limited to the shoe that is attached to a leg brace;

(6) replacement of items is limited to one item every three years, unless there is a change in the MAP eligible recipient's medical necessity; and

(7) therapeutic shoes furnished to a diabetic is limited to one of the following within one calendar year:

(a) no more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; and

(b) no more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

[8.324.5.12 NMAC - Rp, 8.324.5.12 NMAC, 1-1-14]

8.324.5.13 UTILIZATION REVIEW AND PRIOR AUTHORIZATION: All MAD services are subject to UR for medical necessity and program compliance. Reviews can 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. MAD

makes available on its website and other websites UR instructions. It is the provider's responsibility to access these instructions or ask for hard 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. Prior authorization does not guarantee that an individual is eligible for a MAD service.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to UR at any point in the payment process. When services are billed to and paid by a coordinated services contractor authorized by MAD, the provider must follow that contractor's instructions for the authorization of a service. Written requests for items not included in the categories listed or for a quantity greater than that covered by MAD in this rule may be submitted by the MAP eligible recipient's PCP, with a prior authorization request to MAD or its designee for consideration of medical necessity.

B. **Eligibility determination:** The prior authorization of a service does not guarantee that an individual is eligible for a MAD service. A provider must verify that an individual is eligible for a specific MAD service at the time the service is furnished and must determine if the MAP eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with a prior authorization denial or another review decision may request a reconsideration; see 8.350.2 NMAC.

D. **Prior authorization for specific services:** The following services and procedures require prior authorization from MAD or its designee:

- (1) hearing appliances:
 - (a) hearing aid dispensing, purchase, rental and replacement;
 - (b) hearing aid repairs for which the provider's billed charge exceeds \$100;
 - (c) services for which prior authorization was obtained remain subject to review at any point in the payment process; and
 - (d) medical clearance: PCP medical approval is required on any request for prior authorization for hearing aids; the MAP eligible recipient's PCP must certify that her or she is a suitable candidate for hearing aids by signing the hearing aid evaluation and information MAD prior authorization form; documentation must be on the PCP's letterhead or prescription pad; this documentation must be submitted with the prior approval request; a MAP eligible recipient under 16 years of age, must be examined by a physician who is board certified in the diagnosis and treatment of diseases and conditions of the ear for all hearing aid fittings.
- (2) DME, oxygen and medical supplies: MAD covers certain medical supplies, nutritional products and DME provided to a MAP eligible recipient with prior authorization. Please refer to criteria in 8.301.3 NMAC for DME or medical supplies that are not covered. MAD covers the following benefits with prior authorization for a non-institutionalized MAP eligible recipient:
 - (a) enteral nutritional supplements and products for a MAP eligible recipient who must be tube fed oral nutritional supplements;
 - (b) oral nutritional support products prescribed by the MAP eligible recipient's PCP:
 - (i) on the basis of a specific medical indication for a MAP 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 his or her medical needs;
 - (ii) when medically necessary due to inborn errors of metabolism;
 - (iii) medically necessary to correct or ameliorate physical illnesses or conditions in a MAP eligible recipient under 21 years of age; or
 - (iv) 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;
 - (c) either disposable diapers or underpads prescribed for a MAP eligible recipient age three years and older who suffers from neurological or neuromuscular disorders or who has other diseases associated with incontinence is limited to either 200 diapers per month or 150 underpads per month;
 - (d) supports and positioning devices that are part of a DME system, such as seating inserts or lateral supports for a specialized wheelchair;
 - (e) protective devices, such as helmets and pads;
 - (f) bathtub rails and other rails for use in the bathroom;
 - (g) electronic monitoring devices, such as electronic sphygmomanometers, oxygen saturation, fetal or blood glucose monitors and pacemaker monitors;
 - (h) passive motion exercise equipment;

- (i) decubitus care equipment;
- (j) equipment to apply heat or cold;
- (k) hospital bed and full length side rails;
- (l) compressor air power sources for equipment that is not self-contained or cylinder driven;
- (m) home suction pump and lymph edema pump;
- (n) hydraulic patient lift;
- (o) ultraviolet cabinet;
- (p) traction equipment;
- (q) prone stander and walker;
- (r) trapeze bar or other patient-helpers that are attached to bed or freestanding;
- (s) home hemodialysis or peritoneal dialysis system and its replacement supplies or

accessories;

