Chapter 4:
Durable Medical Equipment

Executive Summary

Description

Kansas Health Policy Authority (KHPA) currently maintains a Durable Medical Equipment Program for Medicaid beneficiaries. Durable Medical Equipment (DME) is defined as equipment that meets the following conditions: 1) withstands repeated use; 2) is not generally useful to a person in the absence of an illness or injury; 3) is primarily and customarily used to serve a medical purpose; 4) is appropriate for use in the home; and 5) is rented or purchased as determined by designees of the executive director of the KHPA (K.A.R. 30-5-58). Kansas Medicaid covers a variety of durable medical equipment for adults and children that meet specific conditions defined in Kansas regulation. Examples of DME include the following: canes, crutches, wheelchairs, enteral and par-enteral supplies, oxygen, and diabetic supplies. There are 824 DME suppliers in Kansas and 700 are pharmacies. DME equipment can be purchased or rented depending on the item and need.

In an effort to contain DME costs, Kansas developed a re-use program called Kansas Equipment Exchange Program (KEE) that has been nationally recognized as a model that other state Medicaid programs are implementing. This allows for an item that Kansas Medicaid has already purchased to be re-used once it is no longer needed by the original beneficiary. Common items include wheelchairs and hospital beds. In FY 2007, the KEE program saved approximately $2 for every $1 spent to operate the program. In FY 2007, the KHPA spent $13.9 million for DME. DME expenditures for FY 2007, when compared to FY 2004 indicate a steady increase with FY 2005 showing the largest increase of $3 million. This increase might be explained by the increase in consumers and claims, mostly within the aged and disabled population, which represent the highest DME expenditures.

Key Points

- Concerns identified in the DME program review are focused on the fourth highest DME expenditure: services billed under the "Miscellaneous" code. Some DME products do not have specific billing codes with set (or programmed) reimbursement rates. All products billed under the Miscellaneous code are prior authorized and are manually priced, however, cost invoices are not required to be submitted by the provider. Because Kansas Medicaid may be overpaying under the Miscellaneous code, we are converting this code when possible to specific codes provided from the Centers for Medicare and Medicaid Services (CMS). These codes provide for billing at a fixed percentage discount of the Medicare rate. The KHPA will continue to review the Miscellaneous code expenditures.

- In July 2008, DME supplies provided to patients in nursing facilities will be removed from the fee-for- service (FFS) program per direction from CMS. We now reimburse those products

through nursing home rates. Nursing homes are, in turn, allowed to negotiate the best prices for these products, presumably resulting in net savings to the Medicaid program, which may have been over-reimbursing for some DME products.

- There will be a focus in FY 2009 on the continued high costs and anecdotal evidence of over-reimbursement for DME, especially in light of the recent Congressionally mandated delay in the Medicare competitive pricing project for DME products – a project that would have generated savings for Kansas Medicaid.

Recommendations

- Review potential overpayments and coverage usage issues, specifically for oxygen service.
- Require DME suppliers to show actual costs of all manually priced DME items, which will ensure reimbursement at no greater than 135% of cost.
- Explore the possibility of joining with other state Medicaid programs on a collaborative manufacturer rebate program for some DME items.

Cost Savings Due to Policy Changes for Kansas Durable Medical Equipment

	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
State General Fund (SGF)	$0	$-160,000	$-170,000	$-180,000	$-200,000	$-710,000
Total	$0	$-400,000	$-420,000	$-450,000	$-480,000	$-1,750,000

Program Overview

Kansas Health Policy Authority currently maintains a Durable Medical Equipment Program for Medicaid beneficiaries. Durable Medical Equipment (DME) is equipment that meets the following conditions: 1) withstands repeated use; 2) is not generally useful to a person in the absence of an illness or injury; 3) is primarily and customarily used to serve a medical purpose; 4) is appropriate for use in the home; and 5) Is rented or purchased as determined by designees of the executive director (K.A.R. 30-5-58).

In FY 2007 KHPA spent $-13,929,271 in the Medicaid DME program. At this time, there are approximately 824 Durable Medical Equipment providers in Kansas. This includes approximately 700 pharmacies which have a DME provider number.

The DME program covers many items for adults and children, for example: canes, crutches, walkers, commodes, wheelchairs, beds, enteral and parenteral supplies, ostomy supplies, dressings, wound vacs, oxygen, respiratory supplies, stockings, nebulizers, urinary supplies, and TENS units. There are also items limited to the KAN Be Healthy program for Medicaid recipients under 21 who are eligible for more comprehensive mandatory benefits under federal law. Some of these items include: diapers, CPAP, BiPAP, and Apnea Monitors. Items that are of higher monetary value or have the potential for high abuse require prior authorization (PA). The PA unit located in Medicaid's fiscal agent, Electronic Data Systems (EDS), has four staff members dedicated to the DME program.

The DME process begins with a physician writing a prescription for the DME item needed. The beneficiary then takes the prescription to the Kansas Medicaid DME provider of his or her choice.

If no PA is required, the DME provider dispenses the item and bills Medicaid. If PA is required, the DME provider will gather all necessary documentation, fill out the PA request form and submit the PA to the EDS PA unit. Once received at the PA unit, the request process starts within 24 hours. The request will either be approved, denied or more information will be requested. If more information is needed, a letter will be sent to the DME provider requesting the necessary documentation. The provider has a 15 day time limit to submit the requested information. Once the information is received, the request will be completed. Any requests that fall outside of criteria for the particular requested item are submitted by the PA unit to the KHPA Program Manager. These requests are reviewed twice a week. If a request is urgent and must be reviewed by the KHPA program manager, the EDS PA unit will place a phone call to the manager. Once a PA request is completed, a letter is sent to the DME provider and the beneficiary notifying them of the decision. Appeal rights are listed on the PA letters.

