

# Improving the Delivery of Durable Medical Equipment and Services in Arizona

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## ***RECOMMENDATIONS TO ACHIEVE***

## **“Superior Customer Service”**

**Durable Medical Equipment Task Force**

September 2008

This project was supported by the following organizations:

- Statewide Independent Living Council (SILC)  
[www.azsilc.org](http://www.azsilc.org)
- Arizona Bridge to Independent Living (ABIL)  
[www.abil.org](http://www.abil.org)
- Arizona Center for Disability Law  
[www.azdisabilitylaw.org](http://www.azdisabilitylaw.org)
- Arizona Governor's Council on Developmental Disabilities  
[www.azqcdd.org](http://www.azqcdd.org)

For additional information or inquires please contact SILC

# ACKNOWLEDGEMENTS

The information and recommendations in this report are the direct result of the commitment of many individuals and organizations that participated, provided information and thoughtfully approached the complex task of understanding the system from multiple perspectives and developing recommendations that would ultimately lead to:

## *Superior Customer Service*

Individuals and organizations that contributed substantially to the field of knowledge and development of the recommendations include:

- Consumers of service and their family members who not only shared their stories but also their ideas for improvement and helped everyone understand the need to improve the DME delivery system and the health and safety implications of not implementing improvements.
- DME Task Force members who committed their time, experience and unique perspectives and developed a shared vision of Superior Customer Service, shared goals, and recommendations for improvement.
- Consumers, DME suppliers, and insurers who participated in key informant interviews and helped bring focus to the scope of the issues and identification of the priority areas to be reviewed by the Task Force.
- The Arizona Health Care Cost Containment System and the Department of Economic Security, Rehabilitation Services Administration who provided special data reports regarding DME services in Arizona.

# PREFACE

*Recommendations to Achieve “Superior Customer Service”* in the delivery of durable medical equipment (DME) is a report of consensus recommendations achieved by the DME Task Force in July 2008. The recommendations are designed specifically to result in systemic change throughout the delivery system. Within the recommendations are policy and practice directions that when implemented system-wide will improve service delivery. One policy option for future consideration (not recommended in this report) is that of licensing DME suppliers.

The Task Force was deliberate in their considerations of the complexity of the system and fully acknowledged that the public and private aspects of the system produce different implementation challenges and will require different strategies. In that light, it is important to note that Medicare (a major insurer) and private insurers were not represented among the Task Force members. At its inception, the scope for the Task Force was defined as creating systemic change. The practical approach was to define the issues and recommendations in the context of consumers, suppliers and insurers, including the Arizona state agencies that contract with public funds for DME services. The added caveat was that both Medicare and private insurers in Arizona would be engaged in discussions of improvement once a clear picture of the issues and options was defined. Additionally, although invited, physicians did not participate as a result of the time commitment needed. Follow-up meetings with medical directors are included in the Implementation Plan.

*Recommendations to Achieve “Superior Customer Service”* is the first milestone in what will undoubtedly be a journey to improve the system. This report has the following sections:

- Introduction – background information about the Task Force, purpose and process implemented to develop the recommendations.
- Arizonans with Disabilities – a snapshot of the demographic profile of people in Arizona with disabilities.
- The Current System of DME Service Delivery – an overview of the organizations involved the strengths and weaknesses of the system, issues and key findings.
- The Desired DME Service Delivery System – the principles or characteristics of an effective DME service system, goals to achieve that system, and measurable indicators of success in improvement.
- Recommendations – consensus recommendations developed by the Task Force that, when implemented, will improve the delivery of DME.
- Future Policy Issues –an overview of DME licensing nationwide.
- Implementation – responsibilities for implementing these recommendations.

As a Task Force, our commitment to *Superior Customer Service* does not end with this report – it begins, with the changes made within each organization and continuing through every interaction among DME consumers, family members, physicians, therapists, suppliers, manufacturers, and insurers.

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## EXECUTIVE SUMMARY

In the fall of 2007 the Statewide Independent Living Council (SILC), Arizona Bridge to Independent Living (ABIL), the Arizona Governor's Council on Developmental Disabilities (AzGCDD), and the Arizona Center for Disability Law (ACDL), in their roles as advocates for people with disabilities, had received numerous requests for individual assistance that included access to needed durable medical equipment (DME) and having repairs completed for users of wheelchairs. Because of the volume of requests for assistance, a community forum was held in October 2007 specifically to discuss the issues surrounding delivery and repair of durable medical equipment. The focus of the forum, based on consumer input, was dominated by issues related to mobility devices, with an emphasis on wheelchairs both manual and power. Among the issues identified were:

### ***What is durable medical equipment (DME)?***

*Durable medical equipment (DME) is defined in various ways by federal, state and private insurers. DME generally includes items that have a medical purpose, including mobility devices (walkers, manual wheelchairs and power wheelchairs), medical supplies and prosthetic and orthotic devices.*

1. Lack of communication or incorrect communication from DME suppliers to consumers,
2. Delays, in some cases months, in obtaining critical wheelchair repairs, resulting in loss of work, potential for increased health issues, and an inability of consumers to attend to their day-to-day responsibilities,
3. Lack of choice among DME suppliers because of limited contracting on the part of insurers (Medicare, Medicaid and private), leaving consumers without options to "find a better alternative", and
4. Delays in discharge from hospitals or rehabilitation facilities due to delays in receiving needed equipment and supplies.

### *DME Consumer*

*I am very tired of my life coming to a grinding halt every time my wheelchair goes in for repairs. On April 2<sup>nd</sup> my manual wheelchair was picked up by the supplier to fix the left arm which had broken. I also requested replacement hand grips for the wheels, for the left brake to be adjusted and tightened, and finally the possibility of a new cushion. On April 21<sup>st</sup> I called them to see what the status was and was told they were just waiting for parts so it should be 7 to 10 days. On May 2<sup>nd</sup> I called to see if it was done. The answer was no, and there were no notes in the system about my call on the 21<sup>st</sup>.*

*On May 5<sup>th</sup> I called them again. The parts had NOT been ordered and the insurance company hadn't been contacted for approval. To top that apparently I have to have a whole different prescription for a new cushion, that the one my doctor sent for repairs wasn't sufficient for that.*

*I informed them that I haven't been to the pharmacy, the grocery store, or the doctor for over a month, all of which I'm in desperate need of doing. The representative asked if I wanted a loaner but they don't have loaners where the wheels come off so I can't get it into my car, which means the loaner is useless to me.*

Based on the dialogue at the forum, the challenges identified related to DME were not only individual consumer challenges, but system-wide delays and barriers to effective delivery of DME and services.

The W. P. Carey School of Business at Arizona State University states that a total of 20.1 percent (a little more than 900,000) Arizonans aged five or older reported one or more disabilities in the 2000 Census. Given the increase in population since April 2000, the number of Arizona residents aged five or older with a disability in 2003 likely is nearly 1 million.<sup>1</sup>

The actual number of people accessing durable medical equipment through Medicare, Medicaid, private insurance and self-payment is not known; however from July 2006 through June 2007, 123,012 people accessed durable medical equipment through Medicaid Acute Care or Long Term Care Services administered by AHCCCS. The cost of these services was \$55 million.

*The Task Force:* In March of 2008, the SILC, ABIL, AzGCDD, and ACDL formed the Durable Medical Equipment Task Force. The role of the Task Force was to research and develop recommendations to improve the delivery and maintenance of DME in Arizona.

The DME Task Force was comprised of stakeholders throughout the delivery system, including consumers, their family members, insurers\*, state agencies, Medicaid, managed care organizations (acute health plans and long-term care program contractors), DME suppliers and DME manufacturers.

\* For purposes of this report, the term insurer encompasses all payers of DME services and equipment, including Medicare, Medicaid, private insurers, health plans and managed care organizations.

*The Current System:* The current system of DME service delivery is a microcosm of the larger health care system. In a word, it is complex. The system involves multiple layers, players, policies, and approaches to accessing DME. Inherent in this complexity is the absence of predictability for the consumer of services, since policy and practice vary among insurers and DME suppliers.

### **Goals and Recommendations**

“Superior Customer Service” is the vision of the DME Task Force. “Superior Customer Service” applies to and among all of the customers involved in the DME service delivery process; i.e. the consumers of DME and their family members, the physicians who prescribe DME, the suppliers who provide DME, and the insurers who pay for DME. The goals and recommendations are intended to result in system change and should not be interpreted to mean that none of the actions are currently taking place just that they are not taking place system-wide or at a level that results in “Superior Customer Service.”

Goal I: Communication: To provide direct, specific, and timely communication that is responsive to consumers, suppliers, medical personnel and insurers across the DME service system.

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<sup>1</sup> W.P. Carey School of Business, Arizona State University, Disabled Report – Arizona State University web site - [http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabled\\_report.pdf](http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabled_report.pdf)

Recommendation 1: Implement methods to ensure that consumers have information about the steps in the process of obtaining durable medical equipment and who to contact about DME questions at each of the Arizona state agencies administering programs and services for people with disabilities.

Recommendation 2: Designate DME-specific contact persons or departments at insurers and suppliers. Insurers and suppliers will respond in a timely manner to consumer inquiries on the status of new orders or repairs and will have the ability to track delays and notify consumers of possible delays.

Recommendation 3: Develop a web-based forum for consumers to have easy access to information about available DME suppliers, the performance of DME suppliers and specialty DME suppliers, and to communicate with each other about their “good DME experiences” as well as their “bad experiences.” Include in the web site the following information:

- educational material about the process of obtaining durable medical equipment, information about when and how to file a grievance or appeal,
- an advocacy protocol that can be duplicated and used by all consumers and advocacy organizations,
- the steps for acquiring durable medical equipment – including but not limited to specialized custom equipment to allow consumers to be able to track their equipment delivery process and advocate on their own behalf,
- identify who is responsible for what activities and within what timeframe at each step in the process, including physicians, insurers, DME suppliers, DME manufacturers, and consumers, and
- supplier standards for service delivery.

Recommendation 4: Provide consumers with information at the time of delivery of wheelchairs about the warranty, how to register the warranty, equipment-specific preventative maintenance, what invalidates a warranty, and the consumers’ responsibility regarding care and maintenance.

- Provide a template for consumers to record specifics about their equipment, the maintenance history and the repair history.
- Include information about who to contact when a repair is needed.

Recommendation 5: Implement at the DME supplier level a system to track orders and repairs with the capacity to pinpoint where there are delays, to issue alerts internally within the supplier organization and to notify consumers regarding delays. Additionally, the system should be able to provide aggregate reports on the status of meeting predetermined timelines.

Recommendation 6: Ensure that communication occurs between seating evaluation therapists and supplier representatives before equipment is ordered, if the recommendations of the therapist and supplier representative are different. Use a feature-match approach when determining the right equipment to be provided.

Recommendation 7: Complete a comprehensive research study to provide data about the population in Arizona who use durable medical equipment, the level of utilization, the financial and lifestyle impact of not being able to access DME (i.e., missed work, school, independent living), and the actual timelines required to access DME.

Goal II: Standards and Practice Protocols: To improve the effectiveness of DME suppliers and insurers through a system of uniform standards, reasonable expectations, and streamlined processes.

Recommendation 8: Clarify the rules and requirements that apply when a consumer has the ability and desires to pay, at his or her own expense, for equipment or repairs, and disseminate information about the process system-wide.

- Clarify the possible implications, if any, from the standpoint of Medicare, Medicaid, private insurers, etc.
- Provide a standard form and process to be used by all DME suppliers for informing consumers of these implications and obtaining, if needed, their signature indicating their desire to purchase supplies and / or equipment on their own.
- Make this information available to consumers through web sites, newsletters, public forums.

Recommendation 9: Develop and adopt specific standards and performance indicators in quality, timeliness, and staff qualifications that will improve the effectiveness of DME service delivery.

- Establish uniform standards for “reasonable” timelines for each step in the DME process.
- Distinguish between routine durable medical equipment and specialized durable medical equipment.
- Specify staff qualifications, including level of experience with specific populations and licensed occupational and physical therapists.

Recommendation 10: Require that DME suppliers be accredited and include their accreditation status in a published list of DME suppliers. (Note: DME suppliers that plan to do business with Medicare must be accredited by December 2009.)

Recommendation 11: Require that all DME suppliers have a Certified Rehabilitation Technology Specialist (CRTS), Assistive Technology Practitioner (ATP) and/or Assistive Technology Supplier (ATS) on staff, as appropriate to the DME services they provide.

- Research the availability of CRTS, ATP and ATS (oversupply, adequate, short-supply)
- Determine strategies to implement

Recommendation 12: Analyze existing data and establish across insurers and suppliers a higher, consistent dollar threshold before a repair event requires prior authorization and establish a prior authorization “fast track” for repairs that are estimated to be above the newly established threshold. For example, only repairs in excess of \$1,000 require prior authorization.

Recommendation 13: Establish a standard protocol regarding seating evaluations and seating clinics to include when seating evaluations are to be completed prior to ordering a wheelchair, what follow-up is to occur after delivery of the wheelchair, and on an ongoing basis, what monitoring is recommended. The protocol should address, but not be limited to, the following:

- involvement of the consumer’s current occupational or physical therapist or, if the consumer does not currently have a therapist, a new occupational or physical therapist in the evaluation, such as the therapists who work with students in schools,
- identification of therapy organizations with qualified therapists who are able to provide evaluations,

- ensure a Certified Rehabilitation Technology Specialist (CRTS), Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) is participating in the evaluation with the therapist,
- specify key elements of formal seating evaluations, such as: range of motion, equilibrium reactions, fine and gross motor skills, ability to self propel and transfer, self-care issues, transportation requirements, pain limitations and visual skills including depth perception, and
- Establish minimum qualifications for people who conduct seating evaluations.

Recommendation 14: Establish a practice protocol for the provision of “loaner” equipment and accessing alternative transportation when loaner equipment is not appropriate or not available.

- Have DME suppliers provide the best possible match in loner equipment when a repair requires that a wheelchair be taken to the repair facility, or allow consumers, working with their case managers and the DME supplier, identify appropriate alternative transportation arrangements.
- Provide specific training and education to ensure that Arizona Long Term Care System (ALTCS) case managers or other case managers, in all the systems, have information about transportation alternatives, the potential need for provision of and/or immediate increase in and authorization of attendant care hours and the potential for health and safety issues to arise while a consumer’s equipment is being repaired.
- Consider authorization by the insurers for consumer owned back-up equipment to be repaired and ready for use before the consumer’s current equipment needs repair and / or new equipment is ordered.

Recommendation 15: Develop and implement a practice protocol and a system of quality assurance for follow-up after delivery of equipment to ensure fitting of the wheelchair to the consumer and match the specification of the DME ordered to that delivered, prior to requesting the consumer’s signature accepting the wheelchair or other piece of DME.

- Require DME suppliers to provide customer satisfaction cards at the time of delivery and six months after delivery. Make results accessible to insurers and consumers.
- Provide consumers with a check list of what to expect and what to “watch for” as they begin to use the equipment (similar to possible side effects provided with a prescription – if x happens, stop and call the doctor. For example, if you feel unstable or not centered using the equipment, call the supplier).
- Ensure that occupational or physical therapists who conduct the assessment specifically consider and distinguish “need” versus “want” with regard to wheelchairs. Provide consumers with information about why their desired piece of equipment may not correspond with the needs indicated by the functional assessment.

Goal III: Consumer Choice and Advocacy: To empower consumers of DME to be informed advocates through choice, education, and knowledge of the standards, practice, and policies of their insurer and DME supplier.

Recommendation 16: Require AHCCCS Health Plans, ALTCS Program Contractors and Department of Health Services, Office of Children’s Rehabilitation Services contracted clinics to provide multiple choices of DME suppliers – at least two or more - if providers are available in the geographic area.

Recommendation 17: Provide more consumer choices of suppliers and repair services to enhance access, including choices that may be geographically closer to the consumer and/ or timelier in completing the repair.

Recommendation 18: Provide more consumer choices regarding accessing seating evaluations and seating clinics.

Recommendation 19: Provide easily accessible information about DME suppliers; i.e. create a list of accredited DME suppliers, where they are located geographically, what DME services and equipment they provide, and whether or not they have a Certified Rehab Specialist on staff. Provide the information through multiple web sites. (Possible web sites: AzDisabilityPost.org, Az Association of Law Libraries (AzAll), AzLinks, Disability Resource, Assistive Technology Arizona (ATAZ), and NAU – Az Technology Access Program (AzTAP), health plans, and relevant state agencies).

Recommendation 20: Implement a standardized consumer / advocate guide and checklist to enhance understanding of the process, the roles of each party, and reasonable expectations of timelines.

