

I. Introduction to Wheeled Mobility Device Guidelines

These guidelines and documentation formats apply to the following Durable Medical Equipment (DME) categories and must comply with Provider Bulletin 2017-12:

- Prior authorization requests for a wheeled mobility device purchase, including customized manual wheelchairs, power chairs, wheelchairs with power assist device, power operated vehicles (medical scooter), and medical strollers.

To ensure that HUSKY Health members receive medically necessary and effective DME, the Department of Social Services (DSS) requires adherence to these guidelines. **ALL** of the following criteria must be met:

- 1) The request meets the definition of DME: [Reference: Section 17b-262-673(f) of the Regulations Connecticut State Agencies 17b-262-673(5)].
- 2) The request meets the criteria for medical necessity: [Reference: Section 17b-259b of the Connecticut General Statutes].
- 3) In order for an authorization request for a Wheeled Mobility Device to be reviewed for medical necessity, the following information must be submitted by the DME provider via Clear Coverage™ or via fax to Community Health Network of Connecticut, Inc. (CHNCT): 203.265.3994:
 - a) Completing the relevant sections of the attached **Wheeled Mobility Letter of Medical Necessity form**, the referring health care professional(s) submit(s) typed clinical documentation, which confirms medical necessity and effectiveness for the specific member, including a clinical assessment and associated rationale for the requested DME within the member's customary and anticipated customary environments. This documentation must validate all of the following:
 - The member received an objective, onsite evaluation by a licensed occupational and/or physical therapist, which included the onsite collaboration of the DME provider
 - It is written solely by the evaluating therapist except for technical rationales (for hardware and electronic components) that can be documented by the evaluating Assistive Technology Professional (ATP) as indicated with an asterisk [*]
 - The evaluation occurred within the past 6 months for persons living in the community, or 3 months for persons living in a nursing facility, from the documented evaluation date
 - Included the provision of actual DME trials and simulations
 - The requested DME will restore or facilitate participation in the individual's usual mobility related activities of daily living (MRADL) tasks within their customary and anticipated environments
 - b) The request is supported by a **physician's prescription**; i.e., licensed physician (MD or DO), Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA), enrolled in the CT Medical Assistance Program (CMAP). (Additional physician reports and criteria are required for the Custom Wheelchair Regulation for residents in nursing facilities, section 17-134d-46 of Connecticut State Agencies).
 - c) The request is substantiated by a **medical evaluation by the member's primary care provider or relevant specialist**, which may be either a specific evaluation for a customized wheelchair, or other evaluation of the member, such as the most recent history and physical examination and subsequent progress notes; completed or updated within the past 6 months for persons living in the community or 90 days for persons living in a nursing facility. For members with Medicare coverage, provide the face-to-face examination for the specified DME required by the Centers for Medicare & Medicaid (CMS), which will also meet Connecticut Medicaid's medical evaluation requirement.
 - d) The DME provider submits a **detailed product description and quotation** including manufacturer, model/part number, product description, HCPCS code, unit(s), quantity, Medicaid allowable price, and proof of retail price.
 - e) If this request is for a replacement wheeled mobility device under *Sec. 17-134d-46* of the Regulations Connecticut State Agencies *Customized wheelchairs in nursing facilities regulation*, a copy of the **current positioning program** is required (refer to #35b in **Wheeled Mobility Letter of Medical Necessity form**).
 - f) The completed **Accessibility Survey**, which confirms that an onsite in-home assessment was performed for the requested wheeled mobility device, including the projected dimensions, and the member or designee's agreement that the wheeled mobility device will address the member's medical needs and typical daily tasks. If the member is evaluated in a clinic setting, the survey must be completed after the wheeled mobility device assessment. By signing the Accessibility Survey, the provider certifies he or she performed an in-home assessment, with the requested or similar wheelchair with projected measurements, and it is accessible in the home and meets the member's mobility related activities of daily living. (This is not required for persons residing in a Skilled Nursing or Intermediate Care Facility.)