The Kansas Equipment Exchange Program (KEE) is another part of the DME program. KEE is a medical equipment re-use program that has been nationally recognized; many other state Medicaid programs are using Kansas as a model for start up of a re-use program. DME purchases are tracked by providers, who place stickers on all equipment intended to either supplement Medicaid services or in some cases to substitute free used equipment in place of Medicaid purchases. These stickers list the telephone number for the re-use program so that the beneficiary may call for pickup once the equipment is no longer needed. Although all DME requests for Medicaid beneficiaries are first evaluated for new equipment, in the case that Medicaid coverage requirements are not met, the requested DME may be accessed from the KEE program. Also DME needs that may be temporary in nature may be met by equipment accessed through the KEE program.

Equipment in the KEE is obtained by donation from multiple entities, cleaned and placed into homes of Kansas Medicaid beneficiaries in need. All beneficiaries must complete an application for equipment and are screened before placement is made. The program recycles bath chairs, beds, wheelchairs, walkers, canes, crutches, commodes, enteral pumps, CPAP devices, speech devices, oxygen tanks and concentrators. The program utilizes many volunteers who transport equipment throughout the state. The most common items donated are wheelchairs and walkers. The most common items requested are wheelchairs and hospital beds.

Approximately two months after purchase of a DME item in KEE's list of targeted equipment, Medicaid DME recipients are contacted to ensure that they have proper equipment, customer service by provider, timeliness of delivery, etc. After the KEE program collects donated equipment and it is placed through the re-use process, contacts continue to be made with the beneficiary to ensure that their needs are being met with the equipment obtained through the KEE program.

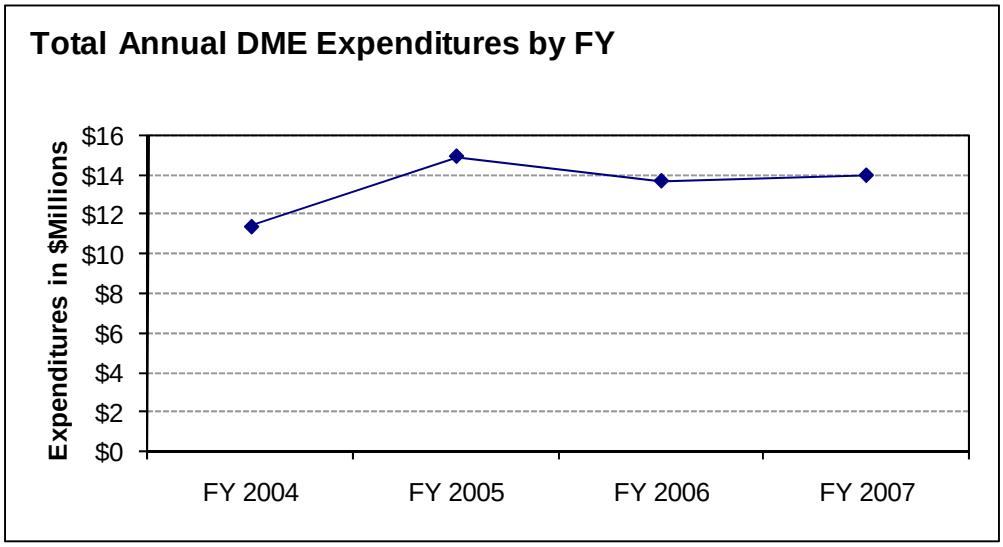
Service **U**tilization and **E**xpenditures

DME Expenditures

Examination of total DME expenditures from FY 2004 through FY 2007 shows an increase of approximately $3 million in FY 2005 (see Figure 2). This increase was due to a 39% increase in volume of consumers and a corresponding 38% increase in claims. The increases were concentrated among the Aged and Disabled populations. The top two services contributing to this increase were Oxygen Concentrators and Diabetic Test Strips.

Total expenditures fell in FY 2006 and remained steady at about $14 million in FY 2007. Reimbursement policy changes help to explain these trends. In FY 2006 policies adjusting reimbursement rates and limitations on miscellaneous respiratory supplies and ostomy supplies were implemented. Both of these policies took effect January 1, 2006. Also, in FY 2006 the manufacturer's suggested retail prices (MSRP's) on manually priced codes began increasing. The majority of manually priced codes are related to wheelchair.

Figure 2



Some DME categories have not had reimbursement adjustments since the late 1980s. Program staff initiated a review of these categories beginning in 2005, focusing on reimbursement and coverage limitations. For example, one review revealed that suction pumps were being rented on an ongoing basis. This practice resulted in Medicaid paying thousands of dollars for a rental fee on a pump that cost $400 to purchase. The coverage policy was updated to allow purchase with prior authorization; renting is only allowed when it is evident that the need will be of short duration. If the need is lifetime, purchase is required.