- A common checklist will assist providers, consumers and advocates in understanding the steps in the DME process, what the reasonable timelines are for each step, and who to contact if a request is delayed.
- The guide must include what action to take in the case of delays.
- Include advocacy tips the top 10 things consumers can do to make the process more accountable and timely. For example, consumers need information about why DME suppliers must be able to see old equipment when a replacement is being requested: consumers are often reluctant to let them see it.

Goal IV: Quality Assurance and Timeliness: To provide quality durable medical equipment within acceptable timeframes.

Recommendation 21: Implement formal quality assurance plans at the insurer and DME supplier levels that include:

- performance improvement indicators for customer satisfaction,
- consumer satisfaction surveys with questions specific to DME and to receipt, delivery and repair of wheelchairs,
- standardized questions regarding DME services in all customer satisfaction surveys,
- a rating system based on customer satisfaction and tracking of delivery; i.e. quality and timeliness,
- sharing of the results of customer satisfaction surveys with consumers, insurers and suppliers,
- analysis and monitoring of grievance and appeals issues raised, resolutions, and timelines for response, and
- mechanisms for seeking consumer advice (e.g., consumer councils) on how to improve the quality and timeliness of the delivery of durable medical equipment.

Recommendation 22: Implement clear and consistent grievance and appeals processes among all insurers and DME suppliers and, as part of quality assurance, monitor and publish the results.

- Develop standardize grievance and appeals timelines for response across the system, such as: (a) consumers will receive a response to a written appeal within 10 days regardless of insurer source (b) consumers will have contact from the organization with which they filed a grievance within 48 hours (if not an answer, acknowledgment that the grievance has been received).
- Provide consumer-friendly information about grievances and appeals, when to use the grievance process versus the appeal process, how to file a grievance or an appeal, and what are the reasonable timelines for receiving a response.
- Publish grievance / appeals processes in newsletters and / or circulate to other organizations on how the process works.
- Monitor the number of grievances and appeals and provide information regarding the results to consumers and advocates.
- Document grievances and track by number and/or name to enhance communication and follow-up.

Recommendation 23: Establish consistent guidelines for all DME suppliers regarding repairs and customer service, including consistent processes and documentation requirements.

Recommendation 24: Discontinue at all levels of the DME service system (insurer and DME supplier) the practice of paying for specialized, customized DME under a capitated rate system and implement fee-for-service rates for all specialized, customized DME, including wheelchairs.

Recommendation 25: Reassess the durable medical equipment fee-for-service schedule for all insurers, specifically addressing the following issues:

- the adequacy of rates to cover costs,
- reimbursement for loaner equipment, seating evaluations, seating clinics, repairs for the life of the product, etc.,
- reimbursement for the costs related to maintenance and management of a “fleet” of loaner equipment, and
- reimbursement for the costs of repairing “back-up” equipment belonging to the consumer that is repaired before the consumer’s current equipment needs repair.

Recommendation 26: Define and implement insurer and DME supplier incentives for exceeding service standards and consequences for noncompliance with standard guidelines, such as consistent delays, lack of or delay in resolution of grievances, and lack of responsiveness to consumer inquiries.

Recommendation 27: Analyze existing processes to ensure that requests for equipment and suppliers are specifically based on the functional needs of the individual consumers and not just the “typical” service / equipment. (for example, a shower chair must take into consideration the weight of the consumer – any standard shower chair may not be appropriate). Modify existing policy or develop new policy as needed.

Recommendation 28: Implement at the state agency, health plan/program contractor and DME supplier levels specific network capacity assessment methods to document DME supplier capacity and be alerted to the need for capacity expansion.

Recommendation 29: Develop partnership opportunities with employment organizations, advocacy groups and Rehabilitation Service Administration to recruit and train technicians to fill the workforce deficiency in wheelchair repair technicians.

Goal V: Training and Education: To provide clear and consistent training and education throughout the DME delivery system.

Recommendation 30: Provide specific information to primary care physicians regarding needed documentation.

- Provide information about what the primary care physician should expect to see in reviewing a quality seating evaluation / assessment.
- Develop standard language or a template for a prescription for complex requests such as wheelchairs, so that prescriptions include the necessary information for insurers to determine medical necessity.
- Ensure physicians have information about the need for both a prescription for the seating evaluation AND a prescription for the wheelchair itself.

Recommendation 31: Increase awareness within the system about the potentially critical nature of delays in obtaining and/or repairing DME equipment.

- Provide specific training and education for insurers, DME suppliers and state agency customer service representatives about durable medical equipment, the health and safety issues surrounding receipt of the wrong equipment and/or delays in getting equipment.
- Provide medical directors, ALTCS case managers or other case managers and prior authorization staff with specific information and education about DME issues and the potential health and safety implications of a lack of appropriate or timely provision of DME.

Goal VI: Repairs and Maintenance: To complete durable medical equipment repairs efficiently and accurately in settings that are respectful of and responsive to the needs of consumers.

Recommendation 32: Discontinue at the insurer and DME supplier level the requirement that a prescription be provided before repairs can be made.

Recommendation 33: Maintain an inventory in stock of standard wear and tear items: batteries, wheels, castors, safety-related devices, arm pads. If needed items are not in stock, allow consideration for expedited shipping based on the needs of the consumer.

Recommendation 34: Offer a variety of options for repairs and preventative maintenance, such as appointments, group maintenance work shop days; mobile and / or same day repair or walk-in repairs, in-home repairs. For example, every Saturday hold a workshop specific to batteries, tires, etc. Conduct a pilot clinic to see if the response warrants this type of service.

Recommendation 35: Inform, on an ongoing basis, case managers and others such as support coordinators, care coordinators, etc. about the availability of repair clinics, so they can communicate with their consumers, and provide information about clinics on web sites or in various organizational newsletters.

Recommendation 36: Implement a focus on preventative maintenance including, but not limited to:

- increasing inventories of common preventative maintenance parts,

- establishing a consistent process and documentation for consumers to have original paperwork of equipment needing repair; i.e. original date of receiving the equipment, PCP's name and a copy of the prescription,
- educating consumers regarding upkeep of the equipment and maintenance/repair requirements, and
- providing, on an ongoing basis, alert information to consumers about preventive maintenance and repair clinics.

Recommendation 37: When the DME supplier is responding to a therapist recommendation or a prescription with an alternative that is of lower quality lower or less functionality than the equipment recommended, the supplier, upon consultation with the therapist, must ensure that the alternative does not compromise the safety of the consumer or the quality of the equipment.

### **Implementation Plan**

Implementation of the recommendations will require the continuation of a spirit of cooperation among all participants in the DME service delivery system. The implementation plan includes the following components:

1. Report Dissemination: The Statewide Independent Living Council (SILC) will take the lead and will solicit support from Task Force members in disseminating the final report of recommendations. The final report is posted to the ArizonaDisabilityPost web site.
2. Ongoing Coordination / Communication: SILC will serve as the coordinating center for ongoing discussions, posting of information, providing quarterly updates and re-convening of the Task Force in one year to do a progress check and to determine next steps.
3. Implementation Work Groups: Work Groups have been established to implement the priority recommendations of the Task Force.
  - Information and Education Work Group
  - Prior Authorization Work Group
  - Delivery Standards Work Group
  - Seating Evaluations Work Group
  - Loaner Equipment Work Group
  - Consumer Choice Work Group
4. SILC will pursue options for development of the comprehensive information envisioned by Recommendation 7: A comprehensive research study be completed to provide data about the population in Arizona who use durable medical equipment, the level of utilization, the financial impact and the lifestyle impact of not being able to access DME (i.e., missed work, school, independent living) and the actual timelines required to access DME.

## INTRODUCTION

*Improving the Delivery of Durable Medical Equipment and Services – Recommendations to Achieve Superior Customer Service* provides an initial pathway to improving the delivery of service through system-wide change. It can be anticipated that as these recommendations are implemented, additional opportunities for improvement will be identified in the spirit of continuous quality improvement.

### **Background**

In March of 2008, the Statewide Council on Independent Living (SILC), Arizona Bridge to Independent Living (ABIL), the Arizona Center for Disability Law (ACDL) and the Governor's Council on Developmental Disabilities (AzGCDD) formed the Durable Medical Equipment Task Force. The role of the Task Force was to research and develop recommendations to improve the delivery and maintenance of durable medical equipment (DME) services in Arizona.

Leading up to the formation of the Task Force, each of the organizations, in their roles as advocates for people with disabilities, had received numerous requests for individual assistance that included access to needed durable medical equipment and having repairs completed for users of wheelchairs. To further explore the status of delivery of durable medical equipment, a community forum was held in October 2007 to discuss the issues surrounding delivery and repair. The focus of the forum, based on consumer input, was dominated by issues related to mobility devices with an emphasis on wheelchairs both manual and power. Based on the dialogue at the forum, the challenges identified related to DME were not only individual consumer challenges, but system-wide delays and barriers to effective delivery of durable medical equipment and services.

### **What is durable medical equipment (DME)?**

Durable medical equipment (DME) is defined in various ways by federal, state and private insurers. DME generally includes items that have a medical purpose, including mobility devices (walkers, manual wheelchairs and power wheelchairs), medical supplies and prosthetic and orthotic devices.

The Medicare definition specifically states that covered durable medical equipment is equipment that is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of the Medicare member. For Medicare purposes, DME must meet the following criteria:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.<sup>2</sup>

The Arizona Health Care Cost Containment (AHCCCS) defines DME as: sturdy, long lasting items and appliances that can withstand repeated use; are designed to serve a medical purpose; and are not generally useful to a person in the absence of a medical condition, illness or injury. Covered prosthetic and orthotic devices are designed to replace or augment a missing or impaired part of the body and are only covered when they are essential for the habilitation or

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<sup>2</sup> [www.cms.hhs.gov/manual/section110](http://www.cms.hhs.gov/manual/section110).

rehabilitation of a member. DME and devices are used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate.<sup>3</sup>

### ***DME Task Force***

The DME Task Force was comprised of stakeholders throughout the system including consumers, their family members, insurers,\* and durable medical equipment suppliers and manufacturers. (See Appendix A for a list of Task Force Participants.)

\* For purposes of this report, the term “insurer” encompasses all payers of DME services and equipment, including Medicare, Medicaid, private insurers, health plans and managed care organizations.

The Task Force had its origin in community discussions focused on the need to improve the delivery and maintenance of wheelchairs (manual and power), the timely receipt of supplies, and the delivery and maintenance of respiratory equipment. However, a broader context emerged from the Task Force discussions and as a result decisions and recommendations were developed in the context of creating system-wide change and addressing the presenting issues from the community forum.

The experiences and examples of service delivery regarding durable medical equipment were focused on wheelchairs (manual and power), walkers, respirators, scooters and other durable items that are rented or purchased. Medical supplies such as urological supplies, surgical dressings, and other consumable items, orthotic and prosthetic devices, augmentative communication devices, hearing aids and oxygen supply were not specifically excluded from the Task Force discussions. However, to maintain focus on the originating issues, specific recommendations for these types of equipment/services were not developed.

The population to be impacted by improvements in the delivery of DME services ultimately includes any individual in Arizona who relies on durable medical equipment. Recommendations are focused on systems’ change throughout the delivery network, regardless of insurer or supplier. Adults and children who are Medicaid-or Medicare-eligible, veterans, individuals with private insurance, and individuals who privately pay for these services should benefit from the recommendations defined by the Task Force.

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<sup>3</sup> [www.azahcccs.gov/policymanual](http://www.azahcccs.gov/policymanual)

## ARIZONANS WITH DISABILITIES

The Arizona population of people with disabilities is highlighted in this section as the primary population using durable medical equipment. It is important to note that specific information is not available regarding the actual number of people who at any given point in time depend on timely receipt of quality durable medical equipment.

### Population Estimates

The W. P. Carey School of Business at Arizona State University states that a total of 20.1 percent (a little more than 900,000) Arizonans aged five or older reported one or more disabilities in the 2000 Census. Given the increase in population since April 2000, the number of Arizona residents aged five or older with a disability in 2003 likely is nearly 1 million.

The percentage of the population with one or more disabilities rises steadily with age. Less than 5 percent of children five-to-nine years old have a sensory, physical, mental or self-care disability. A little more than 15 percent of those 20-to-29 years old have any of the six disabilities. This percentage gradually rises, reaching 30 percent of those 60-to-69 years old and more than half of those 75 or older. The median age of people with a disability is 50, compared to 34 for those without a disability.<sup>4</sup>

### INCIDENCE OF DISABILITY BY AGE IN ARIZONA, 2000

Disability	Lowest Incidence		Highest Incidence	
	Age Group	Incidence	Age Group	Incidence
Sensory	5-9 & 10-14	1.2%	90+	49%
Physical	5-9	1.0	90+	67
Mental	25-29	2.6	90+	41
Self Care	15-19	0.7	90+	43
Go Out on Own	25-29	5.0	90+	62
Work	16-19	7.8	90+	51
TOTAL	5-9	4.7	90+	83

Source: <http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabledreport.pdf>

Veterans: Although no statistics were found for veterans in Arizona with disabilities, national statistics from the Census Bureau reports that the oldest veterans had the highest disability rates in 2000. Almost 3 of every 10 veterans (29.1) have disabilities. However, 1 in 3 Korean War veterans (33.6 percent) and almost 1 in 2 World War II veterans (45.2 percent) have disabilities. Approximately 1 in 4 Vietnam veterans (24.8 percent) has a disability. The disability rates for those who served most recently, from September 1980 to July 1990 or in August 1990 or later, were the lowest, at 18.2 percent and 16.3 percent respectively. If the civilian population for Arizona is 3,747,180 from the Census Bureau as of 2000 and the veteran population is 15 percent for Arizona, there are estimated to be 562,916 veterans in Arizona.<sup>5</sup>

Children: The 2005-2006 National Survey of Children with Special Health Care Needs states that there are 201,608 children who have special health care needs in Arizona. This makes up

<sup>4</sup> W.P. Carey School of Business, Arizona State University, Disabled Report – Arizona State University web site - <http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabledreport.pdf>

<sup>5</sup> U.S. Census Bureau 2000, Census 2000 Brief, May 2003, Christy Richardson and Judith Waldrop-  
[www.census.gov/prod/2003pubs/c2kbr-22.pdf](http://www.census.gov/prod/2003pubs/c2kbr-22.pdf)

12.5 percent of the population. Of these, 7.9 percent are 0-5 years old, 14 percent are 6-11 years old and 15.8 percent are ages 12-17.<sup>6</sup>

Even after adjusting for age, the socioeconomic, household, and housing profiles for people with disabilities differ from those who do not have disabilities. In particular, the population with disabilities has a lower average income, with a lower labor force participation rate and a higher unemployment rate.<sup>7</sup>

## Employment

Based on estimates from the American Community Survey 2005, the Personal Assistance Services and Disability Information organization estimates there were 775,000 people in Arizona with disabilities. Of the 775,000 people with disabilities, 53 percent or 414,000 people are between the ages of 18 and 64. Of the 414,000, 159,000 are employed, 25,000 are unemployed but in the labor force and 228,000 are not in the labor force (2,000 unreported).

Subject	Total Population (Thousands)	With a disability (Thousands)	With a disability (Percent)
<b>Employment (Ages 18-64)</b>			
Employed	2,504	159	6.4%
Unemployed (in labor force)	157	25	16.3%
Not in labor force	843	228	27.1%

Source: [http://pascenter.org/state\\_based\\_stats/state\\_statistics\\_2005.php?state=arizona](http://pascenter.org/state_based_stats/state_statistics_2005.php?state=arizona)

## ***How many people in Arizona rely on durable medical equipment?***

Specific data regarding the total number of people in Arizona that rely on durable medical equipment is not available. The information below provides only an indication based on the number of people who are Medicare-or Medicaid-eligible. Specific information about people accessing DME through state-administered programs is provided; however, it is important to note that this represents only a portion of those actually accessing durable medical equipment services. This information does not include users of DME who are insured by Medicare, private insurance companies or people who privately pay for their durable medical equipment.

### Private Insurance

The Arizona Department of Insurance lists 26 private health insurers in Arizona that have 2,500 enrollees or more as of December 2006. The top 26 companies providing health insurance have 1,486,277 enrollees approximately 78 percent of the market. This includes small business groups, other groups, and individuals but does not include Medicare or other partial benefit policies. It is not known how many of these enrollees access durable medical equipment.