(t) wheelchair and functional attachments to a wheelchair; a wheelchair is authorized every 60 months for a MAP eligible recipient 21 years and older; for a MAP eligible recipient under 21 years of age, a wheelchair can be authorized every 36 months; and earlier authorization is possible when dictated by his or her medical necessity;

- (u) wheelchair tray;
- (v) whirlpool bath designed for home use;
- (w) intermittent or continuous positive pressure breathing equipment;
- (x) manual or electronic augmentative and alternative communication device;
- (y) truss and anatomical supports that require fitting or adjusting by trained individuals, including a JOBST hose;
- (z) custom-fitted compression stockings; and
- (aa) artificial larynx prosthesis.

(3) Prosthetics and orthotics: All prosthetic devices require prior authorization from MAD or its designee. The only prior authorization requirement exception is for a prosthetic limb attached immediately following a surgery for a traumatic injury while the MAP eligible recipient is a hospital inpatient. Prior authorization is required for orthotic devices for the foot or for shoes. Services for which prior authorization was obtained remain subject to UR at any point in the payment process.

[8.324.5.13 NMAC - Rp, 8.324.5.13 NMAC, 1-1-14]

8.324.5.14 SERVICE LIMITATIONS AND COVERAGE RESTRICTIONS:

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

(1) The provider assumes responsibility for correcting defects or deficiencies in the wheelchair and seating systems that make them unsatisfactory for use by the MAP eligible recipient.

(2) 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 MAP eligible recipient's needs.

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

(4) MAD does not pay for special modifications or replacement of a customized wheelchair after the wheelchair is furnished to the MAP eligible recipient.

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

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 the MAP eligible recipient's PCP, 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 MAP eligible recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the MAP eligible recipient's ability to use the communication device must be provided showing that the MAP eligible recipient's ability to use the device is improving and that the MAP eligible recipient is motivated to continue to use this device.

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

[8.324.5.14 NMAC - Rp, 8.324.5.14 NMAC, 1-1-14]

8.324.5.15 NONCOVERED SERVICES: The following services are subject to the limitations and coverage restrictions that exist for other MAD services; see 8.302.1 NMAC and 8.310.2 NMAC. The provider must notify the MAP eligible recipient of the coverage limitations prior to providing services.

A. **Vision appliances:** MAD does not cover the following specific vision services:

- (1) orthoptic assessment and treatment;
- (2) photographic procedures, such as fundus or retinal photography and external ocular photography;
- (3) polycarbonate lenses other than those listed in Subsection A of Section 13 of this part;
- (4) ultraviolet (UV) lenses;
- (5) trifocals;
- (6) progressive lenses;
- (7) tinted or photochromic lenses, except in cases of documented medical necessity; see Subsection D of Section 12 of this part;
- (8) oversize frames and oversize lenses;
- (9) low vision aids;
- (10) eyeglass cases;
- (11) eyeglass or contact lens insurance; and
- (12) anti-scratch, anti-reflective, or mirror coating.

B. **Hearing appliances:** Hearing aid selection and fitting is considered included in the hearing aid dispensing fee, and will not be reimbursed separately.

C. **DME, oxygen and medical supplies:** MAD does not cover certain DME and medical supplies. See 8.301.3 NMAC for an overview of which DME or supply item is not covered by MAD.

D. **Prosthetic and orthotics:** The following services are not covered:

(1) orthotic supports for the arch or other supportive devices for the foot, unless they are integral parts of a leg brace or therapeutic shoes furnished to diabetics; and

(2) prosthetic devices or implants that are used primarily for cosmetic purposes.

[8.324.5.15 NMAC - Rp, 8.324.5.15 NMAC, 1-1-14]

8.324.5.16 REIMBURSEMENT: Once enrolled, a provider receives instructions on how to access documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following: (1) the provider's billed charge; or (2) the MAD fee schedule for the specific service or procedure.

