



Benefits Collaborative Public Meeting: Wheelchairs and Power Mobility Devices

Friday, November 1, 2013

1:00 p.m. – 4:00 p.m.

COPIC Building

7351 E Lowry Blvd, Denver, CO 80230

Mile High Conference Room

Notes

Time	Topic/Agenda Item	Responsible
1:00 – 1:15 p.m.	Welcome and Introductions <ul style="list-style-type: none"> • Ground Rules & Phone Etiquette • Staff Contact Info 	Kimberley Smith
1:15 – 1:35 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
1:35 – 1:40 p.m.	Frame for Today's Discussion <ul style="list-style-type: none"> • Services under discussion include: manual wheelchair bases, wheelchair seating, wheelchair options and accessories and power mobility devices • Today's Focus : Brief Coverage Statement, Eligible Providers, Eligible Places of Service and Eligible Clients 	Kimberley Smith
1:40 – 2:10 a.m.	Review and Discuss Brief Coverage Statement	Andrea Skubal
2:10 – 3:50 a.m.	Review and Discuss Eligible Providers, Places of Service and Clients and other sections, time permitting	Andrea Skubal
3:50 – 4:00 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
- Dr. Judy Zerzan, Chief Medical Officer, HCPF (on phone)

Welcome

Kimberley Smith, Benefits Collaborative Coordinator with the Department of Health Care Policy & Financing (Department) introduced herself and her colleague, Andrea Skubal, Durable Medical Equipment Policy Specialist with the Department.

Kimberley began by discussing some phone technology issues and then invited participants to introduce themselves.

Kimberley then reviewed the ground rules for this and future Dental 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 ends when final draft is taken to the Medical Services Board (MSB) to be approved for incorporation by reference into Colorado Medicaid Volume 8 Rule.

Kimberley explained that all benefit coverage standards must:

- Be guided by recent clinical research and evidence based best practices
- Be cost effective and establish reasonable limits upon services
- Promote the health and functioning of Medicaid clients

Kimberley then reviewed the role of participants and the role of the Department within (and between) Benefits Collaborative meetings. The collaborative exists to assist the Department in making informed decisions by contributing in the following ways:

- Share diverse perspectives to expand understanding ahead of decision making
- Share new information/research

- Ask questions and provide informed insight in response to Analysis offered and suggestions made

In turn, The Department will:

- Work with participants to ensure that concerns are consistently understood and considered
- Wherever possible, work to ensure concerns are reflected in alternatives developed; and
- Provide feedback on how public input influenced decisions made and explanation when input cannot be incorporated/adopted

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. She also point out that the Listening Log is provided to the MSB.

COMMENT – Gary Montrose, member of the Care Coordination Subcommittee on the CLASP Colorado Long Term Assistance Service Providers Advisory Group, representing the Independence Center, noted that, in that subcommittee, they are currently developing quality processes for care coordination inside the medical community. They find that the medical community operates out of a medical paradigm and that social services does not have the benefit of funding to generate evidence for important aspects of care, such as consumer experience or quality of life. He asked what is the balance on the MSB of people who come from the other paradigm/world view and that bring experience based on best practices – rather than clinical evidence – that would affect decision making around the use of wheelchairs?

RESPONSE – Kimberley emphasized that the Department looks at both evidence based clinical research and best practices. Both are important. She explained that there is diverse representation on the board and also on the other advisory councils that review the standard prior to the MSB. She then invited Christy Blakely, MSB member, to further comment on the makeup of the board.

Christy Blakely confirmed that there is a diversity of experience on the MSB. She explained that she has been an advocate for over twenty years and is very familiar with wheelchair technology. There is also a gentleman on the board who uses a wheelchair. She further explained that, when the board does not feel it has experience that bears on a topic brought before them, it always provides an opportunity for people to sign up for public comment. She concluded by stating that the MSB will be very attuned to this concern and that it is, in part, for this reason that she is on the call today.

Kimberley briefly outlined the components of a benefit coverage standard. A BSC generally includes the following:

- Brief Coverage Statement
- Related Services Addressed in Other Coverage Standards
- Eligible Providers
- Eligible Places of Service
- Eligible Clients
- Covered Services and Limitations
- Non-Covered Services and General Limitations
- Requirements
- Billing Guidelines
- Definitions
- References

Frame for Today's Discussion

Today, we are looking at the first half of the standard to be developed. In subsequent meetings we will review special sub-sections. For example, a future meeting may be devoted to the Wheelchair Seating covered services, another covered wheelchair accessories, another to power mobility devices and another to wheelchair bases. The number of future meetings will be dictated by the level of discussion in the room.

Kimberley explained that future meetings have not yet been scheduled because she and Andrea first wanted to gauge interest in order to identify, for example, appropriate meeting space for future discussion. As a result, and due to the need for good public noticing, there will be more than a month between the first meeting and subsequent meetings. However, future meetings should follow one-another in shorter order (perhaps two to three weeks apart).

Kimberley introduced the concept of a Parking Lot List. She explained that any comments and/or questions raised that are not quite on-topic for today's meeting will be placed on the list. The Department commits to addressing anything on the list that does not resolve itself through the course of subsequent meetings. Kimberley invited participants that may have related questions/comments that do not bear on the content of the draft standard (such as provider access issues, billing issues or customer service questions) to discuss them with her post-meeting.

QUESTION – Josh Winkler with the Colorado Cross-Disability Coalition (CCDC) asked if questions and comments received post-meeting would also go in the Listening Log.

RESPONSE – Kimberley confirmed that they would be and encouraged participants to check the log if they desire to see the kinds of comments the Department receives outside of the Benefits Collaborative meetings.