### Top 26 Health Insurers in Arizona

- AETNA Health, Inc.
- AETNA Life Insurance Company
- American Community Mutual Insurance
- American Medical Security Life Insurance
- American Republic Insurance Company
- John Alden Life Insurance Company
- Lifewise Health Plan of Arizona, Inc.
- Madison National Life Insurance Company
- Mega Life and Health Insurance Company
- Mid-West National Life Insurance

<sup>6</sup> 2005 / 2006 National Survey of Children with Special Health Care Needs – Arizona Chart book Page

<sup>7</sup> W.P. Carey School of Business, Arizona State University, Disabled Report – Arizona State University web site - [http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabled\\_report.pdf](http://wpcarey.asu.edu/seidman/ccpr/PDFs/disabled_report.pdf)

- Blue Cross and Blue Shield of Arizona
- CIGNA HealthCare of Arizona
- Connecticut General Life Insurance
- Golden Rule Insurance Company
- Health Net Life Insurance Company
- Health Net of Arizona, Inc.
- Humana Health Plan, Inc.
- Humana Insurance Company
- Company
- Pacificare Life Assurance Company
- Pacificare of Arizona, Inc.
- Principal Life Insurance Company
- Standard Security Life Insurance Company
- Time Insurance Company
- TrustMark Life Insurance Company
- United HealthCare Insurance Company
- United HealthCare of Arizona, Inc.

**Medicare Enrollment**

According to the Centers for Medicare and Medicaid services, in Arizona there were:

- 681,174 individuals enrolled in Medicare as Aged Beneficiaries as of July 2006, the vast majority of which (643,472) were enrolled in both Part A (hospital coverage) and Part B (supplemental medical insurance.)
- 122,390 individuals enrolled as Disabled Beneficiaries as of July 2006. Of the 122,390, 15,730 were enrolled in Part A (hospital coverage) only and 106,660 enrolled in both Part A and Part B (supplemental medical insurance.)

In addition to Part A and Part B Medicare coverage, Part C, Medicare Advantage Plans is also available. Medicare Advantage Plans are health plan options (such as HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans.” Medicare pays an amount for your care every month to these private health plans. Medicare Advantage Plans must follow rules set by Medicare. Medicare Advantage Plans aren’t supplemental insurance.<sup>8</sup>

Medicare Prescription Drug Coverage (Part D) is designed for people in the original Medicare Plan. Part D provides an option of adding prescription drug coverage by joining a Medicare Prescription Drug Plan. These plans are available through private companies that work with Medicare to provide prescription drug coverage.<sup>9</sup>

**Medicaid Enrollment - AHCCCS**

The Arizona Medicaid Program, administered by the Arizona Health Care Cost Containment System (AHCCS) includes both acute care coverage and long-term care coverage. Durable medical equipment is an eligible service in both programs.

The enrollment for persons in the acute care program in Arizona was 901,585 as of June 2008 and for KidsCare, 66,314. The enrollment in the Arizona Long-Term Care System (ALTCS) as of April 2008 was 42,971.<sup>10</sup>

**AHCCCS Acute Care, KidsCare and ALTCS Enrollment by County**

County	Acute Care Enrollment June 1, 2008	KidsCare Enrollment May 2008	Long Term Care Enrollment April 2008
Apache	4,655	860	373
Cochise	23,108	892	1,153

<sup>8</sup> Medicare and You, 2008, CMMS, p 37

<sup>9</sup> Medicare and You, 2008, CMMS, p-38

<sup>10</sup> AHCCCS web site

County	Acute Care Enrollment June 1, 2008	KidsCare Enrollment May 2008	Long Term Care Enrollment April 2008
Coconino	16,358	1,289	679
Gila	8,188	494	426
Graham	6,206	282	224
Greenlee	909	39	46
La Paz	3,059	42,872	112
Maricopa	514,661	1,563	25,953
Mohave	38,270	1,551	1,267
Navajo	13,386	8,525	576
Pima	155,816	1,977	7,035
Pinal	32,975	919	1,983
Santa Cruz	12,807	2,207	378
Yavapai	28,245	2,688	1,666
Yuma	42,942	176	1,100
<b>TOTALS</b>	<b>901,585</b>	<b>66,314</b>	<b>42,971</b>

Source: AHCCCS web site: [www.azahcccs.gov/statistics](http://www.azahcccs.gov/statistics)

There were 123,012 AHCCCS-eligible individuals using durable medical equipment for the period of July 1, 2006 through June 30, 2007. A total of \$55,683,039 was paid by AHCCCS (Medicaid) during this timeframe for durable medical equipment, including replacement equipment and repair expenses.

#### AHCCCS – DME Consumers and Costs

Program	Medicare/Eligible	Total Members (Unduplicated)	Paid Amount
	With Medicare	10,867	\$5,076,972.73
	Without Medicare	97,381	\$32,735,224.12
Acute	Subtotal	107,922	\$37,812,196.85
	With Medicare	9,017	\$4,183,066.32
	Without Medicare	6,740	\$13,687,776.67
ALTCS	Subtotal	15,621	\$17,870,842.99
<b>Total</b>		<b>123,012</b>	<b>\$55,683,039.84</b>

Source: AHCCCS, May 2008

Note: 1. All costs exclude medical supply

Among the users of durable medical equipment, there were 10,185 individuals who received wheelchairs, including power wheelchairs. During the July 2006 through June 2007 timeframe, AHCCCS paid \$5,699,857 for wheelchairs including replacement equipment and repair expenses.

#### AHCCCS – Wheelchair DME Consumers and Costs

Program	Medicare/Eligible	Total Members (Unduplicated)	Paid Amount
	With Medicare	2,038	\$506,055.65
	Without Medicare	3,543	\$1,561,658.89

Acute	Subtotal:	5,526	\$2,067,714.54
	With Medicare	2,779	\$821,285.89
	Without Medicare	2,022	\$2,810,856.59
ALTCS	Subtotal:	4,776	\$3,632,142.48
Total:		10,185	\$5,699,857.02

Source: AHCCCS, May 2008

Note: 1. All costs exclude medical supply

### **ADHS Children's Rehabilitation Services (CRS)**

The CRS program serves children with special health care needs based on specific diagnoses. From January 2008 through March 2008, CRS served 20,465 children. Of those, 17,172 were AHCCCS-eligible and 3,293 were not AHCCCS-eligible.<sup>11</sup> The level of DME usage among the children served is not known; however, the nature of the eligible diagnoses indicates the likelihood that most of the children require some level of DME support.

### **ADES Division of Rehabilitation Services – DME Consumers**

In calendar year 2007, the ADES/RSA served 4,182 persons with significant physical limitations, 178 persons using or potentially using adaptive aids and devices (communication prostheses) and 1,539 persons with deaf or hard of hearing as their primary disability. These three categories represent the larger number of potential users of DME equipment.

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<sup>11</sup> [www.AZDHS/OC SHCN.gov](http://www.AZDHS/OC SHCN.gov)

## THE CURRENT SYSTEM OF DME SERVICE DELIVERY

The current system of DME service delivery is likely a microcosm of the larger health care system. In a word it is complex. The system involves multiple layers, players, policies, and approaches to accessing durable medical equipment. Inherent in this complexity is the absence of predictability for the consumer of services, since policy and practice vary among insurers and DME suppliers.

As a consumer of durable medical equipment, the lack of predictability regarding answers to specific questions and processes to be followed depends on:

- whether individuals privately pay for their durable medical equipment;
- the insurance carrier, public or private, and what services are covered. If both primary and secondary insurers are involved, the allowable service and cost arrangements for both carriers;
- the consumer's shared responsibility for costs based on individual coverage;
- the policies and practices of the insurers;
- the accessibility of DME suppliers based on the insurer's network of suppliers and where a person lives in Arizona;
- the policies and practices of the DME supplier; and
- the specific needs of the individual consumer.

*"Patient's who pay privately for services typically have a more efficient and effective experience. Additionally, the end user has ultimate control of the entire transaction."*

*...Task Force Member*

### **Organizations Involved in the Service Delivery System**

Depending on the individual consumer's insurer and DME supplier, the knowledge and skills needed to navigate the delivery system successfully must include understanding of policy and practice at each level. In addition to the consumer, there are potentially five separate organizations involved in the delivery of durable medical equipment and services: the primary insurer, a secondary insurer, medical personnel, the DME supplier and potentially the DME manufacturer.

Health Insurers– Private Health Insurers, Medicare, Medicaid, Military and other government health insurance programs are the major insurers of DME. Insurers include Health Maintenance Organizations and Preferred Provider Organizations. In addition to Health Plans that private insurers may contract with, AHCCCS contracts with nine Acute Care Health plans and nine ALTCS Program Contractors.

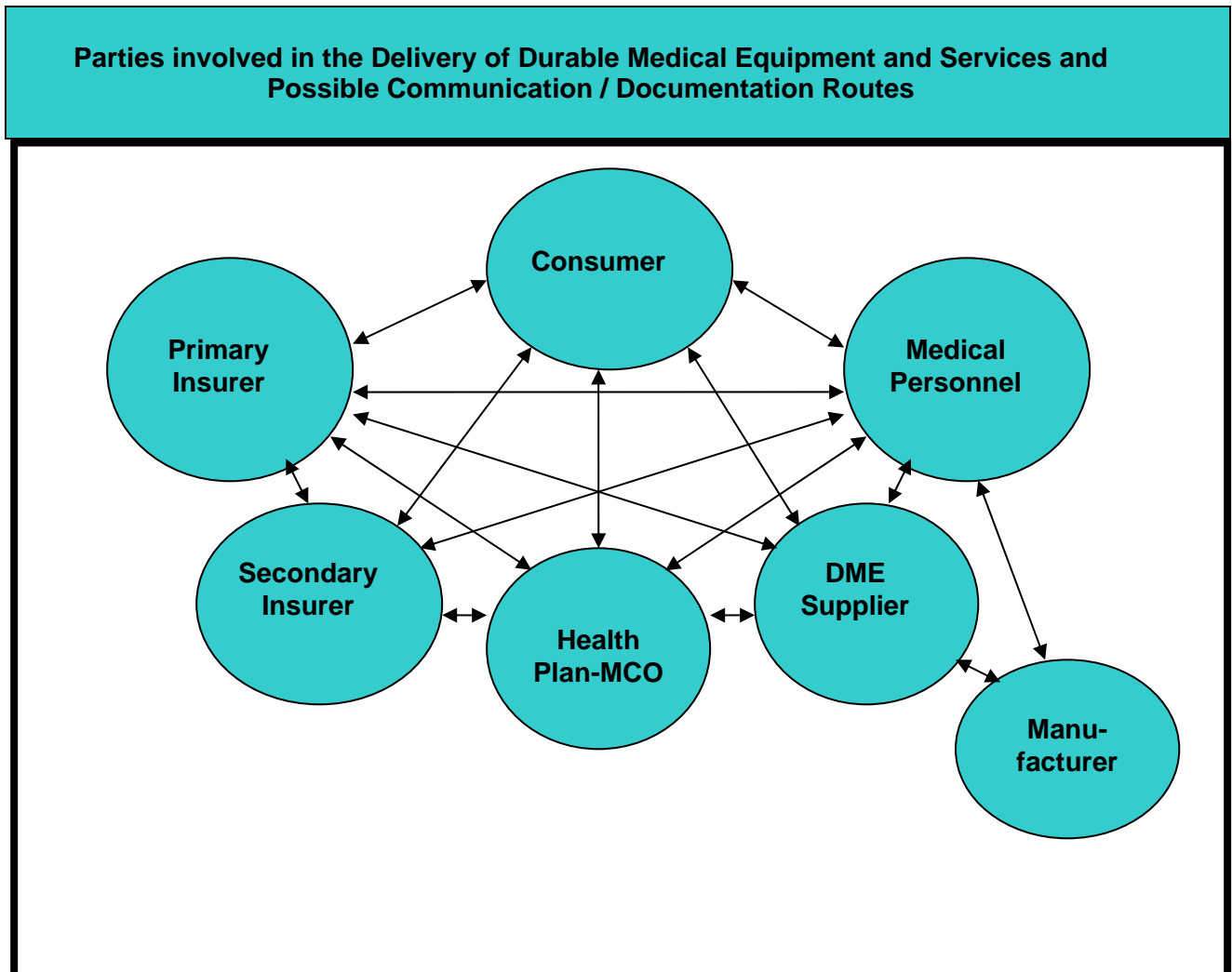
Acute Care (Health Plans)		Long Term Care Program Contractors (Health Plans)
APIPA		Cochise
Care First		DES Division of Developmental Disabilities
Health Choice Arizona (HCA)		Evercare
Maricopa Health Plan (MHP)		Mercy Care
Mercy Care		Pima Health Systems
Phoenix Health Plan		Pinal Gila Long Term Care
Pima Health Systems		Bridgeway
University Family Care (UFC)		SCAN
DES – CMDP - serving Foster Children		Yavapai Long Term Care

Source: [Azahcccs.gov/Statistics/Enrollment/Acute.asp](http://Azahcccs.gov/Statistics/Enrollment/Acute.asp)

Medical Personnel – This includes the primary care physician, specialty physicians, physical and occupational therapists, seating evaluation specialists, health care facilities, etc.

DME Suppliers – Two hundred twelve suppliers were identified in Arizona based on an internet search. The actual service provided varies greatly from full DME service, to specialties such as prosthetics, respiratory equipment and services and/or general medical supplies.

DME Manufacturers – Depending on the equipment needed, a manufacturer may be part of the process to secure DME.



***Timelines and Steps in the Process – An Example***

As an example of the service delivery process, the following chart depicts the key steps, responsible parties, actions needed, likely timeframes and causes for delays in obtaining a specialized, customized wheelchair, one of the primary presenting issues that resulted in the formation of the Task Force. The overall timeline in this example is approximately five to six months not including time needed for suppliers to be reimbursed which could be an additional 45 to 90 days.

Step	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
1. Referral to supplier, receipt of prescription & schedule evaluation	█								
2. Evaluation and Recommendations	█	█							
3. Preparing Documentation for Prior Authorization.			█						
4. Detailed Prescription.			█						
5. Submit Documentation for Prior Authorization.				█					
6. Prior Authorization Decision.				█					
7. Decision Received.				█					
8. Order & receive equipment.					█				
9. Deliver equipment						█	★		
10. Supplier receives payment (if fee for service).							█	█	█

Since there are many variables in the system as described above, the chart cannot be viewed as “fact” for every consumer’s experience but does provide an indication of the steps and specialties involved in obtaining complex rehabilitation equipment.

Steps in the Process	Actions Involved	Timeline (business days)	Notes/ Complications / Barriers
Step 1. Referral to the Supplier, receipt of the prescription and scheduling of the evaluation.	<ul style="list-style-type: none"> <li>a. Referral may be a fax or a phone call from the insurer or physician</li> <li>b. Intake Process: Supplier must verify eligibility and benefits</li> <li>c. Supplier must verify that the consumer is covered by a plan they are contracted with for DME</li> <li>d. Obtaining the prescription from the Physician</li> <li>e. Obtain prior authorization to go forward with the request</li> </ul>	<p>Consumer to receive first contact within 24-48 hours</p> <p>4 to 20 days from referral to scheduling of the evaluation</p> <p>Prior Authorization timeline is 14 days and the</p>	<ul style="list-style-type: none"> <li>1. Change of insurer</li> <li>2. No longer eligible for coverage</li> <li>3. Multiple insurers – coordination of benefits</li> <li>4. Client availability to schedule physician appointment.</li> <li>5. Physician availability</li> </ul>

Steps in the Process	Actions Involved	Timeline (business days)	Notes/ Complications / Barriers
		health plan may request an extension to 28 days.	
Step 2: Evaluation and preparation of the Recommendations	<ul style="list-style-type: none"> <li>a. If seating clinic – scheduling OT, PT and RTS</li> <li>b. Conduct evaluation</li> <li>c. Prepare assessment report and define recommended equipment – coding and pricing</li> <li>d. The occupational therapist, physical therapist or RTS may conduct a home environment assessment depending on the consumer's circumstances and insurance coverage for this assessment.</li> <li>e. Reconfirm eligibility / insurance</li> <li>f. Send the request to the Physician</li> </ul>	30 - 45 days	<ul style="list-style-type: none"> <li>1. Availability of OT / PT to conduct the assessment.</li> <li>2. Availability of the consumer.</li> </ul> <p>(Best to have OT/PT and RTS involved)</p>
Step 3: Compiling information for the Letter of Medical Necessity and Prior Authorization Request <ul style="list-style-type: none"> <li>▪ OT/PT Assessment</li> <li>▪ RTS recommendation</li> <li>▪ Client History / Physician Chart Notes</li> <li>▪ Home Environment Assessment</li> </ul>	<ul style="list-style-type: none"> <li>a. Patient history and chart notes from the physician</li> <li>b. Conduct the Face-to-Face (consumer and physician)</li> <li>c. Physician's Office provides the supplier with the history and chart notes and the supplier puts the packet together.</li> </ul>	2 weeks	<ul style="list-style-type: none"> <li>1. Delays in obtaining information from the Physician</li> <li>2. Delays in scheduling Face to Face</li> </ul>
Step 4. Obtaining detailed Prescription from the Physician.	<ul style="list-style-type: none"> <li>a. Supplier compiles all information needed and prepares the packet for the Physician.</li> <li>b. The therapist (typically but sometimes the RTS or Physician) prepares the Letter of Medical Necessity and Request for Prior Authorization.</li> </ul>	5 days	Delays in review and approval by the Physician
Step 5. Submit documentation to obtain Prior Authorization	<ul style="list-style-type: none"> <li>a. Supplier compiles all information and sends to insurer</li> <li>b. Submit Letter of Medical</li> </ul>	24 – 48 hours to compile and submit	Coordination of Benefits Issues - If prior authorization is not required as in Medicare, and the item is not covered,

