

Department of Health Care Policy & Financing

Benefits Collaborative Listening Log

Policy Name: Wheelchair

Working Log - Subject to Change

Comment Number	Date Received	Name	Comment2	Department's Response	Will Policy be Revised?
Brief Coverage Statement					
1	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Summary of individuals who qualify for a MWB.</i> This needs to change to cannot safely and efficiently walk or use a cane. Some people can walk but fall often or it takes so much energy and causes so much pain that they are non functional elsewhere. Also some might be able to walk at home but need a chair for community or distances.	This statement will be updated to read, "...or other conditions that affect their ability to sit or ambulate safely and functionally."	Yes
2	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Summary of individuals who qualify for a PMD.</i> See earlier comment on MWC. Also very bad to use manual chair for all things for years. End up with shoulder problems that make people go from independence to requiring significant levels of daily assistance and costing way more. Long term disabled people that can use manual should get both, use manual when needed and for exercise but use power for work, distance, etc. Finally, fatigue should be a factor. Pushing oneself is a huge amount of work. Just because someone is not paralyzed above a certain level or does not have existing injuries cannot be reason to deny power chair	This statement will be updated to read, "...or other conditions that affect their ability to sit or ambulate safely and functionally."	Yes

3	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Client's ability to operate the various maneuverability controls on a PMD.</i> Some people cannot operate all completely but should still get power chair and then get attendant controls. They might be able to operate in certain situation or certain times of a day. Some may be able to operate tilt but not drive but still need power chair to operate the tilt.	Considering revision as follows: "...arms and torso which require use of various maneuverability controls."	Under Review
4	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Summary of individuals who qualify for wheelchair seating.</i> Recommendation: "...an individual in a seated <u>or reclined</u> position..."	Addition of "or reclined" has been included in the draft.	Yes
5	29-Oct-13	Julie Reiskin, CCDC	<i>Re: When WOAs are required for client to complete ADLs in the home, community and non-institutional setting.</i> This is a huge issue and also Olmstead issue. One cannot be in integrated setting without good mobility. It is not about just being able to walk, but being able to move enough to live one's life. In Denver, if you are a transit user you need to be able to go several blocks. For example, to go to HCPF one needs to be able to get there from Colfax and Broadway. Mobility devices must be assessed from that perspective. Now that we have Buy-In, we need Medicaid policy to be supportive of work.	Revised as recommended. <i>Normal life activities</i> will be replaced with <i>ADLs</i> .	Yes
6	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Description of non-institutional setting in which "normal life activities" take place.</i> Include employment and include appropriate for the community that client lives in. For example, in metro area it needs to be transit appropriate, for drivers they need piece that allows them to latch chair to van, rural people may need other components.	Under Review. Would home/community/non-institutional setting to perform basic and instrumental ADLs open enough?	Under Review
7	29-Oct-13	Josh Winkler, CCDC	10 CCR 2505-10 8.590 is the correct citation, but 10 CCR 8.590 is better than we used to get. (page 1)	This will be updated to reflect the correct reference.	Yes

8	29-Oct-13	Josh Winkler, CCDC	1862(a)(1)(A) of the SSA is specific to Medicare parts A and B, are you applying that to Colorado Medicaid?	This will be removed from the BCS.	Yes
9	29-Oct-13	Josh Winkler, CCDC	Specifies "cannot", many clients who need manual wheelchairs have the ability to ambulate some but need a wheelchair to maximize independence. (page 1, paragraph 4, sentence 1)	This statement will be updated to read, "...or other conditions that affect their ability to sit or ambulate safely and functionally."	Yes
10	29-Oct-13	Josh Winkler, CCDC	Despite CMS using it, the word "vehicles" can cause issues, we don't need the DMV involved! (page 1, paragraph 5, sentence 1)	Will update upon suggestion. Although it is not preferred language, we do not want to exclude coverage of certain mobility devices based on altering CMS-approved language.	Under Review
11	29-Oct-13	Josh Winkler, CCDC	Specifies "cannot" (page 1, paragraph 5, sentence 2), many clients who need wheelchairs have the ability to ambulate some but need a wheelchair to maximize independence. With "assisted ambulation" a manual wheelchair should be all any client needs?	This statement will be updated to read, "...or other conditions that affect their ability to sit or ambulate safely and functionally."	Yes
12	29-Oct-13	Josh Winkler, CCDC	Some clients who a power chair is appropriate for are not always able to operate the controls (page 1, paragraph 5, sentence 3).	Considering revision as follows: "...arms and torso which require use of various maneuverability controls."	Under Review
13	29-Oct-13	Josh Winkler, CCDC	Why is it not ok to stand or lay down, if needed for a particular client? "within" would be better replaced with "on", "pain alleviation" is also a factor when specifying seating (page 1, paragraph 6, sentence 1).	Revision will be updated as follows: Wheelchair seating includes devices that are used with mobility bases that serve to support an individual in a seated position. Wheelchair seating is most often used to provide postural support, injury prevention, pain alleviation and/or skin protection.	Yes

