



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Benefits Collaborative Meeting: Manual Wheelchair Bases

Thursday, January 9, 2014

3:00 p.m. – 5:00 p.m.

Department of Health Care Policy

225 E 16th Ave, Denver

First Floor Conference Room

Notes

Time	Topic/Agenda Item	Responsible
3:00 – 3:15 p.m.	Welcome and Introductions <ul style="list-style-type: none"> • Ground Rules & Phone Etiquette • Staff Contact Info 	Kimberley Smith
3:15 – 3:35 p.m.	Benefits Collaborative Overview <ul style="list-style-type: none"> • Purpose of the Benefits Collaborative • Review the role of participants and the Department • Parking Lot List 	Kimberley Smith
3:35 – 3:40 p.m.	Frame for Today's Discussion <ul style="list-style-type: none"> • Today's Focus : Manual Wheelchair Bases 	Kimberley Smith
3:40 – 4:10 a.m.	Review and Discuss Brief Coverage Statement	Kimberley Smith Andrea Skubal
4:10 – 4:50 a.m.	Review and Discuss Eligible Providers, Places of Service and Clients and other sections, time permitting	Kimberley Smith Andrea Skubal
4:50 – 5:00 p.m.	Roadmap Moving Forward <ul style="list-style-type: none"> • Updates from the Department 	Kimberley Smith

Facilitators:

- Kimberley Smith, Benefits Collaborative Manager, Department of Health Care Policy & Financing (HCPF)
- Andrea Skubal, Durable Medical Equipment Policy Specialist, HCPF
- Eskedar Makonnen, Policy Specialist, HCPF
- Dr. Judy Zerzan, Chief Medical Officer, HCPF (on phone)

Welcome

Kimberley Smith, Benefits Collaborative Coordinator with the Department of Health Care Policy & Financing (Department) began by discussing some phone technology issues and then invited participants to introduce themselves.

Andrea Skubal notified the group that she will be leaving the Department and introduced Eskedar Makonnen as her replacement on this specific project.

Kimberley then reviewed the ground rules for this and future Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Kimberley also provided her contact information Kimberley.smith@state.co.us 303-866-3977, to which participants can address their future questions and suggestions.

Benefits Collaborative Overview

Kimberley then briefly reviewed the concept of a Benefits Collaborative. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. She explained that The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and becomes standard practice once the Medicaid Director signs it, after much public input.

Kimberley explained to participants that any unanswered questions and all suggestions made will be tracked in the Listening Log posted online and that each question/suggestion will receive a response from the Department. She encouraged participants to check the log periodically, as responses are added.

Frame for Today's Discussion

Today, we are looking at the part of the Wheelchair Benefit Coverage Standard specific to manual wheelchair bases. Future meetings may be devoted to the Wheelchair Seating and another to Wheelchair Accessories and Power Mobility Devices. The number of future meetings will be dictated by the level of discussion in the room.

Draft Coverage Standard Discussion

Kimberley Began by noting that suggested changes to language made in the Nov. 1st meeting have not yet been made to the policy. She then invited comment on the first page of the Manual Wheelchair Bases Covered Services section of the draft Benefit Coverage Standard.

COMMENT – Rich Salm from Numotion suggested that, in the second bullet from the bottom of the page, “fitted cane or walker” be changed to “ambulatory device”.

Jose Torres-Vega with the Colorado Cross-Disability Coalition (CCDC) seconded this suggestion and several others nodded in agreement.

COMMENT – Jose Torres-Vega with CCDC then referred the group back to the first sentence of the first page and suggested that “he or she would be unable to sit or ambulate safely and functionally” to “and/or functionally.”

He also pointed to the second paragraph where it states that a manual wheelchair can be authorized as a primary mobility device. He stated that, in some cases, you may have a client who uses only a manual wheelchair and may require one as a primary and one as a secondary device – which may look exactly the same. He asked about the policy on providing an identical chair as a secondary device.

RESPONSE – Andrea stated that the Department does cover the purchase of a second chair but does not allow for the purchase of two identical items because it is a duplication of services.

Jose offered an example: A client he works with propels himself in his wheelchair by using his feet; because of a vision impairment he cannot safely use a power wheelchair. The client’s current wheelchair is unsafe, it needs repair. When he requested a new one (identical to the one he has now, to have as a backup), he was denied on the basis that the chair is identical.