Steps in the Process	Actions Involved	Timeline (business days)	Notes/ Complications / Barriers
	Necessity, Plan of Care and Prior Authorization request to the primary insurer and the secondary insurer, as appropriate.		may submit billing in order to get a denial so the secondary insurer can be considered.
Step 6. Prior Authorization Decision	Insurer Prior Authorization Staff	14 days and the insurer/health plan may request an extension to 28 days.	
Step 7: Decision received	Decision is faxed or called to the Supplier with an authorization number		Must have decision from all insurers and if not approved by all – contact the consumer to determine if they are able to pay the part not covered.
Step 8: If approved - Order Equipment  If Denied, notify consumer (they should have received the denial letter).	Order the equipment  Consumer to determine if they want to appeal the decision – they have 30 days	4 weeks from order to delivery	Dependent upon the equipment being ordered.  Consumer needs specific information about how to appeal the decision.
Step 9. Deliver the equipment to the consumer.	<ul style="list-style-type: none"> <li>a. Assemble equipment when received from manufacturer</li> <li>b. Re-confirm insurance coverage prior to delivery</li> <li>c. Schedule client to come in for delivery</li> <li>d. Deliver to home</li> <li>e. Provide training</li> </ul>	30 days from receipt by the supplier to delivery to the consumer	<p>At times the consumer does not have the ability to pay the co-pay which delays delivery.</p> <p>Difficulties with the consumer coming to the shop. Delivery is better at the shop so the technicians, tools for adjustments, etc. are readily available.</p> <p>Arranging Transportation</p> <p>For complex rehab equipment – the consumer does need to come in to the shop.</p> <p>For less complex equipment, delivery can be at home.</p>
Step 10. Reimbursement to the Supplier	<ul style="list-style-type: none"> <li>a. Submittal of Claim by supplier.</li> <li>b. Processing of Claim</li> <li>c. AHCCCS Capitated Supplier – encounter to be</li> </ul>	Medicare – 45 days AHCCCS - Fee for Service –	

Steps in the Process	Actions Involved	Timeline (business days)	Notes/ Complications / Barriers
	submitted. d. Reimbursement	average 90 days	

### **Strengths and Weaknesses of the DME Delivery System**

Through Key Informant Interviews with a representative group of Task Force members, multiple strengths and weaknesses within the system were identified. Addressing the weakness by building on the strengths of the overall system resulted in identification of the opportunities to improve the system; i.e. the recommendations.

Following is a summary of the strengths and weaknesses from varying perspectives.

*Recently the supplier did a great job as compared to years ago; Perfect! Chair and process were excellent. ... DME Consumer*

#### **Strengths**

- Suppliers are delivering to the hospital and to the person's home.
- From an insurer standpoint, the DME Delivery System is fairly economical. Capitated contracting affords considerable control over the utilization, and a more manageable claims budget.
- From a contracted supplier standpoint, the capitated contract mechanism places the overall quality control of services strictly with the supplier.
- Regular, routine supplies are timely.
- DME suppliers want to be helpful. They want to give their customer what they want.
- DME suppliers are friendly and accept responsibility.
- Some providers / insurers have established their own standards for DME.
- The people who are actually providing the direct service – mechanics, technicians, evaluators. They truly understand, are concerned and want the process to go well.
- Having ALTCS case management involvement which provides a direct contact with the insurer.
- The data system is good.
- Prior Authorization Requests can be tracked as they proceed through the approval process.
- Suppliers partner with the Children's Rehabilitation Services sites and children can see the supplier with the site staff present allowing others who know the child to be present and allowing the child to be seen in an environment where they are comfortable.
- Pay is fair.
- Pay is timely.
- The repairs did work once they were done.
- Suppliers come and talk with case managers.
- Good companies will bring in the needed equipment, even when it is not their client.

**Weaknesses** – Detailed information regarding weaknesses is included in the next section, Presenting Issues in the Current System.

- Slow, incomplete and non-responsive communication among all parts of the system. Long wait times on the phone, lack of response.
- There needs to be more communication between patient, caregiver, and discharge planners.

- Changes in prescriptions and substitution without communication with the professional writing the prescription.
- Health insurers not clear about their coverage with regard to amount and type of coverage.
- Contract requirements for doing business with the State are onerous for small vendors
- Poorly structured allowable costs and/or fee schedules
- Procedures and protocols for documentation are costly, time consuming and lengthy.
- Too much paperwork
- When a child is AzDES/DDD and ALTCS eligible, the acute care health plans are inconsistent when referring the child to CRS
- Limited choice of vendors/suppliers
- Lack of preventative maintenance on equipment
- No standard timelines for getting repairs complete

### ***Presenting Issues in the Current System***

Through the community forum held in October 2007, Task Force deliberations and real life experiences from consumers, the presenting and persistent issues to be addressed included communication, limited access, delivery delays, repair quality and delays, and seating evaluations.

### **Communication**

*“In November 2007, my case manager and my physician approved a Roho cushion for my shower commode. Today is February 1, 2008 and I still do not have the new cushion. I have received calls from two DME supplier representatives, including a woman who told me that Roho shower seats are not made anymore. My choices were a flat cushion without any opening or a wrap around piece that snaps to the existing shower seat. Not knowing better, I selected the wrap version and was told it was being ordered off the internet. That conversation was in early January. My own research led me to the Roho website and to a 16 inch shower commode seat with a hole in the middle.”*

*Update: Approximately a week after this letter was hand delivered to the supplier, the 16 inch Roho cushion with a hole in the center was delivered to my home.  
DME Consumer Correspondence*

### Stakeholder Description of the Issue

- There are long wait times on phone calls and/or it takes several calls to speak to the appropriate person.
- Always had to talk with someone new.
- People responding to inquiries are not well trained.
- Insurers in general need to be more specific in their coverage with respect to amount and type of coverage.
- Consumers need to understand their specific plans and what to expect from their plan.
- Suppliers do not notify consumers when something is going to be delayed or is not going to happen.
- Can't talk to a person, only a recording or you can't talk to the right person.

### **Limited Access**

*If the customer had more choice, the market / customer would create better services. Now customers can't choose another provider if they are getting poor service.  
DME Consumer*

#### Stakeholder Description of the Issue

- Most suppliers don't stock a lot of products.
- Having only two suppliers on contract with the health plan is not enough. They have too much to do and don't have good service records. Patients have no choice to replace poor vendors.
- Insurers typically limit supplier selection to contain costs and or defer services. Certainly limiting access to providers not only defers claims but diminishes the level of service.
- After 6 months waiting, I still received the wrong chair.
- Wanted another provider – had to go out of network.
- Contract requirements for smaller suppliers are onerous.
- Consumer perspective is that the system is without competition.
- Select suppliers have a monopoly. I have Medicare and can go anywhere, but other companies can't compete with the big supplier companies. Competition will bring better results.
- The delays and poor quality occurs more frequently when limited choice of suppliers is prevalent. There is no disadvantage to lower levels of service in the monopolistic model.

#### **Delivery Delays**

*"As a child you have the option of being carried, as an adult you don't have that option - you are stuck."...DME Consumer regarding their inability to obtain their wheelchair in a timely manner*

#### Stakeholder Description of the Issue

- A. Discharge from hospital or other facility without ordered equipment:
- Typically made to order equipment requires 5-10 working days from date of order before delivery can be made. Equipment that has not yet been authorized for coverage is not ordered.
  - Can't bill for the equipment until the person is discharged.
  - Ready-made items (off the shelf) should be delivered prior to discharge.
  - Frequently confusion exists as to the correct supplier we can use to provide the services.
  - Often patients are confused and reluctant to purchase non-covered items, believing coverage should exist because of poor insurer communication with the insured as to their plan limitations.
  - Since patients cannot go home with substitute equipment, discharge can be delayed. Not only does the patient not get to be in their own home sooner, the insurer frequently denies payment for the additional days in the hospital or rehabilitation facility as beyond medically necessity.
- B. Changes in prescription / substitution without communication with the professional writing the prescription:
- Consumers are not being assessed correctly – trying to find qualified people to complete the seating evaluation is difficult. If the person conducting the assessment doesn't have the correct skills or knowledge of the equipment we end up with errors, wrong equipment, delays, and many phone calls.

- This issue is becoming commonplace among MCOs where their allowed reimbursements are significantly lower than the Medicare Fee Schedule. Reimbursement rates often cut 30% off Medicare Fees to achieve savings of non-provision by their providers. For example:
  - Roho High Profile Cushion:
  - HCPCS Code: K0734
  - Retail Price: 409.00 Ea
  - Supplier Cost: 245.40 + Freight: \$7-\$12 Ea
  - Medicare Allowable: 331.47
  - MCO (Medicare -30%): 232.02
  - Gross Margin: (-8%)
- In the situation described above, there is a significant force in the practice of substitution.

C. Poorly structured allowable costs and /or fee schedules:

- It is confusing because there are so many fee schedules and/or different coverage limits.
- Structuring low fee-for-service (FFS) reimbursement rates is one of the two top strategies in deferring or restricting certain types of products or services.
- There are delays in receiving payment from the insurers.
- Capitation is another effective way to restrict services, defer payments, and limit services. Not only are services deferred as a profitability measure, but typically very low quality products are utilized. Under this methodology the provider has more control over the provision of services.
- Medicare sometimes downgrades a request.
- Delays are caused in the time it takes to work out coordination of benefits.

D. Procedures and protocols for related documentation are costly, time consuming, lengthy and onerous.

- Supplier may be adding documentation requirements – resulting in more barriers / delays.
- Need for documented medical necessity initially is reasonable, however; the requirement for continuous documentation relating to the same condition is excessive, costly, time consuming, and often unnecessary.
- The consumer's medical conditions may, over time, result in greater dependence on products and services resulting in re-documentation of needs.
- The process often includes action to be taken by 3-5 entities. (Patient, Doctor, Therapist, Insurer, and Supplier) Rarely can all of these participants perform their parts in a timely manner.
- Length of time for order between insurance, physician, DME supplier and consumer is too long - accountability is needed – the process could be better.

## Repair Quality and Delays

*I am very tired of my life coming to a grinding halt every time my wheelchair goes in for repairs. On April 2<sup>nd</sup> my manual wheelchair was picked up by the supplier to fix the left arm which had broken. I also requested replacement hand grips for the wheels, for the left brake to be adjusted and tightened, and finally the possibility of a new cushion. On April 21<sup>st</sup> I called them to see what the status was and was told they were just waiting for parts so it should be 7 to 10 days. On May 2<sup>nd</sup> I called to see if it was done. The answer was no, and there were no notes in the system about my call on the 21<sup>st</sup>.*

*On May 5<sup>th</sup> I call them again. Come to find out not only had the parts NOT been ordered, but the insurance hadn't even been contacted yet for approval. To top that*

*apparently I have to have a whole different prescription for a new cushion, that the one my doctor sent for repairs wasn't sufficient for that.*

*I informed them that I haven't been to the pharmacy, the grocery store, or the doctor for over a month, all of which I'm in desperate need of doing. The representative asked if I wanted a loaner but they don't have loaners where the wheels come off so I can't get it into my car, which means the loaner is useless to me.*

*... DME Consumer*

*Update: The supplier went to the consumer's home to address the immediate needs the day after the consumer's correspondence was sent to supplier management by an advocacy organization.*

#### Stakeholder Description of the Issue

- Currently there are no automatic maintenance programs for DME.
- There are too many steps in the process to get a part. Have to order it, it is paperwork, order, get the part, wait for scheduling, etc.
- Typically services are performed on an as needed basis. The end users can make much of the maintenance schedules. Again funding restrictions exist and delays in authorizations
- Having back up equipment in town is a problem.
- Vent wasn't functioning, Should be able to respond with back up vent.
- Getting an appointment.
- Minor repairs are ignored and later become major repairs.
- Too many consumers not enough staff or suppliers.
- Who is fixing this equipment? Are there enough trained people?
- Documentation and funding restrictions are the most common causes for delay.
- Uncertainty with respect to reimbursement rates. Fee schedules are unavailable or HCPCS codes insufficient to describe services. No method to predict the outcome. Arduous to compile all needed replacement parts under the existing HCPCS code structure.
- Documentation for even simple repairs may be overwhelming.
- Not keeping adequate inventory of supplies and parts.
- Huge to get the simplest repairs authorized.
- Some people buy the parts and do the repairs themselves.

### **Seating Evaluations and Clinics**

#### Stakeholder Description of the Issue

- It is difficult (sometimes not possible) to find and schedule a seating evaluation with a qualified therapist and complete it within the 45 days.
- There is not a clearly defined set of standards / requirements for who can conduct seating evaluations; i.e. what are the qualifications.
- Seating assessments / evaluations are not always part of the accepted practice for obtaining the correct wheelchair.
- Seating Clinics or evaluations are not available statewide or regionally resulting in consumers and families not being able to access the clinics and/or traveling great distances – sometimes to find out the clinic has been cancelled.
- There are changes in the evaluation recommendations from the therapist's evaluation once it is submitted to the insurer or DME supplier.
- Lack of quality assurance following delivery of equipment. If the equipment is not correct / not working for them - there is no quality assurance required to ensure the equipment is working for the consumer after the equipment has been delivered.

## **Key Findings Relevant to the Issues**

**Quality Assurance** – While suppliers, insurers, and state agencies have quality assurance / quality management plans, information specific to utilization and the quality of the provision of DME services was limited or non-existent.

- Questions specific to DME or wheelchairs have not been included in consumer satisfaction surveys with the exception of AzDHS Children's Rehabilitation Services who distributed a DME Customer Satisfaction Survey in the Spring of 2008.
- No information is available regarding the number and resolution of grievances or appeals regarding DME.
- While some insurers and DME suppliers indicated they do have standards for timeliness and quality that they monitor, system wide standards that are monitored and published do not exist.

**The Need for Prescriptions for Repairs** - Medicare and Medicaid do not require a prescription for repairs; however, consumers are frequently required to obtain a prescription from their physician, even for minor repairs such as a wheelchair wheel replacement. Medicare defines repairs, maintenance and replacement as<sup>12</sup>:

Repair: To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. However, do not pay for repair of previously denied equipment or equipment in the frequent and substantial servicing or oxygen equipment payment categories. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

Maintenance - Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered. The owner is expected to perform such routine maintenance rather than a retailer or some other person who charges the beneficiary.

Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment

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<sup>12</sup> [www.cms.hhs.gov/manuals/downloads/bp102c15.pdf](http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf)

not available to the beneficiary. Do not pay for maintenance of purchased items that require frequent and substantial servicing or oxygen equipment. Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for maintenance of rented equipment are generally not covered. Payment may not be made for maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items. For capped rental items which have reached the 15-month rental cap, contractors pay claims for maintenance and servicing fees after 6 months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. See the Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS)," for additional instruction and an example. A new CMN and/or physician's order is not needed for covered maintenance.

**Replacement** - Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this section.

Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood). A physician's order and/or new Certificate of Medical Necessity (CMN), when required, are needed to reaffirm the medical necessity of the item.

**Grievance and Appeals Processes** - Grievance and appeals processes and timelines differ among insurers and DME suppliers. The processes, consistent with the overall service system, involves multiple organizations, timelines and steps. The distinction between grievances and appeals is often not clear to consumers of DME. Individuals with private insurance coverage may file a complaint / grievance with their DME supplier, insurance carrier and/or with the Arizona Department of Insurance. Individuals with Medicare coverage may file a grievance or with the supplier and may appeal a Medicare decision directly to Medicare. Individuals with Medicaid coverage may file a grievance with AHCCCS, their health plan or program contractor and/ or with their DME supplier. Appeals, the process to question a specific denial or modification of services are to be filed with the organization that made the decision. Appeal timelines vary and often include opportunities for extensions of the timeline for response.