14	29-Oct-13	Josh Winkler, CCDC	Specifies "cannot" (page 2, paragraph 3, sentence 2), many clients who need wheelchairs have the ability to ambulate some but need a wheelchair to maximize independence.	This statement will be updated to read, "..or other conditions that affect their ability to sit or ambulate safely and functionally."	Yes
15	29-Oct-13	Josh Winkler, CCDC	What is the definition of "normal life activities"? With proper mobility equipment someone's concept of "normal" can increase greatly!	Have replaced ADLs with normal life activities to get at the broader concept of encouraging and allowing participation in community	Yes
16	29-Oct-13	Mark Simon, CCDC	Reiterated J.Reiskin's comment regarding definition of MWBs and made suggestion. Specifically, "...who cannot achieve independent or assisted ambulation with devices such as canes and walkers."	Revision will be made per suggestions of the commenters. "Diminished" or "significantly impaired" or "unable to" were noted as preferable language rather than using words that indicate finality, such as "cannot."	Yes
17	29-Oct-13	Susan Kennedy, Numotion	Recommended, as an adjunct to M. Simon's comments for the definition of MWBs, that "timely, safely and functionally" be added to the language with an emphasis on timely and the ability to get from point A to point B.	Revision will be made per suggestions of the commenters. "Diminished" or "significantly impaired" or "unable to" were noted as preferable language rather than using words that indicate finality, such as "cannot."	Yes
Eligible Providers					
18	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Prescribing providers.</i> In real life therapists do most of this, so why not add PT & OT?	PT/OT provider types do not have prescriptive authority in Colorado. This information was added to the coverage statement and PT/OT providers were addressed in a note below the summary of eligible prescribing provider types.	Yes
19	01-Nov-13	Mark Simon, CCDC	Requested attention to client interaction with physical and occupational therapists in the Eligible Provider section.	Noted and updated per participant suggestion.	Yes

20	01-Nov-13	Wendy DeWitt, Numotion	Requested that the coverage standard address validity of equipment that is prescribed by physicians who are not enrolled in CO Medicaid. Currently, there is a process for allowing this, as is the case with processing requests from military physicians. Will this still be allowed?	This needs to be looked into. The system capability is in place, but there may be provisions per the ACA.	BCS will be updated once federal requirements are clarified.
21	01-Nov-13	Anna Davis, MedStuff	Clarified that the intent of policy referred to above is to continue allowing providers with prescriptive authority to write prescriptions for Medicaid clients regardless of their enrollment status with CO Medicaid. Also, that eligible prescribing providers specifically pertains to providers who have prescriptive authority per state statute.	See comment above.	
Eligible Place of Service					
22	29-Oct-13	Josh Winkler, CCDC	10 CCR 2505-10 8.590.2.A does not mention place of residence (good citation format though)	The citation will be updated to reference only Section 8.590.2.B.	Yes
23	29-Oct-13	Josh Winkler, CCDC	Except as currently described in 10 CCR 2505-10 8.590.2.B.1 Most wheelchairs need to be ordered months in advance, the 14 days prior to discharge seems very inadequate.	The Department is aware of this issue and looking into it with LTSS staff.	Under Review
24	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Eligible place of service.</i> Also need to be clear that place of service for repair and maybe evaluation can be office or other community based setting. I had my PT eval at my office because I needed her to see my set up so seating was right. If chair breaks provider needs to go where it is if chair is not operable. Should not assume that we stay home and having clear expectations of significant community involvement sends right message to providers and clients.	Eligible place of service is not an indication of the client's physical location at the time services are rendered. DME is covered when client's are not receiving care in a medical facility. The Department recognizes this section requires clarification and will update the language per stakeholder recommendations.	Under Review

25	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Eligible place of service.</i> We need to be clear about this, especially for transitioning clients. If someone is transitioning we need to know the SNF will get them appropriate chair for community even if the client leaves next month.	The DME Rules, Section 8.590.2.B address the parameters under which DME can be provided to clients residing in a SNF.	No
26	01-Nov-13	Christy Blakely, MSB member	Commented on vendors' additional capability to ensure that the wheelchair being recommended is maneuverable in all environments in which it will be used.	This is incorporated in the documentation requirements. The requirement is not intended to exceed the provider's capability during a thorough evaluation, but to consider use of the chair outside of the evaluation setting. The Department will consider alternate language upon suggestion	Under Review
27	01-Nov-13	Leslie McLachlan, ATP	Agreed with others that the heading "Eligible Places of Service" requires clarification. She suggested language similar to that of Rich Salm from Numotion. He clarified that eligible place of service is terminology used for billing requirements.	The Department recognizes this section requires clarification and will update the language per stakeholder recommendations.	Under Review
28	01-Nov-13	Anna Davis, MedStuff	Suggested additional information with specific language, such as "...residing in a non-skilled facility."	The Department recognizes this section requires clarification and will update the language per stakeholder recommendations.	Under Review

29	01-Nov-13	Josh Winkler, CCDC	Suggested referencing the Home and Community language in the 1915(i) regulation.	Perhaps: In accordance with the CO Medical Assistance Program, DME and Supply benefits are covered as an outpatient service. These items must not be provided to clients through the DME and Supply benefit if the client is receiving inpatient or home care services covered by Medicaid, or any other medical care in which such equipment/supplies are included in the care.	Yes
30	01-Nov-13	Rich Salm, Numotion	Suggested, as an alternative, listing all places a client may receive service.	The Department recognizes this section requires clarification and will update the language per stakeholder recommendations. However, it should be considered that the list of places where coverage is excluded is much more limited. Listing all places where coverage may be received has the potential to be exclusive or misinterpreted if the list is not entirely comprehensive.	Under Review
Covered Services and Limitations					
31	29-Oct-13	Julie Reiskin, CCDC	<i>Re: "Eligible provider" under Covered Services and Limitations heading.</i> Do you mean rendering or prescribing here?	Eligible provider was left intentionally vague since both the physician and supplier are involved in obtaining DME. The language will be updated to indicate eligible provider(s).	Yes
32	01-Nov-13	Mark Simon, CCDC	Requested that the group remain cognizant of the TL decision, which bases coverage on medical necessity determination and prohibits the State from maintaining exclusive lists of DME that it will or will not provide.	Under Review. The Department is aware of this decision and will review with this in mind.	Under Review