Policy reviews of DME by staff have resulted in a number of changes over the past several years, consistent with evidence based medical standards. Reviews were completed on respiratory supplies, ostomy supplies, diabetic supplies, and insulin pumps. Policy changes related to these categories of DME were implemented in FY 2006. For example, one policy change related to diabetic supplies allowed for coverage for Type II diabetics, a change consistent with the standards of care for a Type II diabetic. Also, in FY 2006 insulin pump coverage began. Associated cost increases were partially offset by cost containment steps taken. In FY 2006, policy changes based on staff research were made for wheelchair cushions, urinary supplies, crutches, canes, walkers, commodes, lifts, and diabetic supplies. These policies were implemented in FY 2007. These policies increased expenditures on wheelchair cushions and urinary supplies due to reimbursement and revisions of out-of-date coverage limitations. In FY 2007, policy changes based on staff research were made for the following DME categories: beds, support surfaces, enteral supplies, parenteral supplies, dressings, TENS units, wound vacs, and breast pumps. The enteral supplies, parenteral supplies and dressing policies had increases in reimbursement and coverage limitations. These policies were implemented in FY 2008.

Several categories of equipment within the DME program will be reviewed as part of Medicaid transformation. The agency continues to review a few categories each year. Subsequently, rates and limitations are adjusted accordingly to industry standards and standards of care.

Prior Authorizations

Prior Authorization (PA) is an important management tool used by the KHPA to insure medical necessity for services and equipment and deter fraud and abuse. Thirty seven percent of all DME codes (purchase and rental) require prior authorization, according to records kept by the EDS Prior Authorization unit. In 2007, there were approximately 1,682 prior authorizations created for the E1399 (miscellaneous DME) code for 1,161 beneficiaries. Of those, 1,216 were approved, 409 were denied, and 57 were cancelled. The distribution of decision outcomes for PA has been essentially identical for the last 4 years.

Administrative costs increase when a DME code is prior authorized due to increased EDS and KHPA staff time. PA also increases the workload for the provider, who must obtain all necessary documents. Some DME items will have to remain on prior authorization due to concerns about fraud and abuse. As categories are reviewed, KHPA staff take into consideration whether to remove or add a code to the prior authorization requirement.

DME items reimbursed under the "Miscellaneous code" E1399 must remain on prior authorization. When possible, switching items from E1399 to the appropriate codes (called HCPC codes) lowers both administrative costs and the burden on providers. Figure 3 shows the distribution of prior authorization outcomes for E1399 by the number of authorizations and Figure 5 represents this by expenditures. Figure 4 represents prior authorized DME items versus non-prior authorized items for all DME codes by expenditures. Additional information on the Miscellaneous code is provided later in this review.

Figure 3

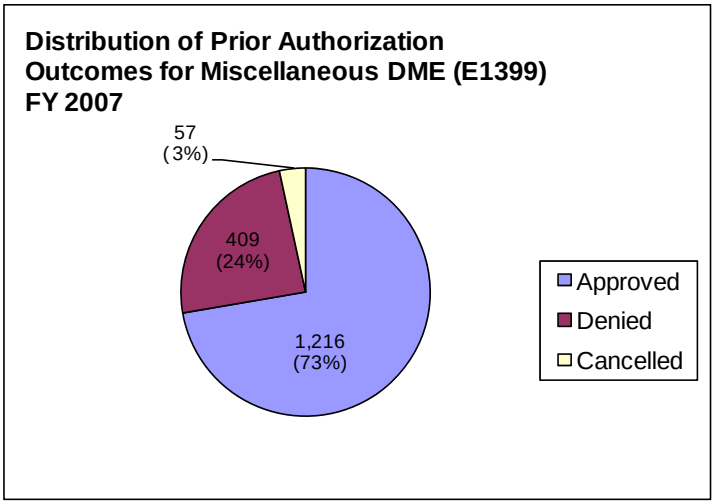


Figure 4

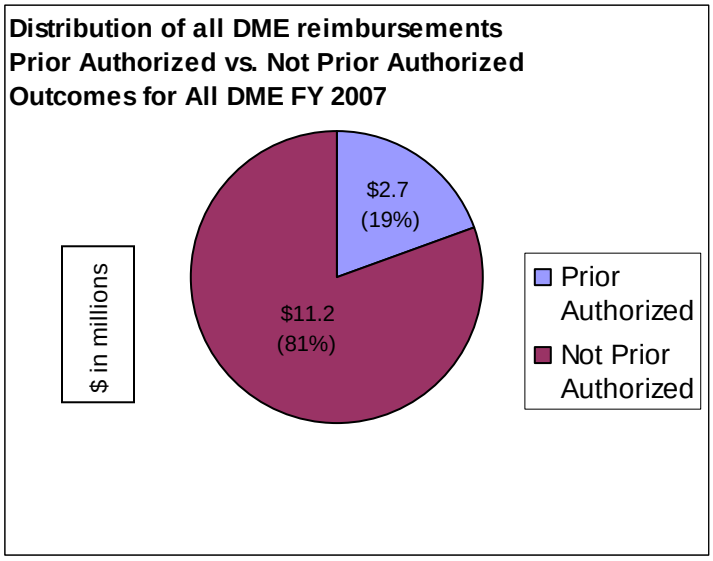
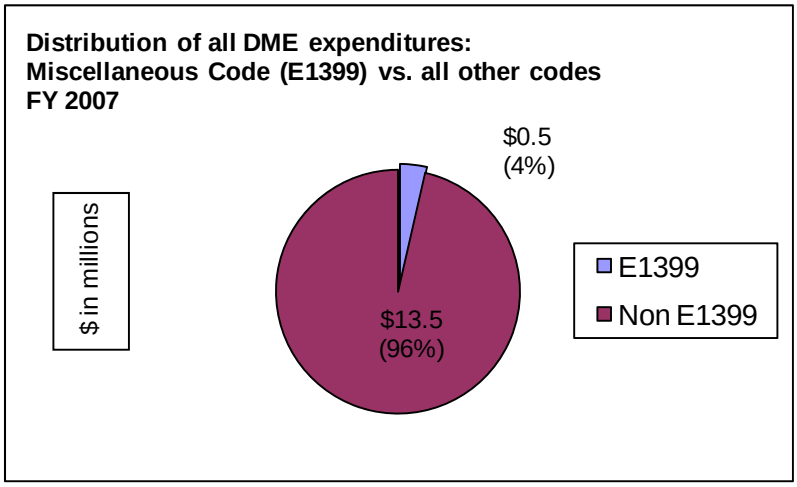