**Choice of DME Suppliers** – The lack of choice in selection of DME suppliers was identified by multiple stakeholders. The following information identifies a sample of the circumstances where choice is limited:

- At three of the four Children's Rehabilitation Services Clinics there is only one DME supplier and at the fourth Clinic there are two.
- Phoenix Health Plan reported having one DME provider
- Mercy Care identifies 11 DME suppliers on their web site: three of which provide an array of DME, one of the three is located in Tucson. The remaining eight companies are either wholesale distributors, manufacturer, medical equipment rental company, specialize in equipment related to diabetes, or orthopedic products.
- Care 1<sup>st</sup> lists five DME providers on their web site: three specific to diabetic products, one patient support systems and medical equipment rentals and one general DME provider.

**Repair Delays** – In addition to multiple consumer reports of delays, two DME suppliers reported having about 100 wheelchairs each in their shops for repair and additional consumers waiting – with their chair still at their home.

**Capitation Rates** - Depending on the insurer and the service, DME suppliers may be reimbursed on a per member per month (capitation) basis or based on a fee for service schedule. The degree to which private insurers may capitate or pay fee for service is not known. Following is information about capitation in the public system of health care.

- Medicare is not a capitation system; therefore reimbursements are based on the Medicare fee for service schedule.
- AHCCCS capitates the Health Plans and Program Contractors (ALTCS) for all services covered under the managed care model. AHCCCS Plans and Program contractors report that they do capitate general DME and that they do not capitate specialized and/or customized DME.<sup>13</sup>
- DES Division of Developmental Disabilities reported that the following acute care health plans do not capitate DME – Mercy Care and Capstone. APIPA does capitate DME providers/suppliers including specialty wheelchairs. There are some exceptions to capitation for some name specific or brand name items. Care 1<sup>st</sup> does capitate DME for “ordinary DME (canes, crutches, walkers, manual wheelchairs, etc.) and specifically does not capitate power wheelchairs, scooters, repairs, and items not usually covered by AHCCCS such as bath seats, elevated toilet seats.
- ADHS, Children’s Rehabilitation Services currently capitates their statewide sub-contractor for all DME services.

**Medicare Implementation of Changes in DME Purchasing and Service Delivery** - Highlights of the new Medicare approach to providing DME are summarized below. The direction of Medicare is important to future planning to improve the Arizona system of delivery of DME since:

1. Arizona has thousands of Medicare beneficiaries
2. According to Task Force members and review of some current practices, private insurance companies generally follow the practices of Medicare
3. New Medicare requirements provided insight into possible approaches in Arizona.

Medicare has implemented DME provider standards, both administratively and at the service delivery level. Those standards may be found in Appendix C. As part of an overall change in how the Medicare program is administered, Medicare DME suppliers will be determine / selected through a competitive bidding process. This process is being phased in over the next several years and does not apply to Arizona at this time. An additional provision of the new Medicare requirements is that DME suppliers must be accredited.

Competitive bidding of Medicare DME services is potentially one of the most controversial provisions in the new approach. Currently in Arizona, the selection of DME providers is driven by which insurer provides the coverage. Medicare provides a list of participating DME providers and identifies other DME providers available to their beneficiaries. When and if, Medicare competitive bidding is implemented in Arizona there is potential for impact on the Medicaid and Private Insurer systems of providing DME.

**Licensing of DME Suppliers** – Approximately 20 States have some form of licensing of DME suppliers. The DME Task Force briefly discussed the possibility of licensing and developed the following pros and cons. Notably was the perspective that some issues with system

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<sup>13</sup> AHCCCS clarification regarding use of capitation, May 2008.

performance are capacity issues rather than quality of services rendered. The customer service aspect may be a capacity issue for insurers to address rather than taking the license of the vendor for poor customer satisfaction.

<b>Pros and Cons of Licensing DME Suppliers</b>	
Pros	Cons
○ Not all suppliers require accreditation – only vendors with AHCCCS Health Plans	○ Won't address bad business practices
○ Standards are already set for certain services – such as 4 hours for oxygen delivery after release from hospital – this would be consistent	○ Non-responsiveness isn't criminal – except when it results in health and safety issues
○ There would be consequences for substandard/dangerous services	○ Won't address capacity issues
○ Provides a vehicle for standards	○ Limits capacity and choice if the vendor's license is taken away or restricted
○ Quality increases if the license is at stake	

**Lack of Data** –Very little statistical data is available regarding DME consumers and the timeliness and quality of the delivery system. To effectively plan for and monitor delivery, the following information about utilization and quality is needed:

- Who are the consumers of DME and what is their satisfaction level – system wide?
- What supplies and equipment are most used and what is the level of utilization of DME?
- What is the impact financially, in employment, in health status, and in ability to live independently of delays in the DME delivery system?
- What are the actual performance data regarding timelines and quality?
- What are the system wide expenditures – all insurers, for DME?
- How many DME related grievances and appeals are filed and what were the outcomes of those actions?

## THE DESIRED DME SERVICE DELIVERY SYSTEM

“Superior Customer Service” is the vision of the Task Force. “Superior Customer Service” applies to and among all of the customers involved in the DME service delivery process; i.e. the consumers of DME and their family members, the physicians that prescribe DME, the suppliers who provide DME and the insurers who pay for DME.

### **System Characteristics**

To achieve “Superior Customer Service”, the desired system must include the following characteristics:

*Accountable* The system of services has clear expectations, checks and balances, methods to monitor status, and processes to identify issue areas and respond to those issues. All parties accept responsibility for their role in the system and in improving the overall service system.

*Choice* Customers have choices among providers and the ability to change providers when service is not meeting the customer’s needs.

*Communication* Consumers have ready access to individuals who can provide information about the status of a particular process.

*Consistent* Processes and timelines are standardized across the service system; i.e. consumers have information on which to base reasonable expectations, supplier and insurer processes and expectations are understood and applied routinely, as a way of doing business.

*Easy Access to Repairs* - Consumers have immediate access to repairs and maintenance.

*Efficient* Process requirements are streamlined to include the least amount of paperwork and steps that will achieve the most direct route to delivery of appropriate and high quality services and equipment.

*High Quality* Service delivery, specific equipment and services meet standards for effectiveness, timeliness, and efficiency throughout the DME system.

*Individualized* Actions to address DME needs are based on the circumstances of the individual customer and designed to respond to that individual, in their context.

*Ongoing Education* - Providers, consumers, physicians, insurance carriers, etc. all have access to current, relevant educational material about DME processes, opportunities, and changes.

*Rational* Processes and required steps are based on thoughtful, intentional actions that lead to the desired result.

*Respectful* All interactions and communications are mindful that each party to the action desires a positive result and differences in approach are acknowledged and incorporated into final solutions.

*Timely* The reasonable schedule of delivery is known and adhered to by all parties. Unanticipated delays are communicated among the parties.

## **Goals and Measurable Indicators of Success**

Although, improvement in the delivery of DME is likely a long-term effort, there are opportunities within the improvement process to positively impact services in the short term. To maintain a focus on the direction and results to be achieved Goals and measurable indicators of success have been defined.

### **Goals**

- Goal I: Communication: To provide direct, specific, and timely communication that is responsive to consumers, suppliers, medical personnel and insurers across the DME service system.
- Goal II: Standards and Practice Protocols: To improve the effectiveness of DME suppliers and insurers through a system of uniform standards, reasonable expectations, and streamlined processes.
- Goal III: Consumer Choice and Advocacy: To empower consumers of DME to be informed advocates through choice, education, and knowledge of the standards, practice, and policies of their insurer and DME supplier.
- Goal IV: Quality Assurance and Timeliness: To provide quality durable medical equipment within acceptable timeframes.
- Goal V: Training and Education: To provide clear and consistent training and education throughout the DME delivery system.
- Goal VI: Repairs and Maintenance: To complete durable medical equipment repairs timely and accurately and in settings which are respectful of and responsive to the needs of consumers.

### **Indicators of Success**

To measure progress toward the achievement of the Task Force Goals, measurable indicators of success were defined by the Task Force. For many of these indicators, current base line information will need to be established.

- Increase in customer satisfaction ratings specific to communication, timeliness and quality of services.
- Increase in customer satisfaction with repair timeliness and quality.
- Decrease the number of grievances received regarding “non-responsive” suppliers or insurers and the number related to delays in delivery.
- Increase consumer choice of DME suppliers with each of the insurers including AHCCCS, DES and DHS contracted health plans.
- Increase in consumer choice regarding DME suppliers / suppliers who can complete their DME repair.
- Decrease time required for processing requests from the physician to the supplier to insurer approval.
- Increased in education, knowledge of consumers regarding their covered services and the system of DME delivery.
- Decrease in the time required to have equipment repairs completed.

## RECOMMENDATIONS TO ENHANCE THE DME SERVICE DELIVERY SYSTEM

“Superior Customer Service” applies to and among all of the customers involved in the DME service delivery process; i.e. the consumers of DME and their family members, the physicians that prescribe DME, the suppliers who provide DME, and the insurers who pay for DME. The recommendations are intended to result in system change and should not be interpreted to mean that none of the actions are currently taking place - just that they are not taking place system-wide or at a level that results in “Superior Customer Service”.

**Goal I: Communication: To provide direct, specific, and timely communication that is responsive to consumers, suppliers, medical personnel and insurers across the DME service system.**

Recommendation 1: Implement methods to ensure consumers have information about the steps in the process of obtaining durable medical equipment and who to contact about DME questions at each of the Arizona State Agencies administering programs and services for people with disabilities.

Recommendation 2: Designate DME specific contact persons or department at insurers and suppliers. Insurers and suppliers will respond in a timely manner to consumer inquiries on the status of new orders or repairs and will have the ability to track delays and notify consumers of possible delays.

Recommendation 3: Develop a web-based forum for consumers to have easy access to information about available DME suppliers, performance of DME suppliers, and specialty DME suppliers and to communicate with each other about their “good DME experiences” as well as their “bad experiences”. Include in the web site the following information:

- educational material about the process of obtaining durable medical equipment, information about when and how to file a grievance or appeal,
- an advocacy protocol that can be duplicated and used by all consumers and advocacy organizations,
- the steps for acquiring durable medical equipment – including but not limited to specialized custom equipment to allow consumers to be able to track their equipment delivery process and advocate on their own behalf,
- who is responsible for what activities and within what timeframes at each step in the process including physicians, insurers, DME suppliers, DME manufacturers, and consumers, and
- supplier standards for service delivery.

Recommendation 4: Provide consumers with information at the time of delivery of wheel chairs about the warranty, how to register the warranty, equipment specific preventative maintenance needed, what will invalidate a warranty, and the consumers’ responsibility regarding care and maintenance.

- Provide a template for consumers to record specifics about their equipment, the maintenance history and the repair history.
- Include information about who to contact when a repair is needed.

Recommendation 5: Implement at the DME supplier level a system to track orders and repairs with the capacity to pin point where there are delays, to issue alerts internally within the supplier

organization and to notify consumers regarding delays. Additionally, the system should be able to provide aggregate reports on the status of meeting pre-determined expected timelines

Recommendation 6: Ensure communication occurs between seating evaluation therapists and supplier representatives before equipment is ordered when the recommendations of the therapist and supplier representative are different. Use a feature match approach when determining the right equipment to be provided.

Recommendation 7: A comprehensive research study be completed to provide data about the population in Arizona who use durable medical equipment, the level of utilization, the financial impact and the lifestyle impact of not being able to access DME (i.e. missed work, school, independent living) and the actual timelines required to access DME.

**Goal II: Standards and Practice Protocols: To improve the effectiveness of DME suppliers and insurers through a system of uniform standards, reasonable expectations, and streamlined processes.**

Recommendation 8: Clarify the rules and requirements that apply when a consumer has the ability and desires to pay, at their own expense, for equipment and disseminate the clarification and information about the process system wide.

- Clarify the possible implications, if any, from the standpoint of Medicare, Medicaid, private insurers, etc.
- Provide a standard form and process to be used by all DME suppliers for informing consumers of these implications and obtaining, if needed, their signature indicating their desire to purchase supplies and / or equipment on their own.
- Make this information available to consumers through web sites, newsletters, public forums.

Recommendation 9: Develop and adopt specific standards and performance indicators in quality, timeliness, and staff qualifications that will improve the effectiveness of DME service delivery.

- Establish uniform standards for “reasonable” timelines for each step in the DME process.
- Distinguish between routine durable medical equipment and specialized durable medical equipment.
- Staff qualifications to include level of experience with ~~which~~ specific populations and licensed occupational and physical therapists.

Recommendation 10: Require that DME suppliers be accredited and include their accreditation status in a published list of DME suppliers. (Note: DME suppliers that plan to do business with Medicare must be accredited by December 2009.)

Recommendation 11: Require that all DME suppliers have a Certified Rehabilitation Technology Specialist (CRTS), Assistive Technology Practitioner (ATP) and/or Assistive Technology Supplier (ATS) on staff, as appropriate to the DME services they provide.

- Research the availability of CRTS, ATP and ATS (oversupply, adequate, short-supply)
- Determine strategies to implement

Recommendation 12: Analyze existing data and establish across insurers and suppliers a higher, consistent dollar threshold before a repair event requires prior authorization and establish a prior authorization “fast track” for repairs that are estimated to be above the newly established threshold. For example, only repairs in excess of \$1,000 require prior authorization.

Recommendation 13: Establish a standard protocol regarding seating evaluations and seating clinics to include when seating evaluations are to be completed prior to ordering a wheel chair, what follow-up is to occur after delivery of the wheel chair and on an ongoing basis, what monitoring is recommended. The protocol should address, but not be limited to, the following:

- involvement of the consumer's current occupational or physical therapist or, if the consumer does not currently have a therapist, a new occupational or physical therapist in the evaluation such as the therapists who work with students in schools,
- identification of therapy organizations with qualified therapists who are able to provide the evaluations,
- ensure a Certified Rehabilitation Technology Specialist (CRTS), Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) is participating in the evaluation with the therapist,
- the key elements of formal seating evaluations such as: range of motion, equilibrium reactions, fine and gross motor skills, ability to self propel and transfer, self care issues, transportation requirements, pain limitations and visual skills including depth perception, and
- Minimum qualifications for people who conduct seating evaluations.

Recommendation 14: Establish a practice protocol for provision of "loaner" equipment and accessing alternative transportation when loaner equipment is not appropriate or not available.

- When a repair requires that a wheel chair be taken to the repair facility, DME suppliers should provide the best possible match in loaner equipment or consumers, working with their case managers and the DME supplier should identify appropriate alternative transportation arrangements.
- Provide specific training and education to ensure that Arizona Long Term Care System (ALTCS) case managers or other case managers, in all the systems, have information about transportation alternatives, the potential need for provision of and/or immediate increase in and authorization of attendant care hours and the potential for health and safety issues to arise while a consumer's equipment is being repaired.
- Consider authorization by the insurers for consumer owned back-up equipment to be repaired and ready for use before the consumer's current equipment needs repair and / or new equipment is being ordered.

Recommendation 15 Develop and implement a practice protocol and a system of quality assurance for follow-up after delivery of equipment to ensure fitting of the wheelchair to the consumer, and accuracy of the piece of DME ordered to that delivered, prior to requesting the consumer's signature accepting the wheelchair or other piece of DME.

- Require DME suppliers to provide customer satisfaction cards at the time of delivery and six months after delivery. Make results accessible to the insurers and consumers.
- Provide consumers with a check list of – what to expect and what to "watch for" as they begin to use the equipment (similar to when we get a prescription – possible side effects – if x happens, stop and call the doctor.) For example, if you feel unstable, not centered using the equipment, call the supplier
- Ensure occupational or physical therapists conducting the assessment specifically consider and distinguish "need" versus "want" with regard to wheel chairs. Provide consumers with information about why their desired piece of equipment may not fit with what the functional assessment result indicates is needed.

**Goal III: Consumer Choice and Advocacy: To empower consumers of DME to be informed advocates through choice, education, and knowledge of the standards, practice, and policies of their insurer and DME supplier.**

Recommendation 16: Require AHCCCS Health Plans, ALTCS Program Contractors and Department of Health Services, Office of Children's Rehabilitation Services contracted Clinics to provide multiple choices of DME suppliers – at least two or more; if providers are available in the geographic area.

Recommendation 17: Provide more consumer choices of suppliers / places to go for repair service to enhance access including choices that may be geographically closer to the consumer and/ or timelier in completing the repair.

Recommendation 18: Provide more consumer choices regarding accessing seating evaluations and seating clinics.

Recommendation 19: Provide easily accessible information about DME suppliers; i.e. create a list of accredited DME suppliers, where they are located geographically, what DME services and equipment do they provide, and whether or not they have a Certified Rehab Specialist on staff. Provide the information through multiple web sites. (Possible web sites: AzDisabilityPost.org, Az Association of Law Libraries (AzAll), AzLinks, Disability Resource, Assistive Technology Arizona (ATAZ), and NAU – Az Technology Access Program (AzTAP), health plans, and relevant state agencies.)