33	01-Nov-13	Christy Blakely, MSB member	Added to Mark Simon's previous comment with a suggestion to also consider EPSDT so that definitions of medical necessity for each of the requirements can work together.	Noted. This suggestion will be applied to all BCS and remain part of the template in development.	Yes
34	01-Nov-13	Rich Salm, Numotion	Suggested that, for consistency in language, verbiage be added to the Coverage and Limitations section to match what is in the Brief Coverage Statement, i.e. "..timely, functionally and safely..."	Suggestion will be incorporated to maintain consistency throughout the BCS.	Yes
Prior Authorization Requirements					
35	29-Oct-13	Josh Winkler, CCDC	[To what does] "DME billing manual" [refer] on the website? Using consistent titles helps everyone.	The title of the DME billing manual will be updated for consistency throughout this BCS and on the Department website.	Yes
36	29-Oct-13	Josh Winkler, CCDC	Can you narrow (page 4, paragraph 1, sentence 1) to 8.590.2.A?	Yes. The rule reference will be updated to specify 8.590.2.A.	Yes
37	29-Oct-13	Julie Reiskin, CCDC	Need PAR to be for first time purchase. Replacement of entire chair but not for replacement of items already approved such as new cushion, additional calf straps, replacement head rest, arm rest, etc. These things wear out or break and need to be replaced immediately. You could put limit and get PAR for certain number of replacements in the five year period that the chair is supposed to last, but do not require PAR for replacement of item you already determined was necessary.	The Department will look into this; however, the coverage standard is policy regarding the general guidelines on when coverage is allowable. Although PAR and claims systems are unable to accommodate such contingencies at this time, most replacement parts and repairs are immediately authorized upon submission in real time or no longer require a PAR.	Under Review

38	10-Feb-14	Julie Reiskin, CCDC	Re: Prior Authorization Requirements. We need to be sure there are NOT PAR for repairs.	The Durable Medical Equipment (DME) & Supplies manual states a PAR is required for each wheelchair repair item. But PARs for wheelchair repair no longer require a prescription or signature from the physician and most repairs are immediately authorized upon submission in real time.	No
39	10-Feb-14	Julie Reiskin, CCDC	Re: Prior Authorization Requirements. There isn't always evidence based standards for this equipment, we need something here that allows those to get equipment approved by FDA/whomever is approving it even without any sot of study or article.	According to the Colorado Medical Assistant Program rules Section 8.590.2.A, to determine medical necessity, equipment/device shall be " in accordance with current medical standards or practice", " not be experimental/investigational ,but generally accepted by the medical community as standard practice." The sentence will be revised.	Yes
40	01-Nov-13	Sheryle Hutter, CCDC	Commented that timeliness is a critical component to helping clients function as well as they can.	The Department agrees that timeliness is key to client care. It is the intention of the BCS to strengthen standards of care through collaborative policy development.	N/A

41	01-Nov-13	Jose Torres, CCDC	Suggested that replacement items not require a new prior authorization.	<p>The requirements are established to maintain consistency with standard medical practices and to provide continuous review and monitoring of client care and utilization.</p> <p>The Department works with the UM vendor to routinely evaluate the items that require a PAR. While a change has not been made to the BCS, this comment will be incorporated during the PAR review with the vendor.</p>	No
42	01-Nov-13	Mark Simon, CCDC	Reiterated J. Torres's comment above and emphasized that the PA requirements cause delays in service that put clients at risk of issues that are detrimental to their health and are of greater cost to the State.	See previous comment.	No
43	01-Nov-13	Mark Simon, CCDC	Noted the inconsistency in language referencing the title of the DME billing manual.	The title of the DME billing manual will be updated for consistency throughout this BCS and on the Department website.	Yes
Documentation Requirements					
44	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Documentation Requirements and length of anticipated need for the requested item</i> . This will often be lifetime, if you want this info DO NOT then deny because provider writes "lifetime" instead of some code	Documenting the length of anticipated need for the requested item is conditional in that it needs to be completed if requesting renting equipment. In which case, a best estimate of how long the equipment will be needed must be documented.	No

45	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Basic Documentation Requirement.</i> A doctor is not going to know this. How do you prove the ability other than saying that someone has used the same or similar equipment in the past or did a trial.	Need more detail to respond.	
46	29-Oct-13	Josh Winkler, CCDC	[On page 5, paragraph 1, senetence 1] Are you asking for a description of the "optimal environment" for the device, or if the client can operate the device in an "optimal environment"? If the latter, who defines "optimal environment"?	This will be updated for clarification. Different chairs are optimized for use in different environments. This documentation requirement is intended to ensure that the client is able to properly operate the chair in all environments it will be used.	Yes
47	10-Feb-14	Julie Reiskin, CCDC	Regarding description of the client's seating and positioning needs: This should be a form or doctors are not going to know how to address	We would like to discuss more with the group before responding.	
48	10-Feb-14	Julie Reiskin, CCDC	Regarding description of where the equipment is to be used: There should be a checklist that they fill out home, school,work,neighborhood, rural land/farm/ranch, then transportation car, bus, city streets, train, etc...	We would like to discuss more with the group before responding.	
49	10-Feb-14	Julie Rieskin	Do they have to do a full letter for each component or can they do a letter identifying the full chair and each thing they need, for ex do yo really need to do a separate letter for a tilt for an adult who cannot move?	We would like to discuss more with the group before responding.	
50	29-Oct-13	Josh Winkler, CCDC	[On page 5, paragraph 3, sentence 2] Define "care for"? Is this referring to cleaning, maintenance, tire repair, or something else?	All "care for" language will be revised per participant suggestion. This was written with the intention to state that the client/caregiver should have the capability to properly operate the equipment that is being recommended to prevent unnecessary damage, repair or harm to the client.	Yes