Andrea noted that the language on page one of the standard is general and that there are exception policies in place to meet individual medical necessity needs. She asked Jose what alternative language he would propose to clarify this.

Jose suggested adding language along the following lines “The difference between a primary and secondary devices can be exempt if covered by medical necessity.”

Becky Breaux from Assistive Technology Partners (ATP), which helped author the standard, noted that this example sounds more like a replacement issue than an issue with the primary and secondary equipment policy. The chair was not working or was too old and the client was attempting to replace the chair –

rather than ask for a duplication of a fully functional chair. There is language in the standard that people are generally eligible for replacement every five years.

Jose noted that the client's primary chair is a "quickie" and that all he is asking for is a second chair as a back-up.

Becky Breaux noted that, the way the language reads now, a primary and secondary chair must have two different purposes, for example, community vs. home use. The question is, if the chairs are exactly the same, why do you need two? That is the sticking point.

Jose stated that, when someone's primary chair breaks, the DME provider does not always have an exact match to replace it. Therefore, it would be a good idea, regardless of needing a replacement, for the DME provider to provide two chairs as a reasonable accommodation, so that the client has the right chair at the right time. Jose noted that he does not want to support Medicaid fraud but stated that there are circumstances where it is a medical necessity.

Post-meeting, Jose provided the following **CLARIFICATION** –

A few months ago, his client's main Manual Wheelchair (MWC) broke, his client was told by the vendor that they could not loan a MWC because in record my client still has an old MWC; his client's old MWC is not safe for anyone, this equipment is over 10 years old. His client, observing how hard it is to get the vendor to provide a loaner, requested a second MWC; for his client any -new or loaned- MWC must meet the exact size, height and weight. Therefore, whether it is a loaner, a new main MWC or a secondary MWC, Jose stated that it must be -if not the same model/brand- it must be identical. Because his client's main and the new -secondary- his client was requesting are/would be identical, his client's request was denied

Kimberley asked if the current exception process is sufficient to accommodate the example given. Do we really need to change the language or would this be an example of something that should be taken care of through the exception process?

Jose noted, apparently, the process is not working for this client.

Kimberley noted this point and stated that the Department would look more into this case in addition to thinking about the language and policy in general and come back to the group with some thoughts.

Kimberley then invited the group to comment on the Standard Manual Wheelchair (SMW) (K0001) section. She explained that the first section defines what a SMW is and the two bullets refer to when it is considered a covered service.

No comments were offered; the group moved on to the Standard Hemi Wheelchair (K0002) section.

COMMENT – Rich Salm with Numotion stated that most manufacturers would define a “Hemi” wheelchair as having a seat-to-floor height of less than 19 inches but greater than 17 inches. He suggested adding the “greater than 17 inches” language to the standard. Several people nodded in agreement.

COMMENT – George O’Brian with CCDC stated that he would have found it very psychologically useful if he had known all of the steps he was going to have to go through to procure his motorized wheelchairs; the process was frustrating. It is better to spell out the steps for people (will you need to see a specialist, etc.) – this may be something that the provider/seller needs to do.

RESPONSE – Kimberley noted that, while a discussion of how to make the standard language more client friendly is welcome, this sounds like more of an education issue on the part of the providers. She asked George if he has suggested changes to the language in the standard he would like to offer.

George did not.

Kimberley noted that there were many providers in the room and invited them to take this feedback back with them. She thanked George for sharing.

Kimberley took this opportunity to remind the group that benefit coverage standards are accessed by providers and clients alike and are meant to be plain spoken documents, easily accessible to all. She asked the group to keep this in mind when suggesting changes to language.

The group moved on to Lightweight Manual Wheelchairs (K0003).

COMMENT – Rich Salm with Numotion pointed to the last bullet, which states “the client requires the removable rear wheel feature to allow safe stowing of the wheelchair in a vehicle”. To his knowledge, such a feature (a quick release one) does not exist on a K0003. Others agreed.

Becky Breaux with ATP guessed that it is in the description of a K0003 but, in reality, it doesn’t exist.

Leslie with ATP could not immediately recall from where she pulled the definition when authoring the first draft of the standard but believes that this language appeared several places. She explained that it is not uncommon for items that do not exist (or do not yet exist) to nevertheless be given a code.