Kimberley then turned the microphone over to Andrea to walk the group through the draft coverage standard one section at a time.

Draft Coverage Standard Discussion

Andrea began with the Brief Coverage Statement.

She pointed out that this section is really a summary of what follows so we don't want to get too caught up in the language that pertains to what is covered – the language will likely be clarified in the following sections. This section does not define coverage. We do, however, want to address any language that may be unclear.

COMMENT – Rich Salm from Numotion stated that, overall, he really likes the document; a lot of thought seems to have been put into crafting the language. He then directed the group's attention to page four, under Documentation Requirements, under the Basic Documentation heading, the sixth bullet point down, which begins "Detailed description of all products"....

RESPONSE – Dr. Judy Zerzan, Chief Medical Officer at the Department, clarified that the group plans to go through the standard section by section and asked Rich if he could hold his comment until discussion of Documentation.

Rich agreed and noted he had no comment on the Brief Coverage Statement Section.

COMMENT – Mark Simon stated that many of his comments have already been received by the Department, as they were previously provided by Julie Reiskin with CCDC, however, some he wishes to emphasize.

He pointed to page one and the underlined language below and asked that it be changed:

Manual wheelchair bases (MWBs): MWBs are a DME benefit for individuals with neurological, orthopedic, cardiopulmonary or other conditions who cannot achieve independent or assisted ambulation with devices such as canes and walkers.

Mark noted that many individuals can walk with a cane but not far and not fast. The purpose of this equipment is to provide people with independence. He pointed to the old Medicare wheelchair rule that required wheelchair recipients be unable to stand and pivot. Then Medicare changed the rule so that you could only have the cheapest wheelchair that you can use within your own home. He explained that he made this point so that all keep in mind that we must get people the right equipment to provide

them with independence. He noted that active individuals with disabilities consume less medical care.

RESPONSE – Andrea noted that the Department did previously receive the feedback. She noted that similar language repeats in many of the sections that follow. She noted that the word “cannot” seems to make a solid statement about what is covered, which is not the intent of the section or the standard in general. She pointed to similar, but more general – and perhaps more positive – language can be found on page 3.

Mark said that he absolutely agrees with Andrea but that, instead of using the word “cannot”, perhaps the words “diminished” or “significantly impaired” can be used.

Andrea welcomed suggestions on alternative phrasing.

Mark clarified that he does not recommend using words with such finality.

Kimberley noted that Julie’s suggestion still used the word cannot and asked Mark for his opinion on her suggestion, which reads “cannot sit or ambulate safely or functionally”.

Mark stated this language would be OK. He suggested, as an alternative to “cannot”, “unable to”.

COMMENT – Susan Kennedy with Numotion suggested to also add “timely, safely and functionally” and emphasized timely (the ability to get from point A and B).

COMMENT – Patrick Mahncke with USA Mobility pointed out that, on page 12, safety, timeliness and functionality are identified in the language.

Andrea moved on to the Services Addressed in Other Benefit Coverage Standards. Hearing no comments or questions, she moved to the Eligible Providers section. She explained that “Rendering Providers” refers to the Colorado Medicaid providers who are eligible to be reimbursed by Medicaid and that “Prescribing Providers” follow. This section does not address all types of providers who may interact with clients who are getting a wheelchair. This section is intended to emphasize who may order a wheelchair for a client and who is able to provide it and be reimbursed.

COMMENT – Mark Simon pointed to Julie Reiskin’s comment that attention be paid to the interaction of physical and occupational therapists – not currently listed. He noted that occupational therapists, for example, often write up the prescription.

COMMENT – Jose Torres with CCDC echoed Mark’s point. He explained that, when individuals with disabilities work with their doctors, often, the doctors do not know what kind of wheelchair the client needs.

COMMENT – Mark Simon also referenced a proposal put together roughly 10 years ago by the Council for People with Disabilities, which he previously provided to Andrea. The proposal encourages the provision of the right DME that meets the client’s need and is appropriate for them. The proposal was meant, in part, to avoid situations in which clients do not get the right equipment and must be bought more equipment 6 months down the road.

COMMENT – Medicaid client shared recent personal experience in which, Numotion contacted them and asked for a new doctor’s note before replacing equipment. The client understands the need to prove medical necessity but does not understand why, once a wheelchair is deemed medically necessary, further doctor’s notes are needed. The client asked why?

RESPONSE – Kimberley noted that this conversation may best be had when discussing the Documentation section to follow.

Kimberley then invited others to speak to Mark and Jose’s earlier point about the inclusion of physical and occupational therapists in the Eligible Providers section.

COMMENT – Wendy with Numotion asked that military physicians be addressed; many are not enrolled in Colorado Medicaid or able to get approval as secondaries. She wants to make sure this standard doesn’t change that. **Clarification received post-meeting:** It is the DME suppliers who require Colorado Medicaid authorization and, when the signing physician is a military physician, they are not enrolled as a Medicaid provider therefore the supplier has no Colorado Medicaid provider number to submit on the PAR. Currently, Numotion indicates on the par eight “0’s” as the provider number and indicates in the comments field that the physician is a “military physician”. Numotion receives authorization from Medicaid following this process.

COMMENT – Anna Davis with Medstuff, Inc Inc. further explained that the desire is to allow clients to bring a prescription from a prescribing authority, regardless of whether that prescriber is a Medicaid provider.

She noted that prescribing authority is very specifically defined in state statute, which is why the standard only lists physicians, physician assistants and nurse practitioners (not physical or occupational therapists).