Figure 5



Utilization by Beneficiary County of Residence

Seating clinics provide beneficiaries who need wheelchairs with the appropriate equipment and proper seat fittings performed by certified providers. KHPA has four approved wheelchair seating clinics within the state of Kansas. These clinics are located in the counties of Shawnee, Sedgwick, Johnson and Wyandotte. Sedgwick County has a higher utilization rate in comparison with other counties. The clinic in Sedgwick County also serves a large segment of the western Kansas population. Sedgwick County has the highest population rate of DME beneficiaries within the state.

The utilization of seating clinics is deemed a "best practice" by the Medicaid Evidence-based Decisions Project (MED). The MED Project creates a powerful collaboration among state Medicaid programs for the purpose of making high quality evidence available to states to support benefit design and coverage decisions made by state programs. The project includes access to the following decision making tools: 1) high quality systematic reviews of existing evidence; 2) technology assessments of existing and emerging health technologies; 3) web-based clearinghouse; 4) support in designing rapid evaluations of products where no evidence exists; and 5) support of highly qualified research staff to assist members in applying the evidence to their own needs.

Table 1 displays the distribution of DME in the top six counties across the state. Sedgwick County remains the number one county for DME due to the size of the county, the availability of medical care, and use of the DME providers by those that live in surrounding counties.

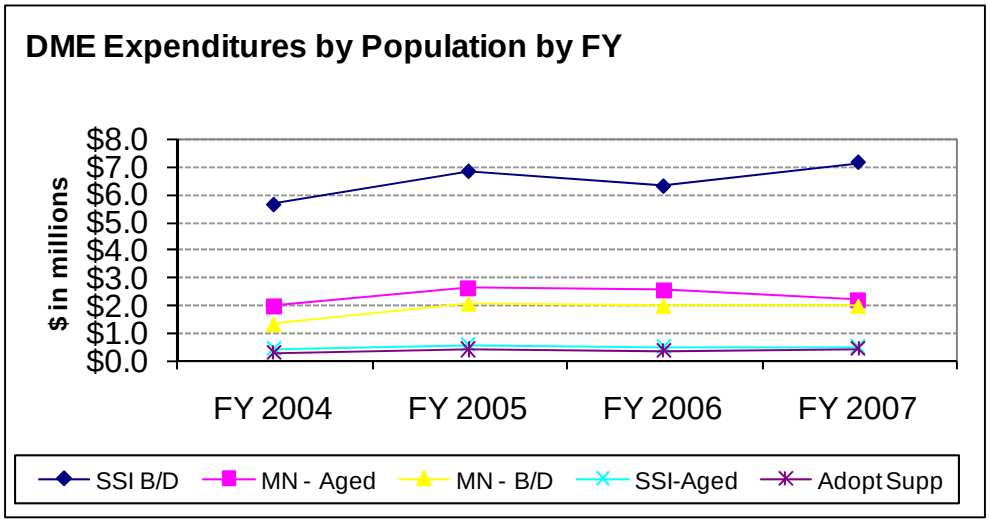
Table 1
Top Six Counties: Use of DME

SEDGWICK			
FY	Aged	Disabled	Total DME
2007	$346,563	$1,724,993	$2,487,100
2006	$422,533	$1,663,604	$2,554,469
2005	$424,630	$1,788,396	$2,793,325
2004	$301,584	$1,545,724	$2,291,319
WYANDOTTE			
FY	Aged	Disabled	Total DME
2007	$121,905	$734,132	$1,028,771
2006	$115,543	$687,419	$996,534
2005	$146,068	$702,695	$1,062,063
2004	$112,070	$559,974	$808,843
JOHNSON			
FY	Aged	Disabled	Total DME
2007	$118,109	$816,575	$1,127,013
2006	$126,672	$704,255	$991,424
2005	$161,660	$722,266	$1,055,082
2004	$129,815	$454,432	$749,302
SHAWNEE			
FY	Aged	Disabled	Total DME
2007	$164,020	$659,853	$972,817
2006	$201,192	$500,101	$868,783
2005	$198,271	$498,113	$880,654
2004	$131,538	$372,712	$636,547
RENO			
FY	Aged	Disabled	Total DME
2007	$57,063	$356,509	$512,242
2006	$73,974	$224,738	$401,381
2005	$98,332	$204,759	$438,672
2004	$86,589	$222,177	$396,770
MONTGOMERY			
FY	Aged	Disabled	Total DME
2007	$118,533	$242,072	$433,711
2006	$183,299	$230,174	$452,686
2005	$108,703	$229,482	$394,282
2004	$91,765	$203,553	$344,989

Expenditures by Population

The SSI Blind and Disabled population have the highest amount of DME expenditures, as would be expected. This population includes the majority of people who are wheelchair bound, ventilator dependent, or have other medical needs that increase DME expenditures. Figure 5 represents DME expenditures by population code.