Kimberley noted this as a point for further research.

Participant noted that his first wheelchair twenty years ago, which weighed 34 lbs., did have removable wheels but he does not know if anyone still makes them.

The group moved on to High Strength Lightweight Wheelchair (K0004).

COMMENT – Rich Salm with Numotion suggested including in the definition of a K0004 wheelchair, one more feature that is common: Adjustable Position Caster Housing.

The group moved on to the Ultra Lightweight Wheelchair (K0005)

COMMENT – Patrick with USA Mobility pointed to the first bullet, which states “The client is expected to use a manual wheelchair full time.” His concern is that this language precludes the amputee population who may use prostheses half the time and a manual wheelchair the rest of the time.

RESPONSE – Jose Torres-Vega with CCDC added that it also precludes people who use the manual wheelchair only at home, but it is a customized wheelchair.

Becky Breaux with ATP asked if it would be better to exclude this language or to change it to say the client “is expected to use it on a regular basis”.

Four people, including Patrick and Jose agreed.

The group moved on to Heavy Duty Wheelchair (K0006)

COMMENT – Patrick with USA Mobility made a comment that applies to both K0006 and K0007. He noted that there are certain clients that may not meet the weight requirements, as currently specified, but may need either chair due to their seat width. For example, the client may be short and wide.

RESPONSE – Mark Dushaw with TRG gave an example that illustrated the above comment. He added that he has a few clients that don’t live in the city and need a heavy-duty chair – not because they meet the weight or width criteria but – because a K0005 is not durable enough for their environment.

Jose Torres-Vega noted that CCDC has a cross-disability approach; there are many kinds and combinations of disabilities that have many needs and it makes sense to include language that allows for these special needs.

Kimberley asked Andrea if the current exceptions process would cover these kinds of cases.

Andrea answered yes, these are the kinds of cases that would be reviewed for medical necessity. These are just general guidelines but perhaps some suggested language could be added.

Jose Torres-Vega stated that it would be better to add the language here, rather than expect every client to go through the exception process, because it can be lengthy and some people might have urgent need.

Susan Kennedy from Numotion suggested that a fourth hollow bullet be added beneath “client has severe spasticity” that addresses the environment.

Dr. Zerzan added that Jose makes a good point – we want to make sure that exceptions truly are exceptions. At the same time, we want to make sure that the policy isn’t so broad that there are big loopholes in it that might be used inappropriately – which may impact how we administer the benefit. This discussion is helpful in helping the Department figure out what the balance is. She offered that the example of a client living in a rural area would be a good example of why the exception process exists.

Jose noted that, no matter how tight or loose you make a rule, there is always someone who will be able to find a loophole. Trying to make a policy or rule based on the fear of fraud is not advisable. In his experience, very few individuals use a wheelchair just to use a wheelchair.

Dr. Zerzan agreed with that but added that there have been cases in other states and ones publicized by Medicare in which people sold wheelchairs that they received for free. In cases like these it is important that the Department has language written somewhere that allows us to enforce our policies and take back those funds. If the language is too loose, the person committing the fraud can say “look, it’s in here” – in which case, the Department can’t enforce the policy and stop the activity. We need to make sure from a program integrity standpoint that we have reasonable limits in place. It is hard to find that balance; that is what we are trying to do in writing this policy.

Rich Salm with Numotion stated that, if a bullet point were added to address Patrick’s comment about seat width, which would be tough to exploit.

Dr. Zerzan agreed.

COMMENT – Mark Simon asked the group to refer back to the Ultra Lightweight Wheelchair section. In the first hollow bullet, where the standard reads “client is able to independently self-propel” can the second to last sentence be changed from “daily” to “regular basis”?

He also noted that nothing in the draft speaks to “assistance”. A client’s wife, for example, may not be able to pick up their 32 lb. wheelchair. Mark explained that, for example, under the Basic Coverage Criteria on page one, there is language that states the client must be able to propel self or “the client has a caregiver who is available, willing and able to provide assistance with the wheelchair.” This – or similar – language should be included in the criteria of each section, where applicable, including the Ultra Lightweight section.