Recommendation 20: Implement a standardized consumer / advocate guide and checklist to enhance understanding of the process, the roles of each party, and reasonable expectations of timelines.

- A common check list will assist providers, consumers and advocates in understanding the steps in the DME process, what the reasonable timelines are for each step, and who to contact if a request is delayed.
- The guide must include what action to take in the case of delays.
- Include advocacy tips - the top 10 things consumers can do to make the process more accountable and timely. For example, consumers need information about why DME suppliers must be able to see the old equipment when a replacement is being requested – consumers are reluctant to let them see it.

**Goal IV: Quality Assurance and Timeliness: To provide quality durable medical equipment within acceptable timeframes.**

Recommendation 21: Implement formal quality assurance plans at the insurer and DME supplier levels that include:

- performance improvement indicators for customer satisfaction,
- consumer satisfaction surveys with questions specific to DME and to receipt, delivery and repair of wheelchairs,
- standardized questions regarding DME services in all customer satisfaction surveys,
- a rating system developed based on customer satisfaction and tracking of delivery; i.e. quality and timeliness,
- sharing of the results of customer satisfaction surveys with consumers, insurers and suppliers,
- analysis monitoring of grievance and appeals issues raised, resolutions, and timelines for response, and

- mechanisms for seeking consumer advice (e.g. consumer councils) on how to improve the quality and timeliness of the delivery of durable medical equipment.

Recommendation 22: Implement clear and consistent grievance and appeals processes among all insurers and DME suppliers and as part of quality assurance monitor and publish the results.

- Develop standardize grievance and appeals timelines for response across the system, such as, consumers will receive a response to a written appeal within 10 days regardless of insurer source or consumers will have contact from the organization with which they filed a grievance within 48 hours – may be not an answer, but acknowledgment that the grievance has been received.
- Provide consumer friendly information about grievances and appeals, when to use the grievance process versus the appeal process, how to file a grievance or an appeal, and what are the reasonable timelines for receiving a response.
- Publish grievance / appeals processes in newsletters and / or circulate to other organizations on how the process works.
- Monitor the number of grievance and appeals and provide information regarding the results to consumers and advocates.
- Grievances will be documented and tracked by number and/or name to enhance communication and follow-up.

Recommendation 23: Establish consistent guidelines for all DME suppliers regarding repairs and customer service including consistent processes and documentation requirements.

Recommendation 24: Discontinue at all levels of the DME service system (insurer and DME supplier) the practice of paying for specialized, customized DME under a capitated rate system and implement fee for service rates for all specialized, customized DME including wheel chairs.

Recommendation 25: Reassess the durable medical equipment fee for service schedule for all insurers specifically addressing the following issues:

- the adequacy of rates to cover costs,
- reimbursement for loaner equipment, seating evaluations, seating clinics, repairs for the life of the product, etc.,
- reimbursement for the costs related to maintenance and management of a “fleet” of loaner equipment, and
- reimbursement for the costs of repairing “back-up” equipment belonging to the consumer that is repaired before the consumer’s current equipment needs repair.

Recommendation 26: Define and implement insurer and DME supplier incentives for exceeding service standards and consequences for non-compliance with standard guidelines such as consistent delays, lack of or delay in resolution of grievances, and lack of responsiveness to consumer inquiries.

Recommendation 27: Analyze existing processes to ensure requests for equipment and suppliers are specifically based on the functional needs of the individual consumers and not just the “typical” service / equipment. For example – a shower chair must take into consideration the weight of the consumer – any standard shower chair may not be appropriate. Modify existing or develop new policy as needed.

Recommendation 28: Implement at the state agency, health plan/program contractor and DME supplier levels specific network capacity assessment methods to document DME supplier capacity and be alerted to the need for capacity expansion.

Recommendation 29: Develop partnership opportunities with employment organizations, advocacy groups and Rehabilitation Service Administration to recruit and train technicians to fill the work force gap in wheel chair repair technicians.

**Goal V: Training and Education: To provide clear and consistent training and education throughout the DME delivery system.**

Recommendation 30: Provide specific information to primary care physicians regarding needed documentation.

- Provide information about what the primary care physician should expect to see in reviewing a quality seating evaluation / assessment.
- Develop standard language or a template for a prescription for complex requests such as wheel chairs, so that prescriptions include the necessary information for insurers to determine medical necessity.
- Ensure physicians have information about the need for both a prescription for the seating evaluation AND a prescription for the wheel chair itself.

Recommendation 31: Increase awareness within the system about the potentially critical nature of delays in obtaining and/or repairing DME equipment.

- Provide specific training and education for insurers, DME supplier and state agency customer service representatives about durable medical equipment, the health and safety issues surrounding receipt of the wrong equipment and/or delays in getting equipment.
- Provide medical directors, ALTCS case managers or other case managers and prior authorization staff with specific information and education about DME issues and the potential health and safety implications of a lack of appropriate or timely provision of DME.

**Goal VI: Repairs and Maintenance: To complete durable medical equipment repairs timely and accurately and in settings which are respectful of and responsive to the needs of consumers.**

Recommendation 32: Discontinue at the insurer and DME supplier level the requirement that a prescription be provided before repairs can be made.

Recommendation 33: Maintain an inventory in stock of standard wear and tear items; batteries, wheels, castors, safety related devices, arm pads. If needed items are not in stock, allow consideration for expedited shipping based on the needs of the consumer.

Recommendation 34: Offer a variety of options for repairs and preventative maintenance such as appointments, group maintenance work shop days; mobile and / or same day repair or walk-in repairs, in home repairs. For example, every Saturday hold a workshop specific to batteries, tires, etc. Conduct a pilot clinic to see if the response warrants this type of service.

Recommendation 35: Inform, on an ongoing basis, case managers and others such as support coordinators, care coordinators, etc. about the availability of repair clinics so they can communicate with their consumers, and provide information about clinics on web site or in various organizational newsletters.

Recommendation 36: Preventative Maintenance – Implement a focus on preventative maintenance including, but not limited to:

- increasing inventories of common preventative maintenance parts,
- establishing a consistent process and documentation for consumers to have original paperwork of equipment needing repair; i.e. original date of receiving the equipment, PCP's name and a copy of the prescription,
- educating consumers regarding upkeep of the equipment and maintenance/repair requirements, and
- providing, on an ongoing basis, information to consumers (alerts) about preventive maintenance and repair clinics.

Recommendation 37: When the DME supplier is responding to a therapist recommendation or a prescription with an alternative that is with lower or less functionality than recommended, the supplier upon consultation with the therapist must ensure that the alternative does not compromise the safety of the consumer or the quality of the equipment.

## **FUTURE POLICY ISSUES**

### ***Licensing of DME Suppliers***

The licensing of DME suppliers was only briefly discussed by the Task Force and was not considered as a recommendation. At this time, licensing as an option was not pursued in order to allow the Task Force consensus process to identify solutions to the problems associated with the delivery of DME in Arizona.

Background information regarding the status of DME supplier licensing in other states included the following findings:

- Nineteen States and the District of Columbia have implemented DME supplier licensing or registration requirements.
- Application fees ranged from \$75 in Alabama to \$1,080 in Tennessee. Additional fees are required for “re-inspections”, provisional licenses, and renewal licenses.
- Oversight is provided most frequently by State Boards of Pharmacy but also was assigned to State Departments of Health, Children and Family Services, Financial and Professional Regulation, and Boards created specifically for this purpose.
- The scope of the licensing / registration laws ranged from wholesale distributors only, retail distributors only and both wholesale and retail distributors. Scope also ranged from a simple registration process to detailed licensing requirements with facility inspections.
- Studies regarding the impact of licensing on the service delivery quality and timeliness were found; however, in telephone conversations with California their perceived greatest areas of impact were 1) an increase in the education and awareness of the needs of consumers of durable medical equipment due to the educational requirements and 2) an increase in enforcement and follow-up on complaints.

“Licensing has provided some level of control. There is a better understanding on the part of the supplier about the importance of the equipment being provided including education about the impact on the individual. People better understand what happens in the life of a customer when the equipment either doesn’t work or is unavailable. It is life threatening at times. The law was designed to end abuse and to heighten the interaction of all parties throughout the system, among the pharmacist or medical practitioner who writes the order, the supplier, the manufacturer, and the consumer.”<sup>14</sup>

### ***Prior Authorization Process and Higher Limits***

The following recommendation was reviewed by the Task Force and while approved, was placed on hold for further discussion.

Recommendation: Implement an open authorization process for members with complicated conditions and establish higher limits for prior authorization and approval of additional fees for services to these members.

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<sup>14</sup> Inge Small, California Department of Public Health, Telephone Conversation April 6, 2008

The intent is that for consumers with multiple, complex and/or chronic conditions; conditions that are considered permanent, do not require the same level of re-diagnosis, prior authorization, new prescriptions, etc. when the situation is permanent or unlikely to change. Better definition is needed in terms of:

- What is an open authorization process?
- What new documentation is really needed when the diagnosis doesn't change?
- How would this work in practice?

## **IMPLEMENTATION PLAN**

The implementation plan includes the following components 1) Ongoing Coordination / Communication, 2) Report Dissemination, 3) Individual Organizational Commitments, and 4) Implementation Work Groups.

### ***Ongoing Collaboration and Communication***

The Statewide Independent Living Council (SILC) will serve as the coordinating center for ongoing discussions, posting of information and re-convening of the Task Force in one year to do a progress check and to determine next steps.

### ***Report Dissemination***

The Statewide Independent Living Council will take the lead and solicit support from Task Force members in disseminating the final report of recommendations. The final report will be posted to the [www.azdisabilitypost.org](http://www.azdisabilitypost.org) web site.

- I. The DME Task Force recommendations will be distributed to the following organizations:
  - AHCCCS Program Contractors
  - Arizona Department of Economic Security, Division of Aging, Division Developmental Disabilities, Division of Employment and Rehabilitation Services
  - Arizona Department of Health Services (ADHS)
  - Arizona Disability Advocacy Organizations
  - Arizona Health Care Cost Containment System (AHCCCS),
  - Arizona House of Representatives Health Committee
  - Arizona Insurance Department - Commission
  - Arizona Medical Association
  - Arizona Senate Health Committee
  - Arizona Technology Access
  - Board of Medical Examiners
  - Centers for Medicare and Medicaid Services (CMS)
  - Driving Evaluations (occupational therapists)
  - Family Voices
  - Governor Napolitano's Advisors for Health and DES
  - Governor's Council on Aging
  - Governor's Council on Developmental Disabilities
  - Governor's Council on Spinal and Head Injuries
  - Health Plan CEOs, Quality Assurance and Medical Management
  - Hospital Rehabilitation Centers
  - Independent Living Community – National Council of Independent Living – Statewide Independent Living Council (SILC) organizations throughout the country
  - Local and State Physician groups
  - Pharmaceutical Board
  - Private Insurance Companies
  - United Cerebral Palsy

- II. Individual presentations

The SILC will involve Task Force members in the presentations as appropriate. The presentations will include that this Task Force was funded by advocacy groups who were willing to work on resolution of problems that resulted in an excellent collaborative effort. Presentation of the recommendations will be scheduled with the following organizations:

- AHCCCS –Executive Management – Medical Management, Quality Management, etc.
- Arizona Department of Administration, Arizona Benefits Options – state employee benefit plan
- Arizona Department of Economic Security (ADES) Executive Management
- Arizona Department of Health Services Executive Management
- Arizona Department of Insurance
- Centers for Medicare and Medicaid Services (CMS) Region IX
- Legislative Committee Chairpersons for Health
- Private Insurers such as Blue Cross Blue Shield and AETNA
- St. Luke’s Health Initiatives

### **Organizational Commitments**

Organizations represented on the Task Force have already begun to address needed changes within their own areas of responsibility. In addition to the Work Groups described in this report, Task Force members will begin the process of addresses changes within their own organizations. Examples of commitments and changes that have begun include:

- ★ AHCCCS has committed to conduct meetings with the Medical Directors of the AHCCCS Contracted Health Plans to provide education and meetings of stakeholder and managed care organizations to determine issues and develop solutions.
- ★ AzDES Division of Developmental Disabilities has committed to, where appropriate, including monitoring of the recommendations in their Operational and Financial Reviews of the Health Plans.
- ★ ADHS, Office for Children with Special Health Care Needs will require in the next contract with Clinics that customer satisfaction surveys be completed specifically including DME.

### **Implementation Work Groups**

Implementation of the recommendations will require the continuation of the spirit of cooperation among all participants in the DME service delivery system.

The DME Task Force prioritized recommendations to be addressed through Work Groups during the first phase of implementation. Individuals volunteered to lead Work Groups and/or to be participants in the Work Groups.

The Work Group ultimate role is to implement the recommendations that have been assigned. This may include conducting information gathering to determine the best implementation methods, engaging other individuals and organizations in the implementation, ensuring the Work Group has consumer representation, and as appropriate to the recommendations, develop protocols, communication tools, etc.

### **Information and Education Work Group**

Recommendation 1: Implement methods to ensure consumers have information about the steps in the process of obtaining durable medical equipment and who to contact about DME questions at each of the Arizona State Agencies administering programs and services for people with disabilities.

Recommendation 31: Increase awareness within the system about the potentially critical nature of delays in obtaining and/or repairing DME equipment.

- Provide specific training and education for health plans/program contractors, insurers, DME supplier and state agency customer service representatives about durable medical equipment, the health and safety issues surrounding receipt of the wrong equipment and/or delays in getting equipment.
- Provide medical directors, ALTCS case managers or other case managers and prior authorization staff with specific information and education about DME issues and the potential health and safety implications of a lack of appropriate or timely provision of DME.

### **Prior Authorization Work Group**

Recommendation 12: Analyze existing data and establish across health plans, program contractors and suppliers a higher, consistent dollar threshold before a repair event requires prior authorization and establish a prior authorization “fast track” for repairs that are estimated to be above the newly established threshold. For example, only repairs in excess of \$1,000 require prior authorization.

### **Delivery Standards Work Group**

Recommendation 5: Implement at the DME supplier level a system to track orders and repairs with the capacity to pin point where there are delays, to issue alerts internally within the supplier organization and to notify consumers regarding delays. Additionally, the system should be able to provide aggregate reports on the status of meeting pre-determined expected timelines.

Recommendation 9: Develop and adopt specific standards and performance indicators in quality, timeliness, and staff qualifications that will improve the effectiveness of DME service delivery.

- Establish uniform standards for “reasonable” timelines for each step in the DME process.
- Distinguish between routine durable medical equipment and specialized durable medical equipment.
- Staff qualifications to include level of experience with specific populations and licensed occupational and physical therapists.

### **Seating Evaluations Work Group**

Recommendation 13: Establish a standard protocol regarding seating evaluations and seating clinics to include when seating evaluations are to be completed prior to ordering a wheel chair, what follow-up is to occur after delivery of the wheel chair and on an ongoing basis, what monitoring is recommended. The protocol should address, but not be limited to, the following:

- involvement of the consumer’s current occupational or physical therapist or, if the consumer does not currently have a therapist, a new occupational or physical therapist in the evaluation such as the therapists who work with students in schools,
- identification of therapy organizations with qualified therapists who are able to provide the evaluations,
- ensure a Certified Rehabilitation Technology Specialist (CRTS), Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) is participating in the evaluation with the therapist,
- the key elements of formal seating evaluations such as: range of motion, equilibrium reactions, fine and gross motor skills, ability to self propel and transfer, self care issues, transportation requirements, pain limitations and visual skills including depth perception, and
- Minimum qualifications for people who conduct seating evaluations.

### **Related Recommendations**

Recommendation 6: Ensure communication occurs between seating evaluation therapists and supplier representatives before equipment is ordered when the recommendations of the therapist and supplier representative are different. Use a feature match approach when determining the right equipment to be provided.

Recommendation 27: Analyze existing processes to ensure requests for equipment and suppliers are specifically based on the functional needs of the individual consumers and not just the “typical” service / equipment. For example – a shower chair must take into consideration the weight of the consumer – any standard shower chair may not be appropriate. Modify existing or develop new policy as needed.

Recommendation 37: When the DME supplier is responding to a therapist recommendation or a prescription with an alternative that is with lower or less functionality than recommended, the supplier upon consultation with the therapist must ensure that the alternative does not compromise the safety of the consumer or the quality of the equipment.

### **Loaner Equipment Work Group**

Recommendation 14: Establish a practice protocol for provision of “loaner” equipment and accessing alternative transportation when loaner equipment is not appropriate or not available.