There is a provision that allows for non-Medicaid prescribing authorities to provide prescriptions to clients, either in cases where they need multiple items prescribed or they have private insurance first and Medicaid as a secondary insurance. There is a “dummy number” that can be submitted for prior-authorization. So, it may be that language is needed that providers don’t need to be Medicaid providers to be prescribing providers.

COMMENT – Christy Blakely, MSB member, stated that, from her standpoint and experience it is also important to look at all the environments, which most vendors do. Vendors are sometimes unable to do a thorough examination of all of the environments in which a wheelchair might be utilized. For example, if a family doesn’t have a wheelchair van, chances are a child is just using wheelchair in school and/or at home, but let’s make sure it fits through the front door. If a family does have a van, we need to make sure the wheelchair will also fit in the van. Evaluations need to take into account all types of possible utilization and environments.

Andrea then moved the conversation on to Eligible Place of Service.

Andrea noted that she has already received several comments about this section and she anticipated discussion here. She explained how the section was developed. It is a section that outlines when something would fall under the DME benefit and not saying that someone has to be in the home to receive service. There is a place in the DME rules that specify, if someone is receiving Medicaid care through a different funding source, such as nursing facilities, they will receive their wheelchair through the nursing facility, not DME.

COMMENT – Jose Torres with CCDC asked how this section applies to current practice. He pointed out that Numotion is able to fix a wheelchair wherever it breaks, not just in the home, and Medicaid pays.

RESPONSE – Andrea clarified. She has received feedback that the standard, as written currently, reads as if a client needs to be in the home to receive service but that this is not the intent. The statement is trying, rather, to get at whether a

client resides in a nursing facility or if they reside in the home and receive home and community based services and should be covered under the DME benefit. Her question for the group is how to modify the language to reflect what the practice is.

Rich Salm from Numotion provided a little more clarity by explaining that this section refers more to a billing terminology. Providers, when filling out a claim form, must indicate the place of service; places of service are numbered and 12 equals “home”. In the example Jose gave, a client who resides in a home can receive services anywhere, but the place of service on the claim form will be filled out as 12 (home).

Furthermore, number 31 is a skilled nursing facility and there are special provisions that don’t allow individuals who are living long-term in nursing facilities to receive services through the DME benefit, because it is paid for through the per diem the facility receives for the custodial care of the individual. There is a provision in the current rule that allows us to provide repairs and modifications to a wheelchair that is owned by the client prior to entry into the nursing home.

COMMENT – Leslie McLachlan, physical therapist with Assistive Technology Partners, helped develop this standard. She stated that this is a topic that involved a lot of discussion. She noted that the title of the section “Eligible Places of Service” doesn’t really match the descriptor and the authors are looking for a better way of explaining exactly what Rich just outlined. She suggested using some of the language Rich offered above. The word “community home” was added to emphasize the fact that the client does not reside in a nursing home.

COMMENT – Anna Davis with Medstuff, Inc Inc. suggested changing language to “residing in a non-skilled facility”. She also suggested adding additional language that helps avoid any possible confusion that might arise around coverage of foster kids who reside in other states but receive Colorado Medicaid.

COMMENT – Rich Salm agreed. This paragraph has more to do with where the beneficiary resides, not where they receive the service.

COMMENT – Josh Winkler with CCDC suggested potentially referencing the Home and Community language in the 1915(i) regulation.

COMMENT – Jose Torres seconded Josh’s suggestion.

COMMENT – Mike Fiss, manufacturer’s representative and a CAMES Board Member, noted that Eligible Place of Service (EPS) is really a subset of Eligible Clients (EC). He was unaware of a possible statutory reason the two must be separated out but it seemed to

him that residence client is what truly impacts their eligibility (so residence could be brought up in the EC section, rather than the EPS section).

RESPONSE – Kimberley noted this as a valid point. She explained that most standard have an EC and EPS section but that sometime sections are removed and they would revisit this as a team.

COMMENT – Rich Salm with Numotion suggested, as an alternative, listing all the places of service.

Andrea then moved on to the Eligible Clients section. Andrea briefly summarized the section by stating that clients must be Colorado Medicaid eligible to receive these services and the services must meet medical necessity criteria. This is general language, not meant to define who, specifically is eligible for any of the sub-parts (wheelchair seating, accessories, bases and power mobility devices) that will be discussed in detail in future meetings.

COMMENT – Jose Torres asked if this is a good place to identify the difference between Medicare and Medicaid eligibility, rather than just Medicaid eligibility.

RESPONSE – Andrea asked what Jose suggests should be clarified, given that the standard is meant to outline what Medicaid is going to cover.

Jose said this makes sense.

COMMENT – Mark Simon stressed the idea of medical necessity. He also asked that, as the group goes through the standard, it not forget the TL Decision. He explained that the TL Decision states that the State cannot have exclusive lists of DME that it will or will not provide; it must be based upon medical necessity. For those in the room unfamiliar, Mark explained, the TL Decision involved a doctor who prescribed a hot tub. Some felt this excessive, however, it was demonstrated that provision of the hot tub was cheaper than going to physical therapy every week. What does not look like medical necessity to some may be medically necessary to another.

COMMENT – Christy Blakely, MSB member, suggested that attention be paid to the definition of medical necessity in Early and Periodic Screening and Diagnostic Testing (EPSDT) standard, so that the definitions work together.

COMMENT - Jose Torres with CCDC seconded both Mark and Christy's comments.

The discussion turned to the Covered Services and Limitations section.

COMMENT – Jose Torres stated that, when a wheelchair is prescribed as medically necessary, a client should not have to provide a medical note for repairs. It is only logical

that equipment will break. It puts extra stress on the client and a time burden on both provider and client.