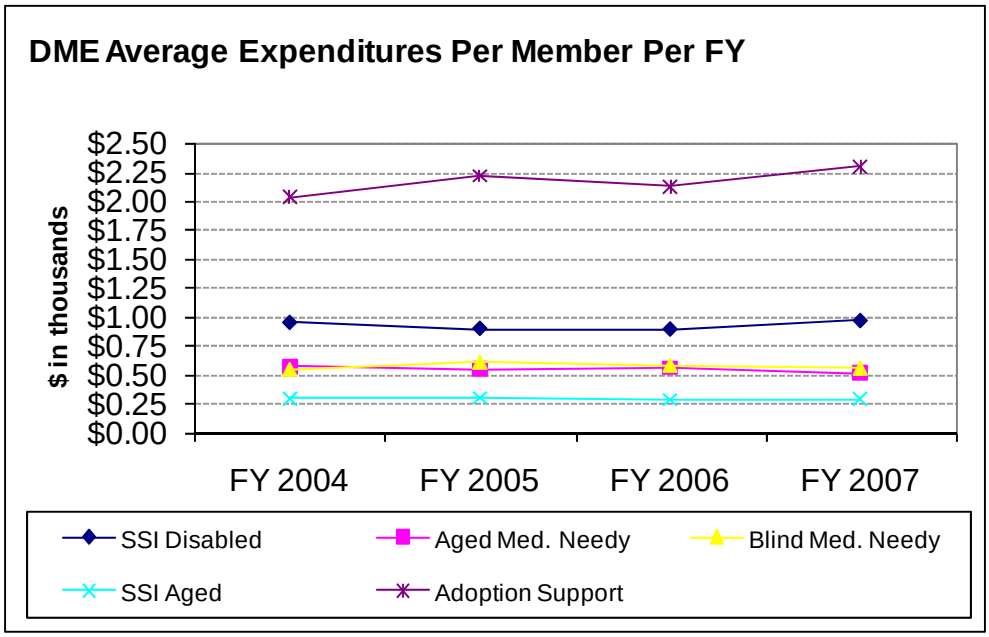
Figure 5



Expenditures per Member per Fiscal Year

Figure 6 presents the average expenditures per member by population code. The category "Adoption Support" is the population code with the greatest expenditures per member. This population includes a few very high cost medically fragile children.

Figure 6



Highest Expenditures by Procedure Code

As determined by an analysis of paid claims from the Medicaid Management Information System (MMIS), oxygen is the most commonly utilized category within the DME program. Currently oxygen is used in the home setting and in skilled nursing facilities. Approximately $2 million was spent on oxygen within the skilled nursing facility settings. A policy taking effect in FY 2009 requires DME as part of the per diem rate for facilities. This is represented in Figure 7.

Also, represented in Figure 7 is an increase in Blood Glucose Supplies during FY 2005. This is a direct result of policy E2004-040 implemented October 1, 2005 adding coverage of blood glucose supplies for non-insulin dependent diabetics. In Figure 8, procedure code expenditures less than $800,000, a significant drop occurred in code B4150 (Enteral Formula) as a result of CMS reconfiguring the Enteral HCPC codes. The number of beneficiaries utilizing B4150 dropped from 554 to 421, which caused a decrease in expenditures for this particular code, spreading the difference in utilization over the remainder of the Enteral codes. This is represented in Figure 8.