51	29-Oct-13	Josh Winkler, CCDC	[Page 5, paragraph 7, sentence 1] When would there not be a need to address seating? Even if the stock seating option is appropriate it should be noted.	Documentation on seating and positioning is required in the basic documentation. This is an example of redundant criteria due to combining general information that applies to all subparts of the wheelchair BCS and will be updated.	Yes
52	29-Oct-13	Josh Winkler, CCDC	[Page 5, paragraph 8, sentence 1] Medicaid does not have a home-bound rule, all mobility equipment should be able to negotiate indoor and outdoor environments, an active lifestyle should be encouraged. If a client needs a special piece of equipment to navigate a particularly difficult environment it seems reasonable to explain, but an expectation of use both indoors and outdoors on carpet, tile, concrete, asphalt, grass, and hard dirt should not require notation.	The Department does support home and community based services. The BCS aims to provide general guidelines for coverage that address the medical needs and ADLs for client's individual needs and lifestyles. Clients are neither assumed to be home-bound nor wheelchair-bound.	No
53	29-Oct-13	Josh Winkler, CCDC	Is Medicaid going to fund lock-down brackets for safe transportation?	Coverage of specific items will be discussed in upcoming benefits collaborative meetings.	
54	29-Oct-13	Josh Winkler, CCDC	Define "care for" Is this referring to cleaning, maintenance, tire repair, or something else?	All "care for" language will be revised per participant suggestion. I believe this was written with the intention to state that the client/caregiver should have the capability to properly operate the equipment that is being recommended to prevent unnecessary damage, repair or harm to the client.	Yes

55	29-Oct-13	Josh Winkler, CCDC	[On page 6, paragraph 3, sentence 1] Is the DME vendor expected to evaluate client's homes for accessibility? Who ultimately decides if the residence is accessible?	<p>The requirement is not intended to exceed the provider or the DME vendor's capability in determining which equipment is best for the client. However, it has been indicated by various stakeholders that accessibility has been an issue in the past because the client's residence and other routine settings were not considered in equipment recommendations. This requirement was included in the BCS in response to that feedback so that the recommendations would be made with acknowledgement that the chair will be used outside of an institutional setting.</p> <p>The Department will consider alternate language upon submission.</p>	Under Review
56	29-Oct-13	Josh Winkler, CCDC	[On page 6, paragraph 7, sentence 2] So Numotion in house specialists cannot order items that require a "specialty evaluation"?	There are items that require specialty evaluation that must be performed by a licensed/certified practitioner. The actual order must be provided by an eligible prescribing provider and the equipment must be provided by an eligible rendering provider.	No
57	29-Oct-13	Josh Winkler, CCDC	[On page 7, paragraph 4, sentence 1] Why only call out tilt? What about elevating seats, elevating footrests, leg bag emptiers, lights, etc.?	Checking with ATP on accuracy of this.	Under Review

58	29-Oct-13	Julie Reiskin, CCDC	[On page 4, 1st bullet under documentation requirements] You only need [height and weight] on basic device.	This information is used to determine medical necessity for basic and complex devices. Basic documentation requirements are applied to all items that require a prior authorization.	No
59	29-Oct-13	Julie Reiskin, CCDC	[On page 4, 2nd bullet under documentation requirements] This is ridiculous. Most of us need chairs for life. What kind of treatment are you looking for? This is really going to upset people and cause a ton of work for everyone. Do you really want 20 years of treatment records? For most of us there ain't no cure.	The Department will clarify this requirement. Medical treatment required in this line item is referring specifically to relevant history related to the item being requested, which is generally already provided for prior authorization review.	Yes
60	29-Oct-13	Julie Reiskin, CCDC	This is what you need, and for each accessory, a brief explanation.	The Department needs further detail to respond.	
61	29-Oct-13	Julie Reiskin, CCDC	[Page 4, 4th bullet under documentation requirements] You need more detail here. This is an area that causes a lot of confusion and appeals, which HCPF always loses because there is no definition of what they are supposed to compare -for example do they need to justify for everyone who uses a power chair why they cannot use a manual each time or only once? Do you have to justify why someone needs a headrest or why a cushion and tilt is cheaper than a pressure sore each time? Do you have to find something for each component to compare?	The Department will update this requirement and incorporate other participant suggestions on clarification.	Yes

62	29-Oct-13	Julie Reiskin, CCDC	Fifth bullet on page 4, under basic documentation requirements, is unclear.	<p>The Department will consider alternative language suggestions, if provided.</p> <p>This item is referring to any additional PA requirements that are indicated for specific items, which are in the subparts of the coverage standard.</p>	Under Review
63	29-Oct-13	Julie Reiskin, CCDC	[On page 4, 6th bullet under documentation requirements] How much detail do they need, can they just send the manufacturer description? How much detail and does it have to be on everything --for example do they need to write a whole paragraph on headrests or calf straps?	The Department will clarify this requirement per the suggestions provided by participants.	Yes
64	29-Oct-13	Julie Reiskin, CCDC	If a manual is the only chair the client is getting, I ask how they will prevent injury from repetitive use. Unless client both walks and uses chair or has a service dog, this is a recipe for disaster.	This information is used with the individual's condition and prognosis to determine whether or not a MWB is the appropriate equipment. All of the information provided is used in the determination and includes the length and frequency of use and potential secondary issues.	No
65	29-Oct-13	Julie Reiskin, CCDC	Revisit language on page 5 under the 4th bullet under Additional Basic Requirement for PMDs. The equipment will be used everywhere.	The coverage guidelines were developed as general coverage guidelines for the spectrum of equipment that is available for typical usage. The medical necessity does not have a direct correlation to environment that routinely need to be accessed by each individual client.	No

66	29-Oct-13	Julie Reiskin, CCDC	[On page 5, 4th bullet under Additional Basic Requirements] You only need to know about the vehicle to determine payment for the bracket.	we want to talk more or are working on this issue	Under Review
67	29-Oct-13	Julie Reiskin, CCDC	Client may not be able to care for chair, that is why we have attendants.	All "care for" language will be revised per participant suggestion.	Yes
68	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Client's ability to "care for" the device</i> : Makes no sense and covered above.	See above.	Yes
69	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Additional basic requirements for wheelchair seating</i> : Provider needs to ask the right questions. For example, someone who has cats or who flies frequently should not have a roho or any air based cushion.	The medical necessity guidelines are based on both the client's medical need and what the most appropriate equipment will be for their treatment, which includes consideration of ADLs.	No
70	29-Oct-13	Julie Reiskin, CCDC	<i>Re: Additional basic requirements for WOAs</i> : This is too much, there should be description of the whole chair. With all this, there could be 20 PARs for some clients for one chair.	The additional basic requirements will be consolidated to eliminate repetition. Typically, though, one PAR is submitted and it includes all of the necessary information and components that make the chair unique to the clients needs.	Yes
71	01-Nov-13	Rich Salm, Numotion	Requested clarification on the Department's expectation on Basic Documentation PAR requirements regarding MSRP pricing information. Rich's suggestion: Only require MSRP/invoice information for items that are manually priced. Providing MSRP information for items in which a rate is established on the Fee Schedule is additional [unnecessary] work.	Noted. This will be updated to reflect suggested language.	Yes

72	01-Nov-13	Shelly Myers, Numotion	Commented on the importance of submitting product MSRP/invoice information with the PAR to help the reviewer with determining whether or not the requested item is the least costly item for the client's medical need.	N/A	NA
73	01-Nov-13	Rich Salm, Numotion	Suggested language for PAR information regarding least costly alternative items: "...provide documentation of what lower cost alternatives were considered and why they were ruled out."	Noted. This will be updated to reflect suggested language.	Yes
74	01-Nov-13	Mark Simon, CCDC	Comment: The PAR review must take into consideration meeting the client's medical need as well as preventing further injuring to the client, e.g. repetitive use of muscles used to propel manual wheelchairs.	Noted. The intention for requiring condition, prognosis and how long the client is anticipated to use the equipment is to capture such information that would contribute to treatment or improvement without causing secondary ailments. Department is considering if there should be a line item that suggests that the recommended equipment is not anticipated to contribute to prevention of secondary conditions.	Under Review

75	01-Nov-13	Jose Torres, CCDC	Commented that clients are experts in their needs and their feedback should be taken into consideration.	<p>The purpose of the BCS is to provide objective guidelines that may be used as a general guideline for clients and providers.</p> <p>The unique needs of each individual are considered by the team of providers who directly interact with each client and contribute to obtaining equipment that meets their need.</p>	N/A
76	01-Nov-13	Patrick Mahncke, USA Mobility	Suggested clarification on requirements of the "Letter of Medical Necessity" indicating chart notes would contain information that would sufficiently demonstrate medical necessity. Unless letter format is required, perhaps the term "clinical documentation" could be used instead.	This will be updated to indicate that there is no required format for submittin the letter of medical necessity and/or clinical documentation.	Yes
77	01-Nov-13	Anna Davis, MedStuff	Commented that a letter of medical necessity helps highlight the client's needs to expedite the review process when manual review is required. When only clinical notes are provided, the review process becomes longer.	The letter of medical necessity does offer a succinct summary of the medical need. Please note, though, that the summary does not always provide enough clinical documentation to complete the PAR review, which could prolong the review process. These are primary reasons for not requiring a specific format for PAR documentation submission.	No
78	01-Nov-13	Jose Torres, CCDC	Suggested that compliance with documentation form requirements that are too specific may be difficult for some providers.	Noted. This is has been taken into consideration, as well, and contributed to the decision for not requiring specific format for PAR documentation submission.	No

79	10-Feb-14	Julie Reiskin, CCDC	<p><i>Re: Specialty Evaluations:</i> While this is good, there may be a capacity issue. Will Medicaid be paying clients in rural areas to travel to Denver or CO Springs to get these evals? These clients will require overnights and attendants to be paid to travel with them.</p>	<p>The specialty evaluation section was developed in such a way that it encompasses what is already happening. The language on the provider was written intentionally inclusive of different clinicians so that the policy is not prohibitive for clients residing in certain areas.</p> <p>The Department will consider alternate language and/or requirements upon suggestion</p>	Under Review
80	10-Feb-14	Julie Reiskin, CCDC	<p>We also need to assess capacity in terms of ability to do timely evaluations. People already wait too long. Maybe do this for first time users not for replacements?</p>	<p>In defining general coverage criteria, there is not a way to exclude evaluation requirements based solely on the fact that the client has had the equipment previously. This information does not take into account the client's condition, any improvements or deterioration in function that may be directly attributed to the equipment or its replacement. The only way for the Department to effectively monitor utilization and client care of such complex items is through the PAR and evaluation process.</p> <p>The Department will consider alternate language and/or requirements upon suggestion.</p>	Under Review

81	10-Feb-14	Julie Reiskin, CCDC	Re: Mat exam for specialty evaluation documentation: Not ok to demand for everyone.	The criteria states that when applicable to the clients evaluation, details must be submitted. In other words, the mat exam documentation only needs to be provided in the PAR if a mat exam is pertinent to the recommended equipment and is performed in the evaluation.	No
82	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Equipment trials/simulations for specialty evaluation documentation:</i> Do not require trials for replacements unless person is getting something very different.	See response above. The documentation requirements indicate that a summary of pertinent assessment findings should be included. Equipment trials are not required for all specialty equipment.	No
83	10-Feb-14	Julie Reiskin, CCDC	IADLS also should add ability to function other than ADL such as ability to work or go to school	IADLS will be used instead	Yes
84	10-Feb-14	Julie Reiskin, CCDC	<i>Re: All speciality evaluation.</i> We really need ONE form that the doc signs, not all these different papers		Under Review
85	10-Feb-14	Julie Reiskin, CCDC	Noted the existance of duplicative language.	Duplicative language will be removed.	Yes
86	10-Feb-14	Julie Reiskin, CCDC	Anyone who is full time user should have a tilt.	There are circumstances in which a client's medical need does not require full time use, but a tilt function is necessary. This documenation requirement captures the necessary information for a PAR review regardless of time spent in the chair.	No

87	10-Feb-14	Julie Reiskin, CCDC	You cannot always predict course of progressive disability. Is this going to be used to deny those of us with progressive disabilities decent equipment?	No, this information is not being used to deny equipment. Rather, it may be used to demonstrate why a client may benefit from more complex equipment that suits their current medical need as well as their near-future medical needs.	No
88	10-Feb-14	Mark Simon, CCDC	Comment: Some documentation requirements in the draft appear to be redundant.	Noted. Redundant requirements will be removed.	Yes
Non-Covered Services and General Limitations					

89		Julie Reiskin, CCDC	<p><i>Re: Back-up mobility devices.</i> This is a MASSIVE change in policy. If this is the case you MUST demand 24 hour repair statewide. This is a serious mistake.</p>	<p>The coverage statement re-defines back-up and secondary wheelchairs. Coverage policies regarding secondary/back-up wheelchairs are not changing. Please refer to page 9 of the draft for draft coverage guidelines regarding secondary and back-up equipment.</p> <p>There was confusion in the fact that the heading Non-Covered Services and General Limitations states that back-up mobility devices are not covered. However, the coverage guidelines and distinction between secondary and back-up equipment are in a following section. Perhaps the organization of these sections should be switched around, or an additional sentence can follow the non-covered statement such as: The Department does allow secondary wheelchairs and back-up mobility device repairs, please refer to the Primary, Secondary, and Back-Up Mobility Devices section.</p> <p>Revision will be made to clarify that secondary equipment will be covered but that two identical wheelchairs will not be provided at the same time, as is the current policy. Services that are duplicative are not covered per the DME rules.</p>	Yes
90	10-Feb-14	Julie Rieskin	The whole point of back up is to have the same thing available.	we want to talk more or are working on this issue	

91	01-Nov-14	Rich Salm, Numotion	Requested clarification on the Department's intention regarding coding verification through the PDAC, and noted that Numotion would not be able to provide certain items to clients with this requirement, e.g. Aspen Seating systems.	<p>The intention is to provide a streamlined process for claims. As exemplified in other states, the PDAC offers a way to correlate claims and proper coding consistently.</p> <p>The Department is open to updating this language so that these requirements do not exclude some of the products that have not been coded by the PDAC.</p> <p>Suggested language from providers on how to accomplish this is requested.</p>	Under Review
92	02-Nov-14	Anna Davis, MedStuff	Requesting revising the language so E1399-coded items are not excluded from coverage.	<p>There are many manufactured items that have been submitted to the PDAC for HCPCS coding verification that have been assigned with procedure code E1399.</p> <p>See comment immediately above.. Upon suggested language for revision.</p> <p>Suggested language from providers on how to accomplish this is requested.</p>	Under Review

93	03-Nov-14	Tom Hetzel, Aspen Seating	<p>Asked what the Department's flexibility is in revising the language regarding PDAC coding requirements, and suggested revising language regarding PDAC requirements to address concerns of covering items that are not PDAC-coded.</p>	<p>The Department is flexible in revising the language regarding PDAC coding requirements. The intention with this requirement in the draft policy is to work collaboratively on how to accomplish consistency and transparency in proper code and billing practices.</p> <p>Suggested language from providers on how to accomplish this is requested.</p>	Under Review
94	04-Nov-14	Anna Davis, MedStuff	<p>Commented that PDAC coding is not a requirement, and suggested other methods of ascertaining whether or not a product should be covered, e.g. FDA approval.</p>	<p>PDAC coding is not a requirement. However, HIPAA Transaction and Code Set compliance is required per federal HIPAA regulations, which specifically include HCPCS codes. Since CMS has delegated authority for coding manufacturer's products to PDAC, it would follow that the State would defer to the PDAC, as well. FDA approval does not address the intent that was stated in the previous responses.</p> <p>Suggested language from providers on how to accomplish this is requested.</p>	Under Review

95	05-Nov-14	Anna Davis, MedStuff	Commented that the DME rules (8.590.2.C) appear to contradict the draft policy statement regarding back-up equipment.	It has been noted that the terminology in the referenced rule requires update. The BCS defines and differentiates between back-up and secondary equipment. The Department is not changing coverage policies that would prevent clients from obtaining medically necessary equipment that is used aside from a primary device. Precautions will continue for preventing duplicate services that aren't deemed essential by medical necessity.	No
96	06-Nov-14	Mark Simon, CCDC	Commented that while providing two brand-new wheelchairs is not practical, rental equipment is not always an option for clients when a back-up/secondary chair is needed. There must be a solution for back-up in these cases.	The Department is not changing current coverage policies. The terminology has been updated. If there is suggested language that would address this scenario, the Department will consider incorporating it. Otherwise, those situations will be addressed on a case-by-case basis.	No
Replacement					
97	29-Oct-13	Josh Winkler, CCDC	[Page 8, paragraph 3, sentence 1] Is this meant to specify MWB?	No, MWB will be omitted.	Yes
98	10-Feb-14	Julie Reiskin, CCDC	Say that repair is not cost effective rather than no longer repairable.	Language will be adapted in the draft	Yes
99	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Clinets under the age of 21</i> . Add while they are continuing growth and physical development	Language will be adapted in the draft	Yes

100	29-Oct-13	Josh Winkler, CCDC	Exceptions for a wheelchair not being reliable, requiring repairs more frequently than average, should also be included.	Average repair is highly subjective to the wheelchair and how the client uses it. Repairs that result in expenses that exceed the cost of replacement is meant to account for high frequency repairs that would indicate the level of reliability.	No
101	29-Oct-13	Josh Winkler, CCDC	[On page 8, paragraph 12, sentence 1] What is the definition of "misuse"? Clients have a right to use their mobility equipment for travel, leisure activities, work, school, etc., despite the disallowance for Medicaid to purchase equipment solely for those activities.	Misuse is defined in the DME rules as follows: Misuse mean failure to maintain and/or the intentional utilization of DME, Supplies and Prosthetic or Orthotic Device in a manner not prescribed, recommended or appropriate that results in the need for repair.	Yes
102		Julie Rieskin	[On page 7, paragraph 2, under "Replacement"] This should include difficulty getting parts quickly.	Per the DME rules, suppliers are required to maintain inventory on the products they provide. If a supplier is unable to provide parts in a timely manner and lacks the capability to provide for a safe alternative while awaiting parts, the provider issue should be brought to the Department's attention. However, turnaround time on wheelchair parts alone does not sufficiently justify wheelchair replacement.	No
103		Julie Reiskin, CCDC	If prediction of future needs is possible.	This comment is captured in the last part of the requirement, "... in the event that changes in the client's condition are foreseeable."	No

104		Julie Reiskin, CCDC	Re: "Projected modifications should not exceed the cost of a new MWB." Not sure what this is about--it could be possible that seating and modifications for complex client is more expensive than the actual chair and there would not be different chair that is possible--would you deny the client a chair in that situation?	The client would not be denied in this situation. "MWB" was inadvertently included, and will be omitted from this bullet item. This requirement is a stipulation of requests that are made specifically for replacement. The requirements for repair and replacement are set up so that neither replacement nor repair are over/under utilized; in most cases, the review is based exclusively on the request being made to see if the minimum criteria have been met for approval of that particular service.	Partially
105		Julie Reiskin, CCDC	See comment above	The client would not be denied in this situation. "MWB" was inadvertently included, and will be omitted from this bullet item. This requirement is a stipulation of requests that are made specifically for replacement. The requirements for repair and replacement are set up so that neither replacement nor repair are over/under utilized; in most cases, the review is based exclusively on the request being made to see if the minimum criteria have been met for approval of that particular service.	Partially
106		Julie Reiskin, CCDC	If in auto accident and accident was someone else's fault it may take years for the auto insurance litigation to occur--the client needs a new chair now. If and when there is a settlement, Medicaid is paid back then. Policy must be clear that one does not have to wait on insurance in this situation.	Policy staff will talk to PI about how this scenario is typically handled and will clarify accordingly.	Under review

107	10-Feb-14	Julie Reiskin, CCDC	In case of auto accident one usually has to litigate, we have a member who just now settled her case (Medicaid got repaid) but she was hit in March of 2012. It is IMPERATIVE that Medicaid buy the new chair immediately after the accident then get reimbursed at settlmenet reimbursed	See comment above	Under Review
108		Julie Reiskin, CCDC	Define misuse and make sure misuse is not normal use. Taking a chair on planes, going out in bad weather and heavy use is not mis-use. Some things are cost benefit, for example do you pay to have lights on all chairs or deal with it when we miss a curb when it is dark out? In any case, you should not call heavy use abuse or misuse.	Misuse is defined in the DME rules as follows: Misuse means failure to maintain and/or the intentional utilization of DME, Supplies and Prosthetic or Orthotic Device in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME, Supply or Prosthetic Device use by someone other than the client for whom it was prescribed. However, if there is suggested language specifically for wheelchairs and this BCS, the Department will consider incorporating it.	No
109		Julie Reiskin, CCDC	[On page 8, the second note] This is nuts. I can see for replacement of the whole chair some prior authorization but not for components. Also how many times does one need to prove one is paralyzed. If there is a cure for any of the bid diseases it will be in the papers.	The PA requirements are, in general, not used to verify diagnoses. The requirements are established to maintain consistency with standard medical practices and to provide continuous review and monitoring of client care and utilization.	No

110	10-Feb-14	Julie Reiskin, CCDC	[On page 8, the second note] What does this mean? If it is a replacement due to accident there should not be new evaluation required, the person needs the chair immediately.	The Dept is open to further discussion about a time frame when a new evaluation would be needed or not. Maybe none needed if an evaluation has been done in the last 2 years?	
111	01-Nov-14	Anna Davis, MedStuff	Commented that it would be helpful to have an approval process in place for clients with progressive diseases in which the client's condition could change rapidly.	Noted. Although that will not be addressed in this BCS, the Department is aware of this issue and exploring options for creating system rules based on diagnosis.	No
112	01-Nov-14	Mark Simon, CCDC	Commented on the replacement period of wheelchairs for children noting that more importance should be placed on the current medical need rather than future medical need in order to prevent ill-fit equipment, which could lead to further impairments.	Noted. The general coverage criteria in this BCS is a basic guideline. Coverage determination will continue to be reviewed on an individual basis.	No
113		Josh Winkler, CCDC	Suggested a caveat be added to the coverage statement regarding chair replacement if the chair is unreliable and requires frequent repairs.	Replacement due to faulty equipment would be a condition for replacement under the manufacturer warranty. Replacement is allowable with high frequency of repair if the cost of replacement is more cost effective than repairs.	No
114		Josh Winkler, CCDC	Suggested defining "negligence" and "misuse."	Misuse is defined in the DME rules as follows: Misuse mean failure to maintain and/or the intentional utilization of DME, Supplies and Prosthetic or Orthotic Device in a manner not prescribed, recommended or appropriate that results in the need for repair. The definitions will be incorporated in Appendix A for quick reference.	Yes

115	01-Nov-14	Anna Davis, MedStuff	Suggested revising "projected modifications" to "projected repairs" in reference to justifying whether or not a MWB should be replaced.	Noted. This will be updated to reflect suggested language.	Yes
and Back-Up Mobility Devices					
116	10-Feb-14	Julie Reiskin, CCDC	Stroller use is ONLY appropriate for young children	We want to talk more or are working on this issue	
117		Julie Reiskin, CCDC	[On page 9, paragraph 4, sentence 2] You must require immediate repair.	Consistent with current practices, back-up wheelchair rentals are covered for clients who do not have secondary or back-up equipment when medically necessary as determined through the PAR process. The coverage of secondary and back-up equipment is not being changed by this BCS, it is the definition and distinction between such equipment that is being updated.	No
118	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Back-up mobility devices.</i> Then Medicaid needs to make it clear the vendors/providers that this is your policy. They EXPECT us to have back up equipment. They need tp do same day repairs ALL THE TIME if our primary device is not functional. This also mean that you need to require them to have adequate parts in stock. This will further enhance thier rate protection.	See Comment Above. Per the DME rules, suppliers are required to maintain inventory on the products they provide. If a supplier is unable to provide parts in a timely manner and lacks the capability to provide for a safe alternative while awaiting parts, the provider issue should be brought to the Department's attention.	No
119	10-Feb-14	Julie Reiskin, CCDC	Back up [devised] for clients in rural areas is more important given that the monopoly is not currently able to meet statewideness.	The Department agrees and will make the change.	Yes

120		Julie Reiskin, CCDC	Anyone who needs specialized seating cannot use a rental. Providers should be required to have adequate base stock so if there is a problem, they can put the client seating system on another base. If someone is a full time power chair user, they have proven that they need back up and then they have medical necessity that they need.	The CO Medicaid rules address inventory requirements for Medicaid providers. Per the DME rules, equipment that is duplicative or serves the same purpose as items already utilized by the client will not be covered unless they are medically required or for back-up support. Items that are medically required or for back-up support are referred to in this BCS as secondary devices. It is through the PAR process that the supplier is able to indicate to the Department the amount of time spent in the chair, which contributes to determining medical necessity.	No
121	10-Feb-14	Julie Reiskin, CCDC	[Page 9, paragrah 5] What you should do instead is require replacement base as rentals, usually a seating system does not fail to the point of making something inoperable, pay the vendors to move a seating system to a rental base in event that a repair cannot happen immediately.	We want to talk more or are working on this issue	
Index A: Definitions					
122	10-Feb-14	Julie Reiskin, CCDC	<i>Re: ADL.</i> Need to be able to go at least 3/4 mile, that is the public transportation standard of how far one needs to be able to walk.	We want to talk more or are working on this issue	
123	10-Feb-14	Julie Reiskin, CCDC	Should include IADL throughout.	IADL is incorporated in the criteria for specific items in the subparts of the BCS. Upon more specific recommendation, "IADL" will be included where applicable.	Under Review

124	10-Feb-14	Julie Reiskin, CCDC	What does "accommodated or non accommodated environment" mean?	<p>Accommodated and non-accommodated environment generally refer to environments that meet ADA standards. These terms and definitions are consistent with those used by the Clinicians Task Force and submitted to Medicare.</p> <p>These terms will be included in Appendix A.</p>	Yes
125	29-Oct-13	Josh Winkler, CCDC	[On page 11, paragraph 7, sentence 1] what does "one's own body" mean?	Caring for the body is included in the major heading, which specifies self-care activities but will be updated for added clarification.	Yes
126	29-Oct-13	Josh Winkler, CCDC	[On page 11, paragraph 14, sentence 3] Most items in this sentence are not defined.	<p>The Department will incorporate definitions that would improve the clarity of the coverage guidelines in this BCS.</p> <p>Please specify which terms require this clarification and then will be added as separate definitions in Appendix A.</p>	Under Review

127	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Misuse.</i> Need to change this to make reasonable layperson standards, for ex the manufacturers always say that no wheelchair should ever be transported. I'm sure that they say one should not take them on an airplane. Only group 4 chairs are meant to be used outdoors so if we adhere to this make sure we are getting a group 4 for all people that are not homebound. If you do this no medicare payment for any of these chairs. Enhanced group 3 can work for lots of people but if this is the rule what we are afraid of is having active lifestyle considered abuse by future management or to avoid appropriate service for a difficult client	We want to talk more or are working on this issue	
128	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Mobility Limitation.</i> Add "or injury" to B	Language will be adapted in the draft	Yes
129	10-Feb-14	Julie Reiskin, CCDC	<i>Re: Specialty Evaluation.</i> I am still confused about when one needs a primary versus speciality evaluation. Development of a form is going to be key to making this work.	We want to talk more or are working on this issue	
130	29-Oct-13	Julie Reiskin, CCDC	[On page 12, paragraph 10, sentence 1] Bad word choice.	Suggestion for alternate word choice: Impairments are body functions or structures in which there is significant deviation or loss.	Yes

