DEPARTMENT OF HEALTH CARE POLICY AND FINANCING MEDICAL POLICY AND BENEFITS

PROSTHETIC AND ORTHOTIC ADULT BENEFIT

The following status report is submitted in response to Footnote 49, of the Fiscal Year 1999-2000 Long Bill, as indicated immediately below.

"Department of Health Care Policy and Financing, Medical Service Premiums - It is the intent of the General Assembly to track the costs of providing services under
Section 26-4-302 (l)(f), C.R.S. Accordingly, the Department is requested to (1) provide an estimate of the costs for FY 1998-99; (2) provide an estimate of the anticipated changes in the second year of implementation; and (3) provide estimates of savings in other Medicaid areas attributable to funding of this program. This report is requested to be submitted to the Joint Budget Committee by December 1, 1999."

PROGRAM HISTORICAL OVERVIEW

Since the inception of the Medicaid Program in 1969, Colorado Revised Statutes