Figure 7

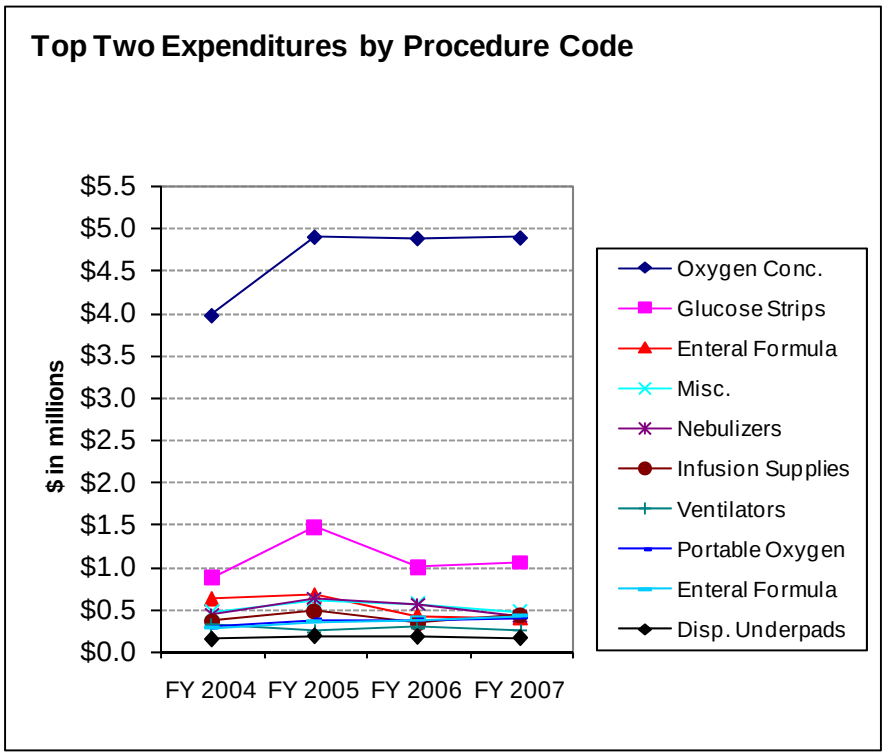
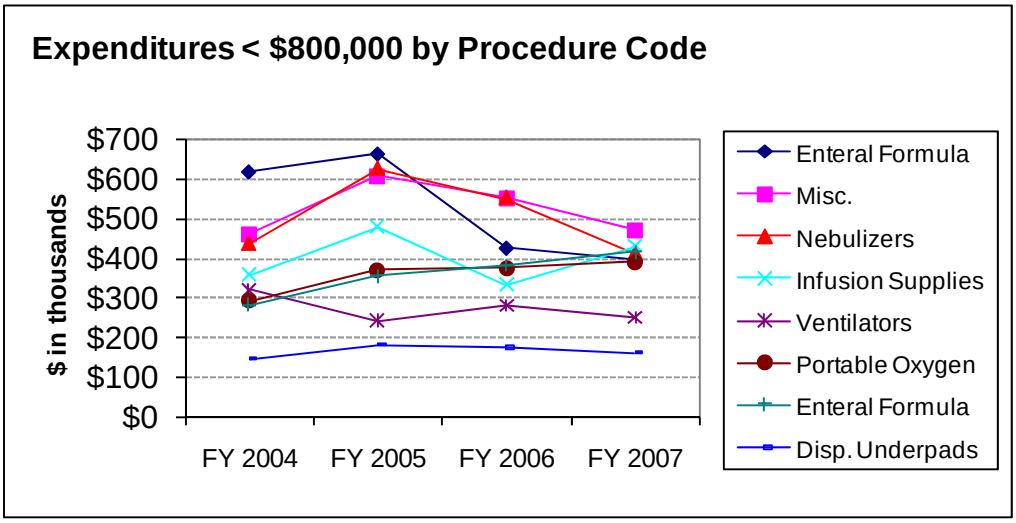


Table 2
Annual Expenditures by Procedure Code

Description	Code	FY04	FY05	FY06	FY07
Oxygen Concentrator	E1390	$3,967,954	$4,887,798	$4,871,021	$4,878,018
Blood Glucose Test Strips	A4253	868,100	1,468,023	997,111	1,051,337
Enteral Formula	B4150	617,184	662,006	425,544	394,281
Miscellaneous	E1399	459,228	606,418	549,540	470,457
Nebulizers	E0570	435,797	623,381	550,464	412,355
Home Infusion Supplies	A4222	356,016	477,557	332,043	429,682
Ventilators	E0450	319,699	239,971	280,886	250,049
Portable Oxygen	E0431	292,033	367,355	372,669	388,927
Enteral Formula	B4035	280,313	353,405	381,181	414,934
Disposable Underpads (chux)	A4554	145,846	181,084	173,655	160,479

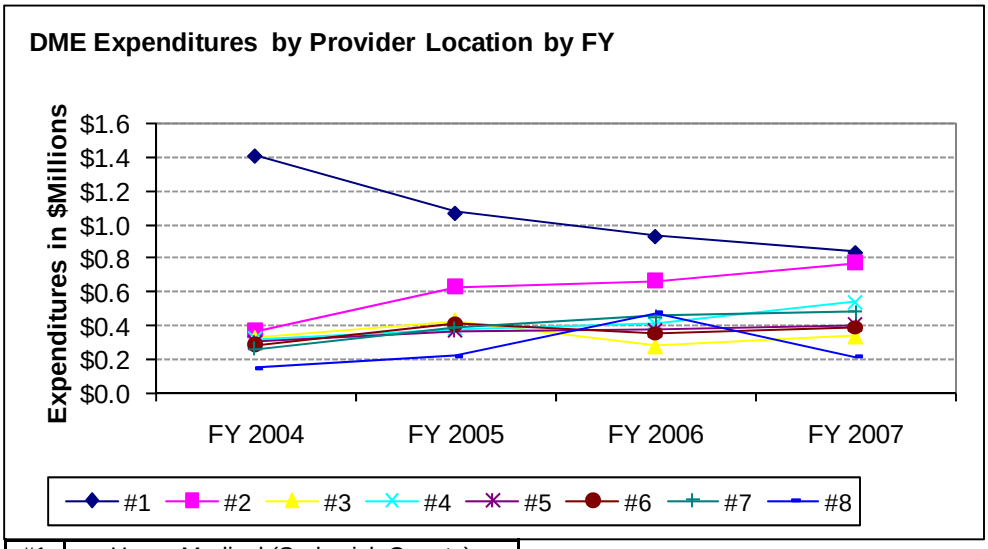
Figure 8



Expenditures by Provider

DME providers with the largest number of clients are located in Wichita and Lenexa. These companies have multiple sites throughout the state and maintain a large selection of DME items. Figure 9 represents DME expenditures by the top eight providers. Significant changes are observed in reimbursements to a number of high volume Medicaid providers. However, no patterns were identified that raised concerns over current Medicaid policies.