The group moved on to the Other Manual Wheelchair/Base section. Hearing no comments, the group moved on to Standard Reclining Wheelchair (E1050-E1070). Hearing no comments, Kimberley opened up the conversation and invited comment on pages 7 – 10 of the draft standard.

COMMENT – Rich Salm with Numotion commented on Adult Sized Tilt-in-Space Wheelchairs. On page 7, in the second to last bullet, he requested that the words “access communication device” be added after the word “or”.

Several people nodded in agreement.

COMMENT – Rich Salm with Numotion commented on the Pediatric Manual Wheelchair section as well. He suggested adding a third hollow bullet that states “client requires growth feature.”

RESPONSE – Becky Breaux with ATP asked Rich if that would be an “or” or an “and” because it is written to accommodate a very small adult as well (the word “and” would preclude adults).

Rich stated “in addition to”. He asked if that would be limiting.

Becky explained that the authors wrestled with this. Thinking of someone, for example, with dwarfism, who is not going to grow and still needs a pediatric sized chair.

Jose Torres-Vega with CCDC suggested using “and/or” rather than “and”. Rich agreed.

COMMENT – Jose Torres-Vega commented on the Manual Standing Wheelchair (K0009+E2230). He noted that it sounds like the Department requires that the person be able to self-propel, which is a bit contradictory.

RESPONSE – Becky Breaux with ATP confirmed that this was the intent. In the research the authors did, a manual standing wheelchair is recommended for people who can push themselves to the sink, stand up, wash dishes and sit back down – using it for functional purposes. Having said that, she noted that a case could probably be made for people who need standing opportunities.

Jose confirmed that the latter is his point. It is sometimes a question of physical and mental health.

Leslie with ATP added that the intent was that, if an individual cannot self-propel a wheelchair they would probably have a caregiver and that, if they have a caregiver, a standing frame may be more appropriate.

Jose suggested that providing standing frames instead of manual standing wheelchairs – to clients who cannot self-propel – defeats the purpose of independent living. Independence doesn't mean doing everything yourself – it also means saying how it is done and who does it and when. It could also mean doing it yourself in a reasonable way, with reasonable assistive technology.

Leslie added that, in thinking about a manual wheelchair, an individual has to be able to generate a pretty good amount of force to elevate themselves. The thought was, with individuals who are not able to propel at all, there are various alternative options for standing (a manual standing wheelchair not being a good one).

Kimberley invited Jose to provide a few descriptive examples of clients who cannot self-propel but who would benefit from a manual (as opposed to power) standing wheelchair.

Jose agreed. He noted that not everyone has an attendant 24-7.

Kimberley explained that, she hears Jose stating this is a good piece of equipment to have when you don't have an attendant around and Leslie saying it can't be used by client's who can't self propel when attendant is not around. She suggested that the group would need to look at concrete examples to understand if we are limiting this benefit before changing the language.

Jose agreed.

COMMENT – George stated that people are able to do a great many things that others may not think they can. If the doctor, physical therapist, or anyone else medically qualified to make such decisions, believes that the client needs a specific device, they should be given that device.

RESPONSE – Leslie with ATP noted that this line of conversation opens up a larger can of worms – that is not exclusive to DME conversations – in terms of who is a qualified medical professional. There are a lot of therapists out there that don't know much about how to fit a chair but get sent referrals to make those recommendations. There are a lot of agencies that don't want to limit their scope of practice. Putting something so general in the standard could open the floodgates. This is probably a larger conversation that is needed about what should constitute and eligible provider, outside of this standard.

Dr. Zerzan spoke directly to the comment “if your doctor prescribes it you should get it.” Most doctors have no idea what they are prescribing when it comes to DME, which is why there are certified professionals who specialize in identifying DME needs. She gave an example from her practice, she often prescribes a brace for someone's foot and she sends them down to the orthotics department because she doesn't know what type of brace, specifically, to prescribe. We have to be careful about the kinds of training and knowledge eligible providers have. Secondly, it is important to have the ability to know how recent the provider's knowledge is. We don't know if a doctor has the most recent knowledge in this area. What a doctor or nurse prescribes is not always the best thing, so we are trying to use this collaborative to identify what might be the best thing and provide some guidance.