RESPONSE – Anna Davis with Medstuff, Inc Inc. noted that, in the current process, a medical note does not need to be provided in the case of repairs. She verified with Andrea that repairs are not covered in this standard.

Jose stated clients are asked to provide these notes.

Shelly Myers with Numotion, responded to Jose by stating that, typically, clients are asked to provide a medical note when there is another payer primary to Medicaid, for example, if Medicare did not pay for the original purchase of the wheelchair but is being asked to pay for the repair. If it is Medicaid only, no prescription is obtained or required.

COMMENT – Rich Salm with Numotion, wondered if, for consistency of language, given that it is addressed later in the policy, verbiage about timeliness, in addition to “functionally and safely”, should be included (also to match what is in the Brief Coverage Statement).

COMMENT – Sheryle Hutter with CCDC added that “timeliness” is critical when it comes to helping clients function as well as they can.

Andrea explained that covered services will be addressed with further detail in the sub-parts to come. She then moved on to Prior Authorization Requirements and Documentation sections. Andrea explained that there are some aspects within these sections that are new.

When the standard was being developed there was discussion about possibly discontinuing the use of questionnaires. As such, this section was developed on the assumption that the questionnaires would not be used and the content herein outlines information that is already in the DME rules or on the questionnaire.

COMMENT – Jose Torres with CCDC stated that, while being fitted for special seating should require prior-authorization and proof of medical necessity, replacing a cushion that has previously been provided, should not require additional prior-authorization documentation. He asked if there was a specific reason why some items require prior-authorization and others don't, specifically when equipment is just being replaced.

RESPONSE – Andrea provided the examples of 1) monitoring utilization and 2) making sure clients are actually receiving what they need.

COMMENT – Mark Simon expounded on Jose's comments. When a wheelchair cushion goes flat, it is flat. If someone doesn't get a new cushion immediately they are at risk for pressure sores. He stated that the average cost for surgery related to pressure sores is

\$200,000, while a new wheelchair cushion is \$86. It can take three weeks to get a new cushion because of the PAR process. This doesn't seem cost-effective for the state.

There are items that we know will wear out and/or break. Why should a PAR be needed for something that always needs to be replaced, for example, once every two years? Why don't we have a policy that says, for example, "for these items that we know are going to wear out, you get one a year or one every two years"? Then, if a client needs something more frequently than that, we should be looking at PARs.

The concern is the timeliness of getting the item. If the client is allowed one cushion a year they can call the vendor, tell the vendor the cushion is flat and get a new one right away.

He noted Julie Reiskin's comments provided pre-meeting echo this sentiment.

COMMENT – Christy Blakely, MSB member, noted that this is a good point. She wondered if the Department has the capability to pre-authorize a wheelchair, for example, for a spinal cord injury that comes with three refills on a cushion and then the fourth needs prior-authorization.

Christy pointed out that the Department does not require prior-authorization on repairs, such as wheels, because it would lead to downtime.

RESPONSE – Andrea noted this is a good suggestion and will be looked into further. She stated that, for a lot of the replacement items, the prior-authorization is one step in the process. Once the Department is able to gauge utilization and can determine that an item is commonly approved, and that there is no reason for it to go through a manual review process, it is then approved in real time going forward. The provider submits and gets an immediate approval. Andrea stated that she will look at any list of items meeting participants think should be considered for refills and also welcomes input on how we do that and how the PARs are currently being reviewed.

Mark Simon noted that, sometimes, the PAR requirements are plain silly. For example, wheelchair gloves are \$12 but require a PAR that costs more than \$12 to process. We need to put common sense into this standard.

COMMENT – Jose Torres also gave the example of someone he knew who recently was told he needed a PAR for new wheels when he did not.

RESPONSE – Andrea asked Jose what he felt could be incorporated in the Prior Authorization section of the standard to address his concern.

Jose could not provide exact language but noted that Mark's common sense suggestion above was a good start.

Andrea assured all that discussion of coverage requirement recommendations will take place in future meetings when discussion each sub-part of the standard. She thanked everyone for bringing these concerns to the Department's attention and reminded everyone that the comments were being recorded.

Kimberley identified this as a Parking Lot item to be revisited later in the collaborative or offline, if aspects of the concern remain unaddressed.

COMMENT – Mark Simon noted that, in the Prior Authorization section, it currently says “as outlined in the Durable Medical Equipment and Supplies Manual” and that there is no such document on the Department website with that title. What is this?

RESPONSE – Andrea noted that Mark is correct; it is the DME Billing Manual and this is inconsistent language.

COMMENT – Anna Davis with Medstuff, Inc Inc. stated that the State did make some changes to the prior-authorization process not too long ago that allows for a lot of auto-authorization on things like wheels and armrests – anything that was under a certain price threshold – and some other conditions. She explained that, now, you can be in the shop and be instantly authorized for certain items.

She also spoke to Mark's question about the “DME Supplies Manual.” She pointed him to the “DME and Supplies Provider Reference Manual” on the website, which provide guidelines for the DME program.

COMMENT – Rich Salm with Numotion noted that there are common repair item codes that don't require a PAR, provided that they stay within certain quantity and frequency guidelines. He pointed to the example of motors and gear-boxes – one set every 18 months. A second set within that timeframe would require a PAR. So, there was a recent effort to speed up the process.

He spoke to Jose's earlier comment and pointed out that the example was really a customer service issue where a provider needed some more training.

Andrea moved on to Documentation Requirements. She noted that there are two subsections: Basic Requirements and Specialty Evaluation Documentation. Specific items that require specialty documentation will be defined later on when discussing the sub-parts and are not defined here. This is general language that can be applied to any one of these items.

COMMENT – Rich Salm with Numotion pointed to the Basic Documentation heading, the sixth bullet point down, which states:

Detailed description of all products that will be provided including manufacturer's retail pricing information, with itemized pricing, including the description of the specific base, any attached seating system components, and any attached accessories.

He asked about the intent here. Is the expectation that providers will provide the MSRP information on their PAR submission or is the Department expecting an MSRP sheet from the manufacturer?

RESPONSE – Andrea asked Rich for his suggestion of what is necessary and realistic for the provider.

Rich suggested that the information be provided on the PAR on the claims side. You only need to provide the MSRP information for the manually priced codes, where reimbursement is based off of that MSRP. To require it beyond the manual price codes, where there is a fee-schedule item with a fee-schedule price attached to it, when not needed for claims, probably just creates extra work for the claims processor.

Andrea, verified that the suggestion is to specify in the standard that “for manually priced items we would like pricing information.”

Rich said “correct”. If it is a fee schedule item, what difference does it make what the MSRP is?

Several providers in the room nodded their heads in agreement.

COMMENT – Shelly Myers with Numotion explained that there is not currently a place on the PAR itself to provide that information. Numotion does provide a manufacturer's quote with most of the PARs that have codes that are manually priced.

She does believe it is important to submit this with the PAR, not just the claim, because there are scenarios where providers will want to provide a very costly piece of equipment and there is a less costly alternative and submitting the manufacturer's suggested retail price helps the reviewers determine this.

Andrea noted, on the topic of providing the least costly option, that the Department has received feedback that the fourth bullet, which states:

A brief description of the impairments in body functions or structures that rule out use of a less costly item and justifies the need for the recommended item.

Implies that the Department will be asking for a comparison on anything that requires a PAR. This isn't true. Andrea asked for any suggestions on how to indicate to a provider that they should be providing the least costly option and, if they are not, why not.

COMMENT – Anna Davis with Medstuff, Inc Inc. noted that it is important to note somewhere that providers must provide the least costly option. She thinks it fits under the Prior Authorization section.

COMMENT – Jose Torres noted that Josh Winkler (with CCDC), in comments provided ahead of the meeting, noted on page 5, paragraph 1, sentence 1, which states:

A description of how the client will propel the MWB, and a statement summarizing the client's mental and physical abilities/limitations providing evidence of client's ability to operate the recommended MWB appropriately for its use and optimal environment.

There is reference to “optimal environment”. Is the Department asking for the optimal environment for the device or is it that the client can operate the device in an optimal environment? If the latter, who defines OE?

RESPONSE – Andrea explained that the intent is to state that the wheelchair is going to be used in the terrains in which it is capable – not the optimal environment for the client. We can look at how to provide a little more clarity around this.

COMMENT – Jose Torres with CCDC continued with Josh Winkler's pre-provided comments. He pointed to page 5, paragraph 3, sentence 2 and asked for a definition of the term “care for”. What does this refer to? Jose later noted that this comment also applies for page 6, paragraph 2.

RESPONSE – Andrea believes the intention of the sentence is to make sure there was some sort of indication that the person using it could use it appropriately in all environments it might be in. When you point it out though, she agrees it requires some clarification.

Jose pointed out that he is not trying to get hung up on the language but, when the language is wrong, there are sometimes unintended consequences.

COMMENT – Rich Salm with Numotion jumped back to page 4, under Basic Documentation, bullet 4 (as typed in italics on page 14 of this document).

Rich believes that the intent of this point is to ask “have we considered lower cost alternatives and how do we rule them out?” So, one way to approach the language might be to just strike “*A brief description of the impairments in body functions or*

structures” and just state something to the effect of “provide documentation of what lower cost alternatives where considered and why they were ruled out.” He also

encouraged the Department to consider if such documentation should be limited to “brief” description.

COMMENT – Mark Simon would like to reinforce Julie Reiskin’s pre-provided comments on page 5, where it states:

Brief description of any anticipated changes in the client’s physical size, medical or functional status which may require modifications to the Power Mobility Device (PMD).

As Julie points out, if a manual wheelchair is the only type of chair a client receives, how will they prevent repetitive use injury? Clients were not designed to “walk on their hands, so to speak”. There is upper body wear when a client operates a manual wheelchair all the time. Also, a 30 lb. temporary replacement chair can’t be lifted into a car easily. We need to make sure we are looking at the chair in terms of it meeting the client’s needs and also preventing further injury to the client on down the road.

COMMENT – Jose Torres with CCDC added that the Department take customer feedback into consideration. The customer is the expert on their needs and abilities.

COMMENT – Patrick Mahncke with USA Mobility noted that the Documentation Requirements state “all items that require a PAR must be accompanied by a Letter of Medical Necessity”. He asked if the intention is that it has to be in letter format because there are other methods to demonstrate Medical Necessity, such as chart notes.

RESPONSE – She asked for Patrick’s recommendation.

He suggested chart notes.

COMMENT – Rich Salm with Numotion noted that, a year ago a panel of PTs and OTs was convened and the hot topic was documentation. They found that they could not come up with a form that Medicaid could adopt because, if it were adopted, it would not preclude the necessity for the provider to document within their own system – it would be double the work. The fallback position then became to identify all of the elements that would be necessary and then allow the clinic to use whatever documentation they have.

RESPONSE – Leslie McLachlan with Assistive Technology Partners noted that there may be two different levels of documentation being discussed. She postulated that Rich was referring to when a specialty evaluation is required. However, under the category of Basic Documentation (currently under discussion) providers can develop their own.

Rich stated that the principle he suggested above applies to both scenarios.

Leslie McLachlan stated it runs deeper than being able to provide whatever is convenient. There is also the consideration of being fairly reimbursed as a therapist for the time it takes her to fill out a form and not really knowing the guidelines. She noted that much discussion in the past has been had around how to make the process more efficient. She pointed out that Shelly with Numotion recently provided her with a useful form. It would be great to have a specific list of what exactly is needed but in every case it is so different. That said, she is completely behind a form that can be completed face-to-face with a client.

Rich confirmed with Leslie McLachlan that her belief is not to prescribe one single format/letter. She agreed.

COMMENT – Patrick Mahncke with USA Mobility suggested the language in the draft be altered to say “clinical documentation” instead of “letter of medical necessity.”

COMMENT – Anna Davis with Medstuff, Inc Inc. noted that the letter of medical necessity really helps to speed up the review process itself, whether it be called “letter of medical necessity” or not. Processing a PAR for manual review takes a long time. When you have that sheet in front of you that says “letter of medical necessity” it really helps to highlight the needs the client has. What is being talked about is really a questionnaire. So, a letter or questionnaire would be helpful. If only clinical notes are provided, the review process becomes longer.

COMMENT – Mark Simon stated, in listening to the conversation above, it sounds to him that what is really being asked for is proof of medical necessity in summary fashion. It might be in a letter, it might be on some form the Department produces. Do I understand correctly? If so, the question becomes what are the submission parameters/allowable formats, etc. How prescriptive are we going to be?

COMMENT – Jose Torres with CCDC added that, in his experience, it is very difficult to have a provider comply with a very specific documentation form. It would be a good idea to create something that still allows the provider to document the way they do but that expedites the Department’s capacity to review PARs.

Kimberley summarized the divergent opinions and possible solutions as she heard them and suggested that the Department look at this more closely and bring suggestion(s) back to the group. There is interest in allowing providers to provide the information in the format that best suits their needs. There is interest in creating some sort of form that allows providers to easily transfer information, to speed up processing timelines. There may be benefit in creating a one-page checklist tool – not to fill out but – for providers to use as they think through what to put in a letter (several heads nodded in agreement with this suggestion).

COMMENT – Leslie McLachlan noted that the language in the standard is meant to serve as a checklist.

Kimberley noted that several of the “special” requirements repeat in three of the four sub-parts and can likely be moved to the general requirements section with a little exclusionary language that references the sub-part for which the requirement does not hold. This would tighten up the language quite a bit and might make the list herein more intuitive. She invited the group to revisit this topic in a future conversation and added it to the Parking Lot List.

COMMENT – Mark Simon brought the group’s attention to the bottom of page 5, “Additional Basic Requirements for Wheelchair Seating.” He noted that this is asked for in the paragraph above and it is an example of several places where it currently looks like we are collecting redundant information. He wants to make sure providers aren’t being asked to complete redundant tasks.

RESPONSE – Andrea explained that, when first created, there were four separate drafts but, in order to ease the process of the collaborative we took all of the general provisions that apply to all four services (PMD, MWB, WOA and Seating) and put them into one document. As a result of this process, there is some redundant language that the Department will clean up.

COMMENT – Mark Simon also pointed to the last bullet on page 5 and asked what the acronym WOA stands for?

RESPONSE – Andrea explained that it is short for Wheelchair Options and Accessories.

The group took a five minute break. Once reconvened, Kimberley invited questions and comments on the Specialty Evaluation Documentation Requirements section.

COMMENT – Christy Blakely, MSB member, asked if Assistive Technology Partners made any comment on this particular section.

RESPONSE – Leslie McLachlan from Assistive Technology Partners explained that she and coworker drafted the initial language in the standard.

COMMENT – Is the certified assistive technology practitioner (ATP) requirement in the standard?

RESPONSE – Leslie McLachlan explained the language reads “performed by a licensed certified medical professional, such as a physician.” This language was chosen because there are very few licensed ATPs in rural areas and, limiting the provider type, may limit services in rural areas. It was also chosen because physicians are probably not going to take the time to get their ATP and it would

fall back on occupational and physical therapists. She is aware that this is a law for group 3 or higher power chair Medicare clients, but they did not feel it was applicable here.

Kimberley invited the group to turn to page 7, Non-Covered Services and General Limitations.

COMMENT – Jose Torres with CCDC asked if there are specific items that are not covered. He pointed to Mark Simon’s earlier comment that any item that is medically necessary should be covered.

RESPONSE – Kimberley, speaking from the point of view of a non-expert, interpreted what she reads in this section to mean that there are certain limitations on what can be covered in the absence of a written coding verification from the Pricing, Data Analysis, and Coding (PDAC) contractor or that do not meet the Coding Guidelines section (referenced but not provided).

Dr. Judy Zerzan with the Department pointed out that some of those criteria are from the National Correct Coding Initiative guidelines and the Department is required to follow some of them by the Federal government.

COMMENT – Rich Salm with Numotion asked what the coding guidelines in that section state. He noted that there are many items that Numotion currently provides that are not code verified by PDAC, namely the Aspen Seating Systems. He noted that, if this language stays in the standard and if it is not stated otherwise in the coding guidelines, Numotion would no longer be able to provide those seating systems in Colorado.

COMMENT – Jose Torres with CCDC noted that there are codes that are currently open for customized items that are needed. There are things that are not considered DME, per say, but that the client needs to keep living in the community.

COMMENT – Susan Kennedy from Numotion pointed to the language that reads:

equipment will not be provided that is solely intended to allow the client to engage in leisure, recreational or social activities if this equipment is more costly than wheelchair seating which meets the client’s medical and basic functional needs.

She gave the example of a specialty bed bought for a client at a mattress store recently, which took a while to procure, but which was ultimately deemed medically necessary – not a luxury item. She believes this addresses Jose’s point.

COMMENT – Anna Davis with Medstuff, Inc Inc. continued that the PDAC does a lot of the coding but it doesn’t code certain, unclassified items. They will either classify it as an E1399 code or have it as non-specified. To clarify, if it doesn’t fit into a category in the

PDAC it is classified as an E1399. If you have items that are medically necessary but that are non-specified or classified as E1399, this would exclude them, as written. It needs to be reworded.

COMMENT – Rich Salm also mentioned K0108, the other miscellaneous wheelchair code. He is not sure that every item without a code that Numotion provides is a K0108. He sees this language as really problematic. K0669 is a more appropriate code for Aspen Seating but it is not PDAC code verified.

RESPONSE – Anna Davis with Medstuff, Inc Inc. added that the State identified code K0669 specifically for Aspen Seating.

COMMENT – Tom Hetzel with Aspen Seating asked that the Department assess and answer what flexibility it has relative to the language in this paragraph, given the federal requirements mentioned by Dr. Zerzan. It may not simply be that the language in this section needs to be reworded. If Federal requirements mandate that the following statement appear in the standard verbatim, he stated the group needs to work on that more diligently.

Any item that has not received a written coding verification from the Pricing, Data Analysis, and Coding (PDAC) contractor or does not meet the criteria stated in the Coding Guidelines section will be denied as not reasonable and necessary.

If there is some flexibility in the language then rewording might address the issues above. PDAC coding is not a big deal if you have a product that fits into those category but, right now, in the absence of a broader based, complex technology, rehab. recognition there are tremendous gaps in the PDAC coding. Colorado realizes this better than other states and we have an opportunity here as a state to lead on this issue.

RESPONSE – Andrea encouraged individuals to send Kimberley there suggested language.

COMMENT – Anna Davis with Medstuff, Inc Inc. clarified that the PDAC is not a requirement; manufacturers don't have to apply for the PDAC coding for medical necessity. There are other methods that can be used to ascertain if the product is legitimate, such as FDA approval.

COMMENT – Mark Simon commented on the reference to *Primary, Secondary and Back-Up Mobility Devices*. He reiterated a concern that Julie Reiskin also provided to the Department. The concern is that there has been a big change in policy and the Department will no longer be covering back-up mobility devices.

RESPONSE – Leslie McLachlan with Assistive Technology Partners clarified that there is no change in policy but, rather, a change in terminology. "Primary"

refers to the piece of equipment the individual uses the most. “Secondary” refers to equipment the individual uses when the primary equipment goes down or if they require alternative access because primary equipment does not fit through doorway or house or in vehicle. The term “secondary” takes the place of what has traditionally been called a “Back-up”. “Back-up now refers to

duplication of a primary device, which the Department does not cover. The goal is to limit the purchase of two identical brand new power wheelchairs.

Mark Simon asked that this be made clear.

Kimberley noted that it may be helpful to put these definitions in the Definitions section.

Leslie McLachlan pointed to page 9, where there are lengthy descriptions of all three terms.

COMMENT – Jose Torres with CCDC noted that CCDC has a great history of getting rules changed at the state and federal level and offered CCDC’s help if language needs to be changed (in reference to the PDAC discussion above).

COMMENT – Anna Davis with Medstuff, Inc. returned to the conversation about “back-up” equipment. She noted that, in rule 8.590.2.C states that Medicaid does cover “back-up equipment”. Specifically, it states “Duplication of services shouldn’t be used to serve the same purpose as items already utilized by the client unless it is medically required for emergency or back-up support.” The language in the draft policy appears to directly contradict this language.

RESPONSE – Kimberley noted that when the standard is incorporated into volume 8 rule by reference, the Department will have the opportunity to edit language currently in rule, to make the language consistent. She thanked Anna for pointing to a section of rule that will need to be edited.

Anna also noted that, in the repair rules, the option for rental equipment exists, which is a benefit, not a purchase.

Andrea noted that all of the other rule language will remain the same, we are just clarifying when it will be provided so that we can all be on the same page.

Mark Simon noted that certain individuals cannot use rental equipment. He asked if any of the providers in the room can provide a client with a Ti Ultralight today. No one said yes. His point is that, while purchasing two brand new identical chairs for a client is not practical, we must figure out a back-up solution that truly works for that client (so that they can still lift their chair into their vehicle, they can avoid pressure sores, etc.).

COMMENT – Medicaid client shared that his chair is very unique. He explained that there was an instance in which he needed a replacement chair and the only chair the provider could secure for him almost broke his feet.

RESPONSE – Kimberley thanked him for sharing his personal experience and noted that it is often difficult to balance the twin mandate of providing quality care and doing so in a cost effective way. She invited participants to continue to share any additional input on this issue with her after the meeting.

COMMENT – Rich Salm from Numotion pointed to page 9, under the *Wheelchair Seating and WOAs for Primary, Secondary and Back-Up Mobility Devices* section, where it states “Duplicate services will not be approved (i.e. purchase of two wheelchair seating systems for the same MWB or PMD).” He asked if this means a second seating system won’t be covered. He noted that it isn’t always possible to transfer seating from a power base to a manual base.

RESPONSE – Andrea clarified that the intention is convey that two seating systems will not be purchased for the same device. Kimberley said the Department will look at how to make this clearer.

Andrea took this opportunity to invite participants who may not presently have suggestions on how to change language in the standard but would like to provide suggestions, to do so at a later date. We welcome them.