Figure 9



#1	Home Medical (Sedgwick County)
#2	Apria (Johnson County)
#3	Advanced Homecare (Douglas County)
#4	Apria (Shawnee County)
#5	Apria (Wyandotte County)
#6	Special Products (Sedgwick County)
#7	Apria (Sedgwick County)
#8	Lincare (Sedgwick County)

Expenditures and Utilization by Age Group

Figure 10 and 11 represent the distribution of use and expenditures between adults and children. These expenditures have remained stable relative to each other and over time. Patterns in overall DME spending observed in Figure 2 are mirrored in both overall spending and the number of consumers for both adults and children, suggesting the prominent role of overall payment and coverage policies in explaining these changes, rather than an explanation specific to a particular population or piece of equipment.

Figure 10

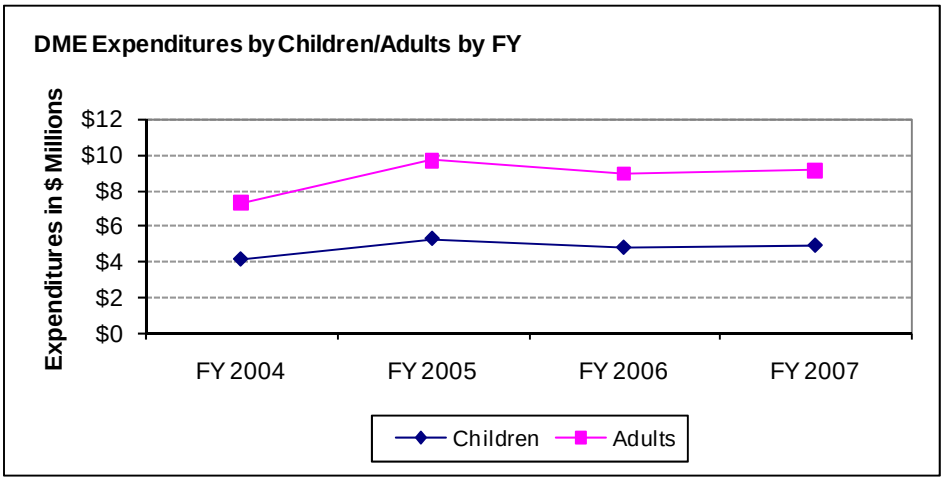
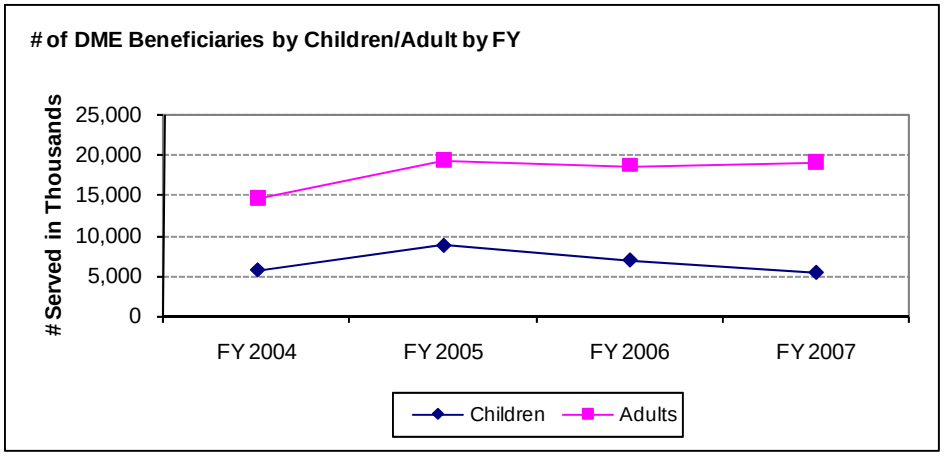


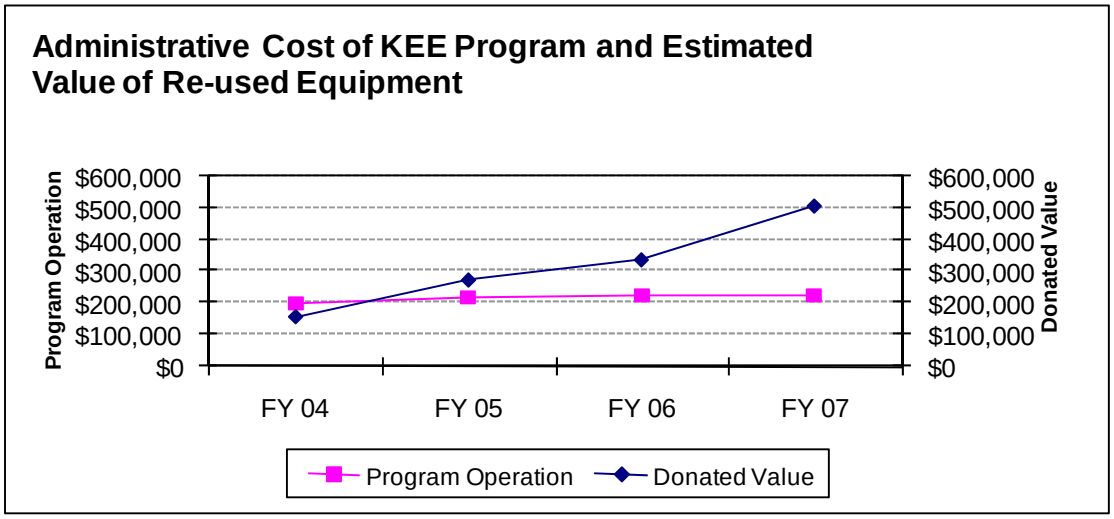
Figure 11



Kansas Equipment Exchange (KEE) Program Expenditures/Savings

In FY 2007 there were 551 reassignments through the Kansas Equipment Exchange Program valued at $594,852 and 566 donations valued at $653,717. This program has continued to grow due to increased beneficiary awareness through beneficiary ID card stuffers, word of mouth, and provider cooperation. As noted earlier, this program was noticed as a "best practice" by the MED Project. Figure 12 represents the KEE program operation costs and donated value of equipment.