- When a repair requires that a wheel chair be taken to the repair facility, DME suppliers should provide the best possible match in loaner equipment or consumers, working with their case managers and the DME supplier should identify appropriate alternative transportation arrangements.
- Provide specific training and education to ensure that Arizona Long Term Care System (ALTCS) case managers or other case managers, in all the systems, have information about transportation alternatives, the potential need for provision of and/or immediate increase in and authorization of attendant care hours and the potential for health and safety issues to arise while a consumer’s equipment is being repaired.
- Consider authorization by the health plan for consumer owned back-up equipment to be repaired and ready for use before the consumer’s current equipment needs repair and / or new equipment is being ordered.

Related Recommendation:

Recommendation 25: Reassess the durable medical equipment fee for service schedule for all payers specifically addressing the following issues:

- the adequacy of rates to cover costs,
- reimbursement for loaner equipment, seating evaluations, seating clinics, repairs for the life of the product, etc.,
- reimbursement for the costs related to maintenance and management of a “fleet” of loaner equipment, and
- reimbursement for the costs of repairing “back-up” equipment belonging to the consumer that is repaired before the consumer’s current equipment needs repair.

### **Consumer Choice Work Group**

Recommendation 16: Require AHCCCS Health Plans, ALTCS Program Contractors and Department of Health Services, Office of Children’s Rehabilitation Services contracted Clinics to provide multiple choices of DME suppliers – at least two or more; if providers are available in the geographic area.

Related Recommendations:

Recommendation 17: Provide more consumer choices of suppliers / places to go for repair service to enhance access including choices that may be geographically closer to the consumer and/ or timelier in completing the repair.

Recommendation 28: Implement at the state agency and health plan/program contractor and DME supplier levels specific network capacity assessment methods to document DME supplier capacity and be alerted to the need for capacity expansion.

## APPENDICES

## **Appendix A: DME Task Force Members**

Benedetti, Sue  
Mercy Care Plan  
4350 E. Cotton Center Boulevard, Building D  
Phoenix, Az 85040-8852  
(602) 453 – 6033  
Email: [sue.benedetti@schalleranderson.com](mailto:sue.benedetti@schalleranderson.com)

Browner, Carol  
St. Joseph's Hospital, Neuro Rehabilitation  
244 W. Thomas  
Phoenix, Arizona 85013  
Phone: 602 406-3102  
Email: [Carol.Browner@chw.edu](mailto:Carol.Browner@chw.edu)

Carey, David  
Arizona Bridge to Independent Living  
2345 E. Thomas Rd, Suite 290  
Phoenix, Az 85016  
Phone: (602) 443-0723  
Email: [davidc@abil.org](mailto:davidc@abil.org)

Coulson, Louette  
Division of Developmental Disabilities  
2200 N. Central, Suite 207  
Phoenix, Arizona 85013  
Phone: (602) 238-9038 x 6013  
Email: [LCoulson@azdes.gov](mailto:LCoulson@azdes.gov)

**Dashefsky, Jay**  
Governor's Council on Developmental Disabilities  
3839 N. 3rd Street, Suite 306  
Phoenix, Arizona 85007  
Email: [jdashefsky@azdes.gov](mailto:jdashefsky@azdes.gov)

DiRienzi, Tony  
Statewide Independent Living Council  
2400 N. Central Avenue, Suite 105  
Phoenix, Az 85004  
Phone: (602) 262-2900  
Email: [silctonyd@qwest.net](mailto:silctonyd@qwest.net)

Elliott, Kim  
AHCCCS / DHCM  
701 E. Jefferson, MD6100  
Phoenix, Arizona 85034  
Phone: (602) 417-4782  
Email: [Kim.Elliott@azahcccs.gov](mailto:Kim.Elliott@azahcccs.gov)

Hedge, Roger  
Southwest Mobility  
Phone: 480-694-0284  
E-mail: [rogerh@southwestmobility.com](mailto:rogerh@southwestmobility.com)

Benz, Wendy  
Raising Special Kids  
2400 N. Central Avenue, Suite 200  
Phoenix, AZ 85004  
Phone: (602) 242-4366  
Email: [wendyb@raisingspecialkids.org](mailto:wendyb@raisingspecialkids.org)

Brumble, Matt  
Southwest Medical and Rehab  
513 W. Thomas Rd.  
Phoenix, Az 85013  
Phone: (602) 230-9493  
Email: [mbrumble@southwestmedical.com](mailto:mbrumble@southwestmedical.com)

Christianson, Jeff  
Southwest Medical and Rehab  
513 W. Thomas Rd.  
Phoenix, Az 85013  
Phone: (602) 230-9493  
Email: [jchristianson@southwestmedical.com](mailto:jchristianson@southwestmedical.com)

Davies, Duane  
Preferred HomeCare  
2546 W. Birchwood Ave, Suite 101  
Mesa, Az 85202  
Phone: (480) 446 – 9010  
E-mail: [duane.davies@preferredhmecare.com](mailto:duane.davies@preferredhmecare.com)

DeNova, Susan  
RSA / ILRS  
4411 S. 40<sup>th</sup> St, #D12  
Phoenix, Az 85040  
Phone: (602) 470 – 1802 x 114  
Email: [sdenova@azdes.gov](mailto:sdenova@azdes.gov)

Early, Scott  
Bridgeway  
1501 W. Fountainhead Corporate Park, Suite  
201 Tempe, Az 85282  
Phone: (480) 221-4816  
Email: [searly@centene.com](mailto:searly@centene.com)

Glenn, Jason  
Evercare  
3141 N. 3<sup>rd</sup> Ave, Suite 100  
Phoenix, Az 85013  
Phone: (602) 745-7904  
Email: [Jason\\_glenn@UHC.com](mailto:Jason_glenn@UHC.com)

Hershey, Gary  
PRN Medical  
2311 W. Utopia  
Phoenix, Az 85024  
Phone: (602) 722-3874  
Email: [gary@prnmed.net](mailto:gary@prnmed.net)

Kahn, Franc  
Governor's Council on Developmental Disabilities  
3839 N. 3rd Street, Suite 306  
Phoenix, Arizona 85007  
Email: [fkahn@azdes.gov](mailto:fkahn@azdes.gov)

Kruck, Amina  
ABIL  
2345 E. Thomas Rd, Suite 290  
Phoenix, Az 85016  
Phone: (602) 443-0722  
Email: [aminak@abil.org](mailto:aminak@abil.org)

Mortensen, Paul  
Az Spinal Cord Injury Association  
901 E. Willeta St, #2306  
Phoenix, Az 85006  
Phone: (602) 274-6287  
Email: [Paul@azspinal.com](mailto:Paul@azspinal.com)

Myers, Ed  
Arizona Center for Disability Law  
3839 N. 3<sup>rd</sup> Street, Suite 209  
Phoenix, Arizona 85012  
Phone: (602) 274-6287  
Email: [emyers@azdisabilitylaw.org](mailto:emyers@azdisabilitylaw.org)

Parker, Debbie  
SCAN  
1313 E. Osborn Rd, Suite 150  
Phoenix, Az 85014  
Phone: (602) 778 – 3332  
Email: [dparker@scanhealthplan.com](mailto:dparker@scanhealthplan.com)

Powers, Donna  
SILC  
2400 N. Central Avenue, Suite 105  
Phoenix, Az 85004  
Phone: (602) 690-4082  
Email: [SILCDonna@qwest.com](mailto:SILCDonna@qwest.com)

Schafer, Alan  
AHCCCS  
701 E. Jefferson MD6100  
Phoenix, Arizona 85034  
Email: [Alan.Schafer@azahcccs.gov](mailto:Alan.Schafer@azahcccs.gov)

Slenske, Rob  
United Seating and Mobility  
760 E. McDowell Rd.  
Phoenix, Az 85006  
Phone: (602) 744 - 5612  
Email: [Robert\\_slenske@apria.com](mailto:Robert_slenske@apria.com)

Walker, Judy  
AZDHS - Children's Rehabilitation Services  
124 W. Thomas Rd

Klimansky, Mike  
Preferred Homecare  
2546 W. Birchwood Ave, Suite 101  
Mesa, Az 85202  
Phone: (480) 446 - 9010  
Email: [mike.klimansky@preferredhome.com](mailto:mike.klimansky@preferredhome.com)

Lehew, Sue  
RSA  
1789 W. Jefferson, 2<sup>rd</sup> Floor  
Phoenix, Arizona 85007  
Phone: 602-568-1634  
Email: [SLehew@azdes.gov](mailto:SLehew@azdes.gov)

Mulholland, Cathy  
Pacific Rehab  
36805 N. Nevermind Trail, Box 5406  
Carefree, Az 85377  
Phone: (480) 213 - 8984  
Email: [cathyotr@aol.com](mailto:cathyotr@aol.com)

Pangrazio, Phil  
ABIL  
1229 E. Washington St  
Phoenix, Az 85034  
Phone: (602) 256-2245  
Email: [philp@abil.org](mailto:philp@abil.org)

Perduta-Fulginiti, Sonya  
Outpatient Rehabilitation  
St. Joseph's Hospital and Medical Center  
Phone: (602) 406-5195  
Fax: (602) 406-4105  
Email: [fulginiti@chw.edu](mailto:fulginiti@chw.edu)

Sabinsky, Bryan  
Mercy Care Plan / LTC Case Manager  
Supervisor  
Phone: (623) 474-7304  
Email: [bryan.sabinsky@schalleranderson.com](mailto:bryan.sabinsky@schalleranderson.com)

Scibilia, Margherita  
Apria Healthcare  
2909 E. Broadway Rd  
Phoenix, Az 85040  
Phone: (602) 282 - 1400  
Email: [Margherita\\_scibilia@apria.com](mailto:Margherita_scibilia@apria.com)

Stewart, Laraine  
Area Agency on Aging  
1366 E. Thomas Rd, Suite 108  
Phoenix, Az 85014  
Phone: (602) 264-2255  
Email: [steward@aaaphx.org](mailto:steward@aaaphx.org)

Wilson, Laura  
Governor's Council on Developmental Disabilities

Phoenix, Az 85013  
Phone: (602) 406 - 5731  
Email: [walker@azdhs.gov](mailto:walker@azdhs.gov)

3839 N. 3rd Street, Suite 306  
Phoenix, Arizona 85007  
Email: [lwilson@azdes.gov](mailto:lwilson@azdes.gov)

Zepeda, Joey  
SCAN  
1313 E. Osborn Rd, Suite 150  
Phoenix, Az 85014  
Phone: (602) 778 - 3316  
Email: [jzepeda@scanhealthplan.com](mailto:jzepeda@scanhealthplan.com)

**Task Force – Interested Parties – Interested parties were not able to attend the Task Force meetings but received copies of all meeting materials and summaries.**

Burns, Representative Jennifer  
State House of Representatives  
1700 W. Washington  
Phoenix, Arizona 85007  
Phone: (602) 926-5836  
Email: [jburns@azleg.gov](mailto:jburns@azleg.gov)

Burton-Cahill, Senator Meg  
Arizona State Senate  
1700 W. Washington  
Phoenix, Az. 85007  
Phone: (602) 926-4124  
Email: [mburtoncahill@azleg.gov](mailto:mburtoncahill@azleg.gov)

Grace, Jane  
Congressman Kyl's Office  
2200 E. Camelback, Suite 120  
Phoenix, Az 85016  
Phone: (602) 840 - 1891  
Email: [Jane\\_Grace@Kyl.senate.gov](mailto:Jane_Grace@Kyl.senate.gov)

Harrocks, Heather  
Congressman Jeff Flake's Office  
1640 S. Stapley, Suite 215  
Mesa, Az 85204  
Phone (480) 833-0092:  
Email: [Heather.horrocks@mail.house.gov](mailto:Heather.horrocks@mail.house.gov)

Herrera-Daniels, Mari  
Congressman Ed Pastor's Office  
411 N. Central Ave, # 150  
Phoenix, Az 85004  
Phone: (602) 256-0551  
Email: [mari.herrera@mail.house.gov](mailto:mari.herrera@mail.house.gov)

Mings, Doug  
Congressman Harry Mitchell's Office  
7201 E. Camelback, Suite 335  
Scottsdale, Az 85251  
Phone: (480) 946-2411  
Email: [dougming@gmail.com](mailto:dougming@gmail.com)

Mockbee, Stacy  
Parent of Consumer  
10660 E Deerfield Place,  
Tucson 85749  
Phone: (520) 877-8527  
Email: [jsmockbee@aol.com](mailto:jsmockbee@aol.com)

Radecic, Peri Jude  
Arizona Center for Disability Law  
3839 N. 3<sup>rd</sup> Street, Suite 209  
Phoenix, Arizona 85012  
Email: [pradecic@azdisabilitylaw.org](mailto:pradecic@azdisabilitylaw.org)

Osmon, Patricia  
Staff Attorney/Policy Advisor – Dem. Caucus  
1700 W. Washington  
Phoenix, z 85007  
Phone (602) 926-4387  
Email: [posmon@azleg.gov](mailto:posmon@azleg.gov)

*Task Force Staff*  
Cannon, Linda  
Roberts, Leslie  
Voytek, Ruth  
Linda Cannon & Associates, INC.  
Phone: (602) 279- 7905  
Fax: (602) 266-9266  
Email: [lindac@cannon-inc.com](mailto:lindac@cannon-inc.com)

Engelhardt, Sharon  
Statewide Independent Living Council  
2400 N. Central Avenue, Suite 105  
Phoenix, Az. 85004  
Phone: (602) 262 - 2900  
Email: [silcsharon@qwest.net](mailto:silcsharon@qwest.net)

## **Appendix B: Acronyms & Glossary of Terms**

### **Acronyms**

<b>Term</b>	<b>Definition</b>
ABIL	Arizona Bridge to Independent Living
ACDL	Arizona Center for Disability Law
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care Services – Administered by the Arizona Health Care Cost Containment System (AHCCCS)
AT	Assistive Technology
ATAZ	Assistive Technology Arizona
ATS / ATP	Assistive Technology Practitioner (ATP). Assistive Technology Practitioner (ATP)
AzALL	Arizona Association of Law Libraries
AzDES/DDD	Arizona Department of Economic Security, Division of Developmental Disabilities
AzDES/RSA	Arizona Department of Economic Security, Rehabilitation Services Administration
AzDHS/CRS	Arizona Department of Health Services / Children’s Rehabilitation Services
AzGCDD	Arizona’s Governor Council on Developmental Disabilities
AzTAP	Arizona Technology Access Program
CARF	Commission on Accreditation of Rehabilitation Facilities
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
CRTS	Certified Rehabilitative Technology Supplier
DHHS	U S Department of Health and Human Services
DME	Durable medical equipment
DME/POS	Durable medical equipment, prosthetics, orthotics and supplies

Term	Definition
FFS	Fee for service
HCPCS	Health Care Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HM	Home Modification
MCO	Managed Care Organization
NRRTS	National Registry of Rehabilitation Technology Suppliers
PCP	Primary Care Physician
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America
RET	Rehabilitation Engineering Technologist
RTS	Rehabilitative Technology Supplier
SILC	Statewide Independent Living Council

## Glossary

Term	Definition
Durable medical equipment (DME)	AzDES / Division of Developmental Disabilities: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, disability or injury and is appropriate for use in the home.
	AHCCCS: DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury. Covered prosthetic and orthotic devices are designed to replace or augment a missing or impaired part of the body and are only covered when they are essential for the habilitation or rehabilitation of a member.  DME and devices are used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate
	Medicare: Durable Medical Equipment— Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds. <a href="http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf">http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf</a>
	DME Supplier
Feature Matching and Device Trial	This service helps match the best AT device to a person's ability. Source: NCATP.org/overview.html North Carolina Assistive Technology Program.
Health Plan	The term 'health plan' means an individual or group plan that provides, or pays the cost of medical care. <a href="http://www.hipaabasics.com/glossary.htm">www.hipaabasics.com/glossary.htm</a>
Insurer	Payers of health care services and equipment
Medicare	Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
Medicare Part A	Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits. <a href="http://www.cms.hhs.gov/medicaregeninfo">www.cms.hhs.gov/medicaregeninfo</a>
Medicare Part B	Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational

Term	Definition
	therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. <a href="http://www.cms.hhs.gov/medicaregeninfo">www.cms.hhs.gov/medicaregeninfo</a>
Medicare Prescription Drug Coverage	Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later. <a href="http://www.Cms.hhs.gov/medicaregeninfo">www.Cms.hhs.gov/medicaregeninfo</a>
Program Contractor	Health care organizations that are contracted with AHCCCS to provide long term care services under the Arizona Long Term Care Program.
Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)	The purpose of the organization as stated on their web site is to improve the potential of people with disabilities to achieve their goals through the use of technology. We serve that purpose by promoting research, development, education, advocacy and provision of technology; and by supporting the people engaged in these activities.
Rehabilitative Technology Supplier (RTS)	A qualified RTS is an individual that has one of the following credentials: <ul style="list-style-type: none"> <li>▪ Certified Rehabilitative Technology Supplier (CRTS);</li> <li>▪ Assistive Technology Supplier (ATS); or</li> <li>▪ Assistive Technology Practitioner (ATP).</li> </ul>
Seating Clinic	A Team approach to planning for training, identification of need, and follow-up actions to be taken.
Seating Evaluation	The process to specifically evaluate the needs of the consumer and determine the specific requirements for a wheelchair and accessories for a specific consumer. This could occur in a clinic or in a separate session specifically for the evaluation.
Vendor	See DME Supplier

## **Appendix C: Medicare DMEPOS Quality Standards**

Medicare regulations have defined standards that a supplier must meet to receive and maintain a supplier number. The supplier must certify in its application for billing privileges that it meets and will continue to meet the standards. The supplier standards can be found in 42 CFR Section 424.57(c) and were effective on December 11, 2000.