A. The provider's billed charge must be his or her 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 procedure or service.

C. **Vision appliances:** A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor.

D. **Hearing appliances:** A hearing aid or related service provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. Reimbursement for hearing aids is made at the lesser

of the provider's billed charge, at the cost to the billing provider as indicated by the manufacturer's, the distributor's or wholesaler's invoice, which shall not exceed MAD's maximum reimbursement limitation amounts.

- (1) Reimbursement for rental of hearing aids includes the following:
 - (a) rental charge for hearing aid; and
 - (b) hearing aid mold and batteries.
- (2) Rental payments apply to the allowed amount for purchase. When the rental payments equal the amount allowed for purchase, the aid is considered purchased and owned by the MAP eligible recipient.
- (3) Reimbursement for repairs to hearing aids is based on the MAD fee schedule. Reimbursement for repairs to hearing aids done by a manufacturer is the lesser of the provider's billed charge or the manufacturer's charge for the repairs plus a predetermined handling fee. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented.
- (4) Reimbursement is made for additional accessories and supplies, including batteries, when required. Reimbursement is made for an additional mold when a single aid type is used for both ears.
- (5) Reimbursement is made for replacement ear molds.
- (6) Reimbursement for insurance for hearing aid loss and accidental damage is paid at the lesser of the provider's billed charge or the maximum fee allowed by MAD. If the insurance policy cost exceeds the maximum fee established by MAD, reimbursement can be made at the actual policy rate if the actual cost is documented.
- (7) Hearing appliances reimbursement limitations:
 - (a) Hearing aid purchase: Hearing aid purchase is limited to one monaural or binaural purchase per four year period with the following exceptions:
 - (i) a MAP eligible recipient under 21 years of age and is subject to prior approval;
 - (ii) progressive hearing loss, such as otosclerosis;
 - (iii) changes due to surgical procedures;
 - (iv) traumatic injury; and
 - (v) replacement of lost hearing aid in accordance with his or her insurance coverage.
 - (b) Dispensing fees: The hearing aid dispensing fee includes payment for the services listed below. If a binaural dispensing fee is paid, it includes payment for all services listed below for both hearing aids:
 - (i) hearing aid selection and the fitting of the aids;
 - (ii) testing of the hearing aids;
 - (iii) one ear mold per hearing aid;
 - (iv) one package of batteries per hearing aid;
 - (v) any other accessories required to fit the aid;
 - (vi) all follow-up visits and adjustments necessary for a successful fitting;
 - (vii) cleaning and adjustments for the life of the aid; and
 - (viii) shipping and handling.
 - (c) Hearing aid evaluation: MAD covers the evaluation of a MAP eligible recipient for the hearing aid, subject to the following limitations:
 - (i) the evaluation for hearing aid is not payable to the same billing provider who bills for the hearing aid dispensing fee incidental to the purchase of a hearing aid;
 - (ii) the evaluation for hearing aid is not payable to a billing provider under the same corporate ownership as another billing provider who bills for the hearing aid dispensing fee incidental to the purchase of the hearing aid; therefore,
 - (iii) physicians and audiologists can be reimbursed for audiologic and vestibular function studies in addition to a dispensing fee.

[8.324.5.16 NMAC - Rp, 8.324.5.16 NMAC, 1-1-14]

8.324.5.17 REIMBURSEMENT OF DME, MEDICAL SUPPLIES AND NUTRITIONAL PRODUCTS:

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, 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 there is no applicable MAD fee schedule, payment is limited to the provider's acquisition invoice cost plus a percentage, as follows.

(a) DME, 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, 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) for a custom specialized wheelchair and its 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. 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) the provider must keep a running total of rental payments for each piece of equipment;

(b) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient when 13 rental payments have been made for the item;

(c) the provider must consider the item sold and the item becomes the property of the MAP eligible recipient 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;

(d) 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, 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 regulations 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 13th month 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) the provider must retain a copy of his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request;

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

C. Reimbursement for home infusion drugs: Unless otherwise specified in this rule, the provider's billed charges must be the usual and customary charge for the item or service. Home infusion drugs are reimbursed at the lesser of:

(1) the provider's billed charge; or

(2) the MAD fee schedule;

(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 his or her acquisition invoice showing the provider's purchase of an item and make it available to MAD or its designee upon request.