Figure 12



Program Evaluation

As mentioned briefly earlier, one issue within the DME program is the utilization of the E1399 (Miscellaneous) billing code. From 1995 through 2002, there were many DME items that were not assigned a specific DME code. Over that time period, the only way to bill for these items was to use the Miscellaneous code, which is manually priced. Current DME policy for manually priced items is to pay at the lesser of: 1) Medicaid rate 2) Provider cost plus 35% or 3) Manufacturer's Suggested Retail Price (MSRP) minus 15-20% (depending on the item). However, DME suppliers are not currently required to provide both cost and MSRP information, leaving suppliers with an implicit choice between the two methods based on the information they choose to provide. This leaves open the possibility that KHPA could be paying the greater of these two amounts in some cases. The lack of available DME codes and recommended prices from the Centers for Medicare and Medicaid Services (CMS) caused an over-utilization of the Miscellaneous code and its ambiguous and potential generous pricing policy. In 2004, CMS began assigning specific codes to some of these items. At that time, efforts began within Kansas Medicaid to write policies to cover the appropriate codes for DME items, and decrease the over-utilization of the Miscellaneous code.

Due to the increased possibility of fraud and abuse, the Miscellaneous code E1399 must be prior authorized. DME providers within this unstructured billing code could utilize this code to obtain higher reimbursement and by-pass limitations. All requests for E1399 are reviewed by the PA unit. If an appropriate code is covered the provider is directed to make his request using the appropriate CMS billing code ("HCPCs"). Several HCPC codes lack a corresponding coverage policy within Kansas Medicaid and instead are covered within the E1399 Miscellaneous code.

The DME program has several categories of equipment that remain manually priced on the pure HCPC codes. For example, wheelchairs are priced either by cost plus 35% or 80% of the MSRP. Providers are not required to submit their cost invoices. Some providers do submit these invoices and try to provide Medicaid with an appropriate cost request. Currently there is no regulation that states a provider must submit his cost invoice with the prior authorization request.

Another issue within this program is the upcoming DME Bidding Project being instituted by CMS. The Durable Medical Equipment Prosthetic Orthotic Supplies (DMEPOS) bidding project is a new bidding program for certain DME as required by section 302 of the Medicare Modernization Act of

2003. This program will change the way Medicare pays for these items under Part B of the Medicare program by using bids submitted by DMEPOS suppliers to establish payment amounts. The only area that will be affected in the initial implementation is the Kansas City area. Medicare beneficiaries who reside within the project area will be required to utilize a CMS contracted bidder. KHPA will also require Medicare beneficiaries to obtain their equipment and supplies from a contracted bidder (if required by Medicare). Reimbursement for DME equipment and supplies that are included in the bidding project have been announced by Medicare. KHPA will adjust its rates to, at or below the Medicare rate for these items.

In FY 2008, the CMS bidding project was postponed by the United States Congress for 18 months. Work is ongoing to continue improving this project, making changes that synchronize with Medicare, and prepare for the implementation of this program. The initial implementation, or "round one", may occur in 2009. This is expected to be an ongoing project over several years under the direction of CMS.

A new policy regarding DME supplies in nursing facilities was implemented in FY 2008. CMS recently referred KHPA back to a previous federal regulation (C.F.R. 42-440.70) which states that DME equipment and supplies can only be supplied to beneficiaries in their home. The regulation states that nursing facilities, hospitals, and ICF/MR's are not classified as a beneficiary's home. Both the Medicaid state plan and state regulations are being updated for this change. KHPA has been working closely with Kansas Department on Aging (KDOA) and the Kansas Department of Social and Rehabilitation Services (SRS) on this issue. Expenditures related to DME in these have been calculated and are being transferred to KDOA and SRS. These agencies have made per diem rate adjustments to include these additional expenses. All DME equipment and supplies for beneficiaries within these facilities will now be considered part of the per diem rate and will not be billed separately to KHPA. This policy was implemented July 1, 2008, and is expected to reduce overall state Medicaid expenditures on DME, since nursing homes are likely to negotiate better rates on average than are currently paid through Medicaid's Fee For Service (FFS) price schedule.

Recommendations

1. Review the home use Oxygen category within DME.

Oxygen expenditures will decrease due to the DME nursing facility policy that was implemented July 1, 2008. However, even apart from the CMS mandated shift in DME for nursing homes, KHPA is aware of a number of potential overpayments and coverage issues for Oxygen DME.

2. Require providers to show the actual cost of all manually priced DME items.

As stated previously, current Medicaid policy regarding reimbursement for DME items is to pay the established Medicaid rate when one exists, or to manually price the equipment at the lesser of: 1) Medicaid rate 2) cost plus 35% or 3) MSRP minus 15-20%. At this time providers are not required to show their actual cost, nor in every case are they required to provide the MSRP, leaving open the possibility that KHPA may be reimbursing at the greater of the two levels. Cost-plus pricing may not be a sustainable approach for any significant number of products, however it seems a prudent and administratively straightforward interim step.

3. Continue to decrease the over utilization of E1399 (miscellaneous) billing code.