II. Instructions to Submit the Wheeled Mobility Device Guidelines Document

1. The forms are available in Adobe Acrobat® and Microsoft Word™ at www.huskyhealthct.org/providers.html
2. To avoid losing data, it is important to **download and save** the uncompleted file before filling out the form.
3. The **Wheeled Mobility Device Guidelines** must be utilized after May 1, 2017 for an authorization request for a Wheeled Mobility Device. The typewritten or handwritten Letter of Medical Necessity forms will be accepted.
4. There are numerous methods to complete and use this form, including but not limited to:
 - The **Microsoft Word .doc version** can be completed by using a PC desktop, laptop, iPad, or tablet
 - The **Adobe .pdf version**, which includes pull-down menus, may be completed on a PC desktop, laptop, or tablet
 - The user can also complete this version using an iPad application which allows pull down menus, such as Adobe Reader® or PDF Expert (Readdle)
 - The **Microsoft Word .doc version** can be used to create Electronic Medical Record (EMR) SmartForms
 - The **Microsoft Word .doc version** can accept an agency's header/logo if necessary. Refer to **Microsoft Support** for instructions on how to unprotect a document and change the document template:
<http://office.microsoft.com/>
5. Health care agencies using an EMR, Word, or PDF of a pre-May 2017 version of the Wheeled Mobility Device Letter of Medical Necessity form have the option to use the current form or update to the May 2017 Wheeled Mobility Device Letter of Medical Necessity form. All other requirements effective May 1, 2017 must be met.
6. **All form fields must be completed. Indicate "N/A" if not applicable.** Comments are optional.
 - In the Acrobat® version, the default choices were chosen to promote efficient form completion. Each choice should be verified or changed for each individual. If none of the options are appropriate, select "**Other**" in a pull-down list and then type over the selected text to insert an unlisted entry; or use "**N/A**" to indicate "**not-applicable.**"
 - Selections with an asterisk (*) should be completed by the evaluating occupational and/or physical therapist, or by the DME Provider. The form may be used as a worksheet during the assessment with a measurement form.
 - Section #29 can be used when information cannot fit within a designated text box.
 - Additional medical information, documented solely by the evaluating therapist, including objective clinical data, can be attached to the completed form on the health care agency's letterhead, and sent to the DME provider for prior authorization submission.
 - When the DME provider uses the Clear Coverage™ prior authorization process, photographs are accepted. Adherence to appropriate HIPAA and other permissions are necessary. Photographs should not be faxed.
7. **The evaluating therapist should save the completed Wheeled Mobility Letter of Medical Necessity form** for each individual request. After the form is saved, the **therapist should forward the completed form to:**
 - **the DME provider; AND**
 - **CHNCT using one of the following methods:**
 - Fax to **203.265.3994**
 - Mail to **Community Health Network of Connecticut, Inc., Prior Authorization DME, 11 Fairfield Boulevard, Wallingford, CT 06492**
 - Secure email to **DMETeam@chnct.org**
8. The DME provider will attach the additional documents indicated on page 1, section 3, and all documents from the evaluating therapist. **The DME Provider must submit all documents** to CHNCT to pursue the prior authorization review process. This can be accomplished by creating an Authorization Request in the Medical Authorization Portal or via fax 203.265.3994.
9. For questions, contact **CHNCT DME Team at 1.800.440.5071** or **DMETeam@chnct.org**. Provide the member's name, date of birth, Medicaid identification number, and authorization number (if available), and the reason for the inquiry to be directed to the appropriate team member. If special consideration is needed regarding a specific prior authorization request, please request to speak with the assigned nurse or a therapist reviewer.



10. Medical Necessity Determinations Timeframes and Appeals Procedures

Timeframes for Medical Necessity Determinations (precertification)

CHNCT complies with timeliness standards for review determinations as defined by DSS. Timelines are measured from the time all reasonably necessary information to make a decision has been received. All decisions are rendered within twenty (20) business days of the request.

A DME prior authorization request is entered based on the date the fax is received by CHNCT, or the date the provider enters the request from the Medical Authorization Portal. CHNCT has fourteen (14) calendar days from the date of receipt of the prior authorization request to perform a review. The request will be approved, denied, partially denied, or pended for additional clinical information. If the request is deemed to be incomplete and hence pended for additional clinical information, then the request is held for additional time, up to twenty (20) business days. Accordingly, the timeframes require fourteen (14) calendar days prior to review of the request, and then it changes to business days if pended for additional information and held until it reaches the 20-day mark.

Peer-to-Peer discussion

CHNCT offers a peer-to-peer discussion to the prescribing physician when notified of a medical necessity determination. Providers are notified telephonically of all adverse determinations and are advised that they have two (2) business days to request a peer-to-peer discussion with a CHNCT physician or other designee. The provider has the option to submit additional written documentation for the peer-to-peer discussion. The discussion will occur at the agreed time scheduled for the prescribing physician. If the prescribing physician is available, the peer-to-peer must take place within 24 hours. The prescribing physician can initiate a peer-to-peer discussion by calling 1.800.440.5071.

Member Appeal

The HUSKY Health member has the option to request an appeal, which must be received within sixty (60) days of the documented medical necessity denial decision date. Appeals rights and procedures are documented on the medical necessity determination letter sent to the member.

Provider Appeal

The CMAP provider has the option to request an appeal, which must be received within ten (10) days of the documented medical necessity denial decision date. Provider appeal procedures are documented on the medical necessity determination letter sent to the provider.

For all questions, contact CHNCT at 1.800.440.5071.