COMMENT – Jose Torres-Vega with CCDC asked, if we don't know if doctors have the appropriate expertise to qualify as an eligible provider, how we know that, for example, Numotion specialists do have the appropriate expertise to prescribe equipment. He noted that there is a certain amount of common sense that providers exercise within their specialty through conversation with the client.

RESPONSE – Dr. Zerzan clarified that she does not mean to say that a doctor or nurse doesn't know what they are doing in this space but, rather, that it is not enough to just have one person and that we need a team of people to understand what are the best needs. Medicine in general is moving in this direction.

Certainly, the people fitting your wheelchair may need to know (from a doctor) if you have a certain kind of condition that, for example, effects your skin. In general, my comments meant to say that one person can make this decision.

COMMENT – Becky Breaux with ATP made a general comment that there is a provision for a specialty evaluation for all items within this benefit coverage standard that are considered complex rehab. technology. It is a team eval. and it does require a certified assistive technology professional. It also requires the objective participation of someone who is not being paid by that company to help provide that evaluation.

Shen noted that there are not a lot of occupational and/or physical therapists who do these types of evaluations. Some of these evaluations can take 3-4 hours (in a power wheelchair with complex seating). The other big issue is that OTs and PTs are not reimbursed for this extra time. This is a huge problem that needs to be addressed.

One thing to think about is that we are requiring these specialty evaluations but we don't want to have a bottleneck where there aren't enough professionals to carry them out.

Kimberley identified this as a Parking Lot Issue and committed to discussing it in greater detail, as time allows, at a future Wheelchair Collaborative meeting.

Kimberley then invited comment on the remaining pages of the Covered Services section.

COMMENT – Mark Simon stated that, with regard to RESNA, there should be some sort of exception process to any kind of evaluation done.

He also stated that we should generally make more of an effort to involve the primary care doctor in this process.

COMMENT – Eddie Busam with Aponte & Busam Public Affairs Consultants discussed what happens in this arena with DME in general. With regard to Becky's comments about specialty evaluations – when they are appropriately done you don't run into issues of fraud. Essentially, when providers are trained, fraud decreases.

RESPONSE – Kimberley noted this as a great point and asked if Eddie had any recommendations specific to this standard.

Eddie responded that she would think on it. Her comment was born out of the great discussion. She noted that there are doctors that order things when they don't really know what they are ordering and then specialty providers provide the equipment because it is part of the prescription. Lack of education is part of the problem and Eddie suggested this too be placed on the Parking Lot for further discussion.

COMMENT – Becky Breaux with ATP commentator added that the CRT legislation that is being proposed as a process by which we screen out individuals who have complex needs vs. individuals with less complex needs. In looking at the draft coverage standard, the Department is requiring a specialty eval. for certain types of equipment. Becky

suggested it might be easier to request that every person goes through a simple screen (made up of very specific questions and performed by their doctor) and the outcome of that screen will either send them on to a specialty evaluation conducted by a team or will be referred to any DME provider to provide the equipment with a doctor's prescription (for, for example, a leg brace or walker).

Becky also noted that she has seen people with ALS in a scooter because they called the Scooter Store. Two years later they need a complex group-rehab. wheelchair. This would not have happened if they were required to go through the process as described above.

Becky concluded by stating that this is the direction the nation is moving. Even if the legislation mentioned is not adopted, this is a very useful strategy that we can consider in Colorado.

COMMENT – Eddie Busam wondered if it might be helpful to bring that draft legislation to the group to discuss.

RESPONSE – Dr. Zerzan stated no because it is not appropriate for the Department to comment on legislation and it is really outside the scope of the Benefits Collaborative.

COMMENT – Rich Salm with Numotion stated that the dialogue above really underscores the need to define Complex Rehab. Technology as something different – or above – DME. It is so unique and does deserve its own distinction – apart from DME.

Kimberley then invited the group to discuss the Appendix – Definitions.

COMMENT – George with CCDC asked if there is room in the standard to allow for invention if a client knows they need a certain piece of equipment (or modification) that doesn't exist – or is not easily found – and has a contractor willing to create it for them.

RESPONSE – Dr. Zerzan noted that the Department has had these discussions in other stakeholder groups around DME and, unfortunately, there is not a way that we can pay for that due to federal regulations, quality control, contractor monitoring, etc.

The meeting adjourned at 5pm.