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. MAD does not pay for charges for shipping items from a supplier to the provider.

E. Reimbursement limitations: MAD does not cover DME or medical supplies that do not meet the definition of DME as described in Section 12 of this rule. The following criteria are applied to each request as part of the determination of non-coverage:

(1) items that do not primarily serve a therapeutic purpose or are generally used for comfort or convenience purposes;

(2) environment-control equipment that is not primarily medical in nature;

- (3) institutional equipment that is not appropriate for home use;
- (4) items that are not generally accepted by the medical profession as being therapeutically effective or are determined by medicare regulations to be ineffective or unnecessary;
- (5) items that are hygienic in nature;
- (6) hospital or physician diagnostic items;
- (7) instruments or devices manufactured for use by PCP;
- (8) exercise equipment not primarily medical in nature or for the sole purpose of muscle strengthening or muscle stimulation without a medically necessary purpose;
- (9) support exercise equipment primarily for institutional use;
- (10) items that are not reasonable or necessary for monitoring the pulse of a homebound MAP eligible recipient with or without a cardiac pacemaker;
- (11) items that are used to improve appearance or for comfort purposes;
- (12) items that are precautionary in nature except those needed to prevent urgent or emergent events;

and

(13) a provider or medical supplier that routinely supplies an item to a MAP eligible recipient must document that the order for additional supplies was requested by the MAP eligible recipient or his or her authorized representative and the provider or supplier must confirm that the MAP eligible recipient does not have an excess of a 15 calendar day supply of the item before releasing the next supply to the MAP eligible recipient.

[8.324.5.17 NMAC - N, 1-1-14]

8.324.5.18 REIMBURSEMENT FOR PROSTHETICS AND ORTHOTICS:

A. A prosthetic and orthotic service provider must submit claims for reimbursement on the CMS-1500 claim form or its successor. Reimbursement for repairs made by the provider is made at the actual repair cost plus 50 percent. Repairs made by the manufacturer are reimbursed to the provider at the actual manufacturer's repair cost plus a handling fee of \$20. If complications in securing the manufacturer's repair cause the provider to incur handling costs exceeding the predetermined amount established by MAD, the billing provider can be reimbursed for actual handling costs incurred if these actual costs are adequately documented. Reimbursement for additional accessories and supplies is made at the lower of the actual cost of the supply or accessory or the MAD fee schedule for the particular item.

B. **Reimbursement limitations:** The amount billed for the item includes all minor attachments, adjustments, additions, modifications, fittings and other services necessary to make the device functional. These items cannot be billed separately.

(1) MAD does not cover an additional charge for a hospital visit or home visit if fittings or measurements take place away from the provider's office.

(a) If the place of service is outside the provider's city limits, mileage can be billed for travel to the place of service.

(b) A prosthetic or orthotic device for a MAP eligible recipient hospitalized in a diagnostic related group (DRG) reimbursed hospital is reimbursed by the DRG methods described in 8.311.3 NMAC.

(2) Date of service: The date of service declared on a claim is the date when the device is supplied to the MAP eligible recipient, not the fitting date or measuring date.

(3) No specification of brand or quality: When an ordering provider requests an item and does not specify the brand or quality of the item to be dispensed, the item chosen must be of a quality and minimal cost which adequately serves the purpose for which the device is required.

[8.324.5.18 NMAC - N, 1-1-14]

HISTORY OF 8.324.5 NMAC:

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MAD Rule 310.08, Medical Supplies, filed 12-1-87.

MAD Rule 310.08, Medical Supplies, filed 5-31-88.

MAD Rule 310.08, Medical Supplies, filed 4-3-92.

MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4-21-92.

History of Repealed Material:

MAD Rule 310.08, Durable Medical Equipment and Medical Supplies, filed 4-21-92 - Repealed effective 2-1-95.

8.324.5 NMAC, Durable Medical Equipment and Supplies, filed 6-16-04 - Repealed effective 1-1-14.