### Business Standards - Apply to all DMEPOS suppliers

Following is an abbreviated version of the supplier standards as found in the CMS 855S application form.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or nonprocurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare-covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, or cell phone is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare-covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e. the supplier may not sell or allow another entity to use its Medicare Supplier Billing Number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.

### **III. Complex Rehabilitative Wheelchairs and Assistive Technology**

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall:

1. Employ at least one qualified Rehabilitative Technology Supplier (RTS) per location. A qualified RTS is an individual that has one of the following credentials:
  - Certified Rehabilitative Technology Supplier (CRTS);
  - Assistive Technology Supplier (ATS); or
  - Assistive Technology Practitioner (ATP).
2. The Rehabilitative Technology Supplier shall have at least one or more *trained technicians* available to service each location appropriately depending on the size and scope of its business. A trained technician is identified by the following:
  - Factory trained by manufacturers of the products supplied by the company;
  - Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
  - Completed at least ten hours of continuing education specific to Rehabilitative Technology; and
  - Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.
3. The Rehabilitative Technology Supplier shall:
  - Coordinate services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and include input from other members of the health care team (i.e., PT, OT, prescribing physician, etc.);

- Provide the beneficiary with appropriate equipment for trial and simulation, when necessary;
  - Maintain in the beneficiary's record all of the information obtained during the assessment; and
  - Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.
4. If beneficiaries are evaluated in the supplier's facility, the supplier shall:
- Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations; and
  - Maintain a repair shop located in the facility or in close proximity or easily accessible from another location of the supplier as well as an area appropriate for assembly and modification of products.

## Appendix D: My Mobility Device -- Sample Template

Your Name \_\_\_\_\_ Diagnosis \_\_\_\_\_ Date \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

DME Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Scooter  Manual Wheelchair  Power Assist W/C  Power W/C  High Tech Power W/C

### Product Information

Weight of Chair \_\_\_\_\_

Seating System \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Warranties:

\_\_\_\_\_

\_\_\_\_\_

Types of Control:

\_\_\_\_\_

\_\_\_\_\_

Custom Features:

\_\_\_\_\_

\_\_\_\_\_

Tires (Size / Type / Brand): \_\_\_\_\_

Battery: (Size / Type / Brand): \_\_\_\_\_

Cushion: (Size / Type / Brand): \_\_\_\_\_

Other:

**Maintenance History:**

Type of Maintenance	Date of Maintenance	Maintenance Completed By (Name & Company)

**Repair History**

Type of Repair	Date of Repair	Repair Completed By (Name & Company)

**Contact Information for Repairs:**

Name of Technician: \_\_\_\_\_

Company Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## **Appendix E: Durable Medical Equipment - Information Sources**

### **Demographic Information**

1. Disability Data Resources; [www.dol.gov/odep/pubs/fact/data/.htm](http://www.dol.gov/odep/pubs/fact/data/.htm)
2. Disability Status: 2000; U.S. Census 2000, U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, March 2003
3. 2006 Disability Status Report: United States;  
[www.ilr.cornell.edu/edi/disabilitystatistics/Status Reports-HTML/2006-StatusReport](http://www.ilr.cornell.edu/edi/disabilitystatistics/Status%20Reports-HTML/2006-StatusReport)
4. Medicare health outcomes survey applied research center  
<http://www.hosonline.org/surveys/hos/hosresults.aspx>
5. Medicare Health outcomes Survey; Report of the Health Status of the Medicare Dual Eligible, Health Services Advisory Group; December 15, 2000
6. The Disabled Population in Arizona: Data from the 2000 Public Use Microdata Sample, Center for Business Research, L William Seidman Research institute, W.P. Carey School of Business, Arizona State University, October 2003
7. Demographics and Effective Risk Communication, Arizona Department of Health Services, Research Report, April 2005
8. Number of Beneficiaries with Benefits in Current payment Status; Arizona 2006;  
[socialsecurity.gov/policy/docs/statecomps/oasdi\\_zip/s006/indez/html](http://socialsecurity.gov/policy/docs/statecomps/oasdi_zip/s006/indez/html)
9. PAS Center for Personal Assistance Services; Arizona Disability Data Table from the 2005 American Community Survey;  
[www.pascenter.org/state\\_based\\_\\_stats/state\\_statistics\\_2005.php](http://www.pascenter.org/state_based__stats/state_statistics_2005.php)

### **Policy, Practice and Standards**

1. **Quality Standards; Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies**  
[http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/CMS\\_DMEPOS\\_Quality\\_Standards\\_081406.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/CMS_DMEPOS_Quality_Standards_081406.pdf)  
  
*Medicare Quality Standards description including Business Services (Financial Management, Human Resources Management, Consumer services, Performance Management, Product Safety), and General Product Specific Service Standards including Appendix B: Manual Wheelchairs and Power Mobility Devices.*
2. Arizona Health Care Cost Containment System; Quality Assessment and Performance Improvement Strategy  
[http://www.ahcccs.state.az.us/Publications/Reports/QualityStrategy/12\\_07CMS\\_FinalQualityStrategy.pdf](http://www.ahcccs.state.az.us/Publications/Reports/QualityStrategy/12_07CMS_FinalQualityStrategy.pdf)

*AHCCCS – provides a comprehensive description of the approach to drive quality throughout the AHCCCS system. Not specific to DME.*

3. Durable Medical Equipment (DME) Rider (Provider Agreement Sample)  
[http://www.eikids.com/la/matrix/docs/pdfs/RiderC\\_DME.pdf](http://www.eikids.com/la/matrix/docs/pdfs/RiderC_DME.pdf)

*State of Indiana – Children’s Services sample of DME Provider Agreement Standards*

4. U.S. Department of Health & Human Services; Medicare Program Integrity  
<http://www.hhs.gov/asl/testify/2007/03/t20070308f.html>

*Medicare – HHS testimony to Congress March 8, 2007 regarding Medicare Program Integrity.*

5. Medicare Expectations on determination of subparts by Medicare organization health care providers who are covered entities under HIPAA  
<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf>

*Medicare – January 2006 paper on Medicare’s program expectations based on the National Provider Identifier (NPI) final rule on statutory and regulatory requirements on which Medicare must comply and policies documented in Medicare operating manuals not yet codified.*

6. Durable Medical Equipment Medicare Administrative Contractor Award General Fact Sheet  
[http://www.cms.hhs.gov/MedicareContractingReform/Downloads/DME\\_MAC\\_Awards\\_General\\_Fact\\_Sheet.pdf](http://www.cms.hhs.gov/MedicareContractingReform/Downloads/DME_MAC_Awards_General_Fact_Sheet.pdf)

*Contract information regarding the administration of Medicare claims from suppliers of DME, prosthetics and orthotics as awarded to contractors for these services by CMS.*

7. More effective screening and stronger enrollment standards needed for medical equipment suppliers  
<http://www.gao.gov/new.items/d05656.pdf>

*Government Accountability Office report on verification of compliance with 21 standards related to Medicare billing related to CMS contracts.*

8. Durable Medical Equipment Medicare Administrative Contractor  
[http://www.cms.hhs.gov/MedicareContractingReform/08\\_DurableMedicalEquipmentMedicareAdministrativeContractor.asp](http://www.cms.hhs.gov/MedicareContractingReform/08_DurableMedicalEquipmentMedicareAdministrativeContractor.asp)

*Announcement of the contractors by CMS in Jurisdictions A, B, C and D (Arizona) regarding contract awards in the four jurisdictions regarding DME claims.*

9. 21 Supplier Standards  
[https://www.noridianmedicare.com/dme/enroll/21\\_standards.html](https://www.noridianmedicare.com/dme/enroll/21_standards.html)

*List of the application certification standards that every Medicare DMEPOS supplier must meet to obtain and retain their billing privileges.*

10. 2007 CAHPS Health Plan Survey Chartbook  
[https://www.cahps.ahrq.gov/content/NCBD/Chartbook/2007\\_CAHPS\\_HealthPlanChartbook.pdf](https://www.cahps.ahrq.gov/content/NCBD/Chartbook/2007_CAHPS_HealthPlanChartbook.pdf)

December 2007 annual results of the most recent national Health Plan survey presenting national summary-level results for the CAHPS Health Plan survey 3.0 and 4.0 versions.

11. Delivering on the Promise, Self Evaluation to Promote Community Living for People with Disabilities; <http://www.hhs.gov/newfreedom/final/hhsfull.html#sol1b2>

Document is an agency self-assessment, review and analysis of comments from more than 800 individuals and organizations representing diverse interests and disabilities. From this, HHS identified critical barriers to community-based alternatives for people with disabilities and actions necessary to reduce and eliminate those barriers.

12. Compendium of Home Modification and Assistive Technology Policy and Practice Across the States; <http://aspe.hhs.gov/daltcp/reports/2006/HM-HM-ATI.htm>

Information regarding the extent and type of assistive technology (AT) and home modification (HM) services offered by State Plans and HCBS waivers, the processes available to Medicaid-eligible recipients to facilitate access to AT and HM and the policies and practices employed by states to limit or restrict access to AT and HM services.

13. Compendium of Home Modification and Assistive Technology Policy and Practice Across the States; Arizona Profile: <http://aspe.hhs.gov/daltcp/reports/2006/HM-HM-ATI.htm>

Information about Arizona's coverage of services through AHCCCS and ALTCS for home modifications, assistive technology, personal emergency response systems and specialized medical equipment.

14. Assist Home Care, Inc., Shamokin Pennsylvania, Sample – Customer Complaint Form.

Example of a customer complaint form to show customer satisfaction with services provided.

15. Arizona Acute Care Health Plans, 2006 Member Satisfaction Survey, AHCCCS.gov

This report includes the results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) program survey questions about members' experience with their Health Plan and medical care during the last six months.

16. DME / Wheelchair Satisfaction Survey – Children's Rehabilitative Services Program; Survey Format, March 2008

Example of the CRS DME Wheelchair Satisfaction Survey utilized by the Arizona Department of Health Services, Office for Children with Special Health Care Needs.

17. Arizona Department of Economic Security, Division of Developmental Disabilities, FFS Provider Manual, Covered Services and Prior Authorization Requirements; October 31, 2005, p 48 – 52

List of the covered services provided under the direction of a Primary Care Physician (PCP) dentist or specialist under the referral of a PCP. The list is subject to the limitation and exclusions in AHCCCS and ALTCS rule and are minimum coverages.

18. Overview of CARF accreditation for DME POS suppliers; CARF Commission on Accreditation of Rehabilitation Facilities; [www.csrf.org/providers.aspx?content=content/Accreditation/Opportunities/DMEPOS](http://www.csrf.org/providers.aspx?content=content/Accreditation/Opportunities/DMEPOS) 3-5-08

Information is provided to assist suppliers in obtaining accreditation in order to be able to participate as a Medicare Part B supplier of DME equipment and supplies.

19. AHCCCS, Medical Policy Manual, Medical Supplies, Durable Medical Equipment and Orthotic/Prosthetic Devices; Chapter 300; Policy 310, Covered Services and full Policy Manual Chapter 300 on Medical Policy for all AHCCCS Covered Services

Policy manual information regarding DME and orthotic/prosthetic devices covered by AHCCCS as well as medical policy for all AHCCCS covered services.

20. DMEPOS State License Directory, Arizona, [www.palmettogba.com/palmetto/statelicensure.nsf/AZ](http://www.palmettogba.com/palmetto/statelicensure.nsf/AZ)

DME licensing regulations by state.

21. AHCCCS, ALTCS Performance Measure – Initiation of Home and Community Based Services for Elderly and Physically Disabled Members – Measurement Period: October 1, 2005 through September 30, 2006, Prepared by the Division of Health Care Management, August 2007.

Information regarding the number and percentage of sample members to whom a home and community-based service was provided within 30 days of enrollment and the reasons why services were not provided within 30 days of enrollment.

22. DHHS, Office of Inspector General, Medicaid Provider Enrollment Standards: Medical Equipment Providers, October 2006 – OEI-04-05-00180

Identification of standards used by selected States to enroll Medicaid DME providers, determine the extent to which states verify that providers meet these standards and to determine the extent to which States reenroll Medicaid DME providers.

23. National Registry of Rehabilitation Technology Suppliers (NRRTS) Standards of Practice

Ten categories of standards including definition of a rehabilitation technology supplier, use of various models for providing services, functions, communicating rights and responsibilities to consumers, assessment processes, proper fitting of equipment, training requirements, cost-effective options for consumers, alternative funding source communication and interaction with other providers.

24. Rehabilitation Engineering & Assistive Technology Society of North America (RESNA) Credentialing Program – RESNA Standards of Practice for Assistive Technology Practitioners and Suppliers - <http://www.resna.org/PraInAT/CertifiedPractice/Standards.html>

Fundamental concepts and rules considered essential to promote the highest ethical standards among individuals who evaluate, assess the needs for, recommend, or provide assistive technology.

25. Rehabilitation Engineering & Assistive Technology Society of North America (RESNA) Policy on the Qualification of Service Providers in Assistive Technology – <http://www.resna.org/PraInAT/CertifiedPractice/Qualifications.html>

Certification requirements for Assistive Technology Practitioners (ATP), Assistive Technology Suppliers (ATS) and Rehabilitation Engineering Technologists (RET).

26. Centers for Medicare and Medicaid Services, Durable Medical Equipment, Prosthetics/Orthotics and Supplies Fee Schedules – [http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp)

Detailed description of payment rate calculations associated with recently published rules affecting Medicare payment for oxygen and oxygen equipment.

27. State of Arizona, Department of Insurance, Report on Arizona Health Insurers – An aid to comparison shopping for health insurance, December 2007 – Timely Pay and Grievance Law, Information for Health Care Providers – May 2006; and A Consumer Guide to Health Care Appeals – May 2006

Brochures from the Department of Insurance regarding insurers, pay and grievances and appeals.

28. USDHHS, Supplier Directory – [http://www.medicare.gov/Supplier/Static/About/WhatIsParticSupplier.asp?dest=NAV/Hom/About Supplier...](http://www.medicare.gov/Supplier/Static/About/WhatIsParticSupplier.asp?dest=NAV/Hom/About%20Supplier...)

List of approved suppliers for drugs or supplies through Medicare.

29. Federal Register / Volume 73, No. 17, Friday, January 25, 2008 / Proposed Rules – DHHS, CMS – Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards

Proposed rule clarifies, expands and adds to the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.

30. Medicare's Covered Services – Section 1 – DME

Definition of Durable Medical Equipment and coverage through Medicare.

31. Medpac – Durable Medical Equipment Payment System – Revised October 2007 - [medpac.gov](http://medpac.gov)

Examples of equipment Medicare pays for, use of fee schedules, competitive bidding process information for phased in process and a list of the 10 metropolitan statistical areas included in the competitive bidding process beginning in 2008 which expands to 80 in 2009.

32. Carolina Mobility and Seating, Inc. Feedback Form

Feedback form to evaluate services for timeliness, needs met, rights and responsibilities, payment, and referral to others. Also included are questions regarding the staff interactions with the consumer.

33. National Registry of Rehabilitation Technology Suppliers (NRRTS) Code of Ethics

The registry provides 10 categories for its code of ethics.

34. AHCCCS – Article 2. Appeal, Grievance, and Hearing for an Enrolled Person – R9-34-201 through R9-34-225 made by final rulemaking at 10 AAR 828, effective April 3, 2004 (Supp. 04-1)

AHCCCS Rules regarding Appeals, Grievances and Hearings for Enrolled Persons

35. Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Chapter 2200 Grievance and Appeals

DES policy and procedures for Grievances and Appeals

36. Nordian – Medicare Repairs, Maintenance and Replacement. [Nordianmedicare.com/dme](http://Nordianmedicare.com/dme)

Provides an overview of Medicare rules and details about what will be replaced, need for an order and/or certificate of medical necessity.