Kimberley opened the floor to comment on the Replacement section of the standard.

COMMENT – Jose Torres with CCDC pointed to the language:

Clients 21 and older are eligible for wheelchair replacement every five years. Although a client is eligible every five years, documentation must demonstrate a medical or functional need, and why modifications to the current wheelchair are not sufficient.

He stated that many clients do need replacements every five years; just replacing parts is not reasonable. He asked that there be some clarification here.

RESPONSE – Kimberley stated that, as she reads this passage, she gets the sense it is targeted to those individuals who don’t need a new chair every five years, and she believes this language is necessary to convey that the Department does not automatically replace every chair every five years as a matter of policy. However, to Jose’s point, she does not believe the language is meant to convey that, “if it is more cost effective to provide replacements, the Department will always do this over providing a new chair.” She asked if others agree with this assessment. Four providers nodded in agreement.

COMMENT – Anna Davis with Medstuff, Inc Inc. keyed in on the language “Equipment requested should accommodate current needs as well as anticipated future needs OR have the ability to be modified.” She then notes that clients with progressive disease

(like ALS) start in a manual wheelchair and need a power wheelchair a year later. She stated it would probably be helpful to have the ability, during the PAR process, to approve equipment that is not presently medically necessary but that the providers

knows will be necessary in the near future, for individuals with progressive disease. She did not know where this language would be most appropriate.

RESPONSE – Kimberley noted that this was a good point and something they would consider.

Rich Salm with Numotion seconded the point and suggested it be another bullet that, perhaps, is specific to an “ALS program”. He stated that current procedures are inadequate to keep pace with the progression of this particular disease.

Anna noted that Duchenne syndrome in another; Rich agreed.

COMMENT – Mark Simon brought up children and the policy of replacing chairs every three years. He stated that, in reading the draft standard, attention seems to be paid equally to current and future needs. However, if you want to fit a chair so that it will fit a child in three years, it will not likely fit that child today. In the case of manual wheelchairs, if the chair does not fit correctly you are asking for upper body mobility impairments. One disability leads to another. With children, this is even more likely. We need to be looking at current need with greater weight than future need.

COMMENT – Jose Torres with CCDC pointed to Josh Winkler’s pre-provided comment with reference to page 8, where it states “Note: Exceptions to the replacement guidelines defined above will be made on a case by case basis for unforeseen changes in medical and/or physical condition.”

Josh Winkler (on the phone) jumped in and explained that, sometimes, chairs are not as reliable as they should be, so they need repair more often and it becomes an auto warranty issue. It is not really a change in the user’s medical condition but, rather, a chair issue.

RESPONSE – Kimberley asked if Josh has a suggestion for additional language in this section.

Jose explained that the “Note” is a good suggestion.

Josh agreed but suggested the addition of the language “or if chair is not reliable”. The concern is that something/someone will fall through the cracks because the chair it is not bad enough of a chair to qualify for the lemon law and be replaced but is not an obvious warranty issue.

Kimberley noted the suggestion and invited Josh to send any suggested language.

COMMENT – Josh Winkler also commented on the last bullet point of page 8 and the language “Additional circumstances which may justify a replacement include... damage equipment beyond repair ... and is not the result of client negligence or misuse.” He noted that, what one person considers “misuse” another considers part of their daily life. He is concerned about the possibility that someone may be denied a wheelchair because they are an active person.

RESPONSE – Kimberley noted that, at the least, we need to define what is meant by “misuse”. Josh and Jose agreed.

Josh noted that there is a difference between a client who willfully burns up their motor and a client who misses the bus and chooses to take their chair 6 miles downtown to a meeting, which is their choice, regardless of what it might do to the motor.

Kimberley noted the point.

Jose noted that certain clients are very active and it is their choice to use their chair a lot.

COMMENT – Anna Davis with Medstuff, Inc Inc. noted, on the bottom bullet of each section of page 8, “projected modifications should not exceed the cost of a new MWB” needs to be changed to “projected repairs”. Rich Salm agreed.

RESPONSE – Andrea noted that this language is specifically under the Replacement section. She asked if the language should be changed to “modifications and repairs.” She noted that, if you are going to modify it to the point of providing a different base, to replace the current one, would that make sense?

Anna replied that a tilt system is not a modification, you are just adding on to that base. A tilt system can cost upwards of thousands of dollars, whereas having to replace the base and add tilt system would be \$20,000.

Jose added that modifications to chairs are sometimes a matter of safety or medical necessity.

Andrea asked if there are every modifications that might be done that would exceed the cost of a new chair. Several individuals chimed in that repairs could.

Rich Salm noted that the point is, if the combination of repairs and modifications together would exceed the cost of a brand new chair (with all of the items that would otherwise be modified in the old chair), then it makes sense to get brand new equipment.

Kimberley stated that conversation around the provided Appendix A will occur in future meetings. She asked for final comments.

COMMENT – Jose Torres with CCDC asked Andrea to integrate the many conversations that have been had around DME over the past year into the document.

COMMENT – Mike Fiss, manufacturer’s representative and a CAMES Board Member, noted his appreciation for the opportunity the Department has extended to participants to be part of this process. He noted that many states don’t convene these types of meetings and he wanted to applaud Colorado for including stakeholders in the process.

Kimberley asked if there are any conferences or important meetings that the team should be aware of before scheduling future meetings. Hearing none, she offered to send tentative dates out to a few individuals, so that they may check their calendars, and she will then schedule (within the next two weeks) all future meetings for December/January, including what topics will be discussed on which days.

Meeting adjourned at 4pm.