DME ADVISORY COMMITTEE MEETING

MINUTES

April 23, 2019

ATTENDEES:

Members Present

Justin Decker – Alliance Rehab & Medical Equipment

Dave Hosman - BJC Home Medical Equipment

Karen Atkins – Mobility First and MAMES

Amy Ogle – Hannibal Medical Supplies

Chris Cobb – Cox Health

Mike Williams – Cox Health

Members Absent

Mike Seidel

Consultants Present

Dr. Tim Hogan, Hogan Consulting, Oxy & Resp

MHD Agency Staff Present

Glenda Kremer

Gina Campbell

Cindy Wininger-Watson

Amanda Gibbon

Beth Stokes

Jessica Viet

Rebecca Logan

Welcome/Introductions/Announcements

Pat Naeger, Chairman, introduced the new Director of MO HealthNet, Todd Richardson, to the committee. Brief conversation was made.

Minutes from the November committee meeting were approved with a correction to Dave Hosman's name under the heading Home Health Changes and Supplies.

Pat advised that his business, HealthCare Equipment and Supply Company, was sold to AeroCare, Inc. Pat will be remaining with the company as a regional manager. Mike Henry, formally a committee member, will also be a regional manager. The store will keep the name of HealthCare Equipment and Supply Company, but the Board of Directors and Stockholders has changed to AeroCare, Inc.

Gary Schemerhorn, member of the committee, has retired. Gary sold his business to CVS Pharmacy. A recommendation to fill his position on the committee was requested.

MHD Update

Gina Campbell, MHD, announced the Director of Social Services, Steve Corsi, will be leaving effective June 3rd.

She gave a brief update on the Face-to-Face (F2F) requirements as set forth in 42 CFR 440.70, which affects both the Home Health and DME programs. She is in the process of updating the MO Code of State Regulation (CSR) for Home Health and has begun working on the DME CSR. Once drafted, the committee will be included in the stakeholder review. The hope is to submit a proposal to MHD Administration in May and to the Director's office and OA in June. It was noted, once the regulation has been updated, the place of service for DME will no longer be restricted for use in the home. DME services will be allowed in any setting in which normal life activities occur, with the exception of hospitals, nursing facilities, and ICF-IDs, per 42 CFR 440.70. MHD is federally mandated to comply with the F2F requirements, and Missouri is currently not in compliance.

There was open discussion on how this change will affect the DME industry. There is concern that this will put the brunt of responsibility of documentation on the DME provider. They have no way of knowing if there has been an actual F2F with a physician. A suggestion was made that MHD construct a form specific to F2F and require the physician to maintain the form within the participant's chart.

It has not yet been determined how many of the DME items that will require F2F are currently in CyberAccess. There was discussion on adding steps to the affected algorithms with questions for the physician regarding F2F so DME providers could use that as documentation that F2F requirements were met MHD will review the possibility of making changes to the process. However, there is no guarantee that that these changes can or will be made.

Certificate of Medical Necessity (CMN)

A request was made to extend the approval time of a CMN from 6 months to 12 months. It was explained that this required a system change and would have to get prioritized along with other MHD system change requests. Discussion was held regarding the possibly of creating a system parm to house specific procedure codes to be allowed more than 6 months of approval. MHD will take under consideration.

Revalidation

Mike Williams voiced concern regarding the MMAC revalidation process to maintain a MO HealthNet provider. Frustration was expressed regarding contacting the MMAC Provider Enrollment Unit, as providers must email and are not able to speak with an actual person. Voicemail or email is the only option.

The committee was advised that the revalidation process changed in December 2018 and is now handled through eMOMED. It was also noted that the change of revalidation is a requirement within the Affordable Care Act, and with change comes education. Provider Enrollment has more than 7,000 providers pending processing.

As a side note, it was expressed that the revalidation process in Missouri is far easier than in other states.

Home State Requirements

Rebecca Logan, with Managed Care Contract Compliance, addressed concerns with the managed care Home State health plan. Pat advised that Home State is requiring re-authorization every three months for items such as oxygen, BiPAP, CPAP, etc, that are needed longer than 3 months. In most cases, these items are medically necessary for a lifetime. This process of obtaining repeated PAs for items needed long-term creates an unnecessary burden on DME providers, as the process creates excessive paperwork and is time-consuming. Rebecca stated that MHD urges providers to communicate directly with the health plans with concerns. Rebecca stated that if there was no resolution in working with the plans directly, providers could then contact the Managed Care Unit with any complaints regarding the plans. MHD will work with the plans on a case-by- case basis. In this particular case, Rebecca stated that she will encourage the plans to extend the authorized approval date beyond 3 months when the prescribing physician documents that the need will be long-term.

Rebecca suggested this agenda item to be added to the next scheduled DME Advisory Committee meeting, and that she will attend future advisory committee meetings to address managed care concerns. She asked the committee members to bring specific examples and exceptional trends for review.

The committee asked if MHD had reports that would reflect a cost savings by contracting Managed Care Organizations (MCOs). Rebecca stated she would check to see if there were any cost saving reports available. She also stated there are some reports on the MHD website, under the Managed Care program section.

Tim Hogan suggested the health plans do a cost analysis. Rebecca stated that the health plans tend to mirror their commercial coverages, but also have to work within the parameters of Medicaid. Tim Hogan suggested that future agendas include discussion of managed care reports, and this would give members the opportunity to provide examples of exceptional cases and trends be brought to the committee.

PAP Supplies

Amy Ogle requested the quantity limitations for PAP supplies should mirror Medicare's allowed quantities, especially cushion pillows and masks. She stated that masks need to be replaced more often than every 6 months. Additionally, she requested we add heated tubing, A4604, as a covered service. The heated tubing adds more humidification and has become the standard for PAP equipment.

A suggestion was made to require documentation as to why nasal cushions and masks need replacing to eliminate room for fraud. MHD will take under consideration.

Knee Walker

Pat stated that reimbursement for a knee walker (E0118) does not cover cost, and that Medicare does not cover. Pat suggested we change the knee walker to a 2-3 month rental with a reasonable reimbursement rate of $35-$40 per month. It could possibly reduce the rental for a manual wheelchair. MHD will take under consideration.

Trach Supplies

Current reimbursement of trach suction tubes are below provider cost, making it difficult to find a provider who will supply them. Pat told of a situation where a child with a trach had to stay in the hospital an extra three to four weeks because the hospital could not find a provider that was willing to take the child, due to the costs associated with the trach. The hospital offered to pay for the traches for one year, and that is when Pat took the patient. This is an issue, as hospital stays are far more costly than trach supplies. Pat will send Glenda the DCN of the child that was in Cardinal-Glennon hospital.

The Bono trach tube (A4624) is higher end trach tube not covered by Medicare, and is usually used for kids. Pat made a suggestion to change reimbursement for this trach tube to manually-priced at cost plus 20% to relieve access issues for kids. Pat also suggested to add the EP modifier and restrict to under 21 years of age.

Power Assist Wheels/Smart Drive

Karen requested an update regarding criteria and coverage of power assist wheels, smart drive, for manual wheelchairs. She reiterated that this would assist the participant with propelling if they tire, as it goes further with one push while keeping the participant active, and it does not hurt the shoulders. It is also lightweight, and can be folded up and loaded easily into a car or bus. A power wheelchair cannot do this.

As an example, for a paraplegic, Medicare would reimburse for a Group 3 power wheelchair. This cost would far exceed the cost of a manual wheelchair with power assist wheels.

MHD will continue review.

Heavy Duty Power Chair – Group 2 vs Group 3

PAs for a heavy duty power chair, group 3, are being denied in the SNF setting. DME Bulletin Volume 40, Number 19, dated August 24, 2017, states a Group 3 in a SNF setting will be considered in place of a Heavy Duty Group 2 as availability for heavy duty Group 2 is limited. The quality of this chair is poor. It requires excessive replacement of batteries.

MHD will address.

Manual Tilt for SNF Participants with 3 Non-Functioning Limbs

Karen Atkins requested a status update on the issue of manual wheelchairs with tilt not being allowed in the SNF setting when the participant has 3 non-functioning limbs. This was implemented for power wheelchairs on September 1, 2017. See DME Bulletin Volume 40, Number 19, dated August 24, 2017. Karen felt that a manual wheelchair was to be included in the bulletin as well.

MHD advised they had spoken with the consultants, and it is not being recommended for coverage, as utilization would increase, thus, leading to a significant fiscal impact. MHD will not move forward with this request at this time.

Purchase K0004

Justin requested that MHD consider adding a purchase option for K0004, as it is only available for rent to purchase at this time. This would only be requested when the participant needs the chair for lifetime use. For example, when a participant dies, the providers currently remove all the custom seating and accessories purchased by the participant, and take the rented chair out of the home.

It was mentioned that there is an increase of requests for K0005s, which are more expensive. Justin proposed that the State would save money if the option to purchase the K0004 was added.

Glenda asked Justin if he could write up a justification to add the purchase option for K0004, as well as fiscal impact, and submit to MHD. Justin stated he will do so.

MHD will investigate to see if requests for K0005 have increased.

CURES Act

Reports were submitted to the committee with partial numbers for FY 2019. It was noted that the committee would like to continue tracking the CURES Act codes on a quarterly basis. MHD agreed.

Cost Reports

Cindy Wininger Watson, MHD, asked if the committee would mind if she discontinued the separate break out of oxygen, wheelchairs, and wheelchair accessories, on the yearly cost report. Changes that were made to these services a few years ago appear to be maintaining. They agreed this was no longer needed.

The CURES Act codes and complex rehab codes will continue to be monitored.

Meeting adjourned.

NEXT MEETING

OCTOBER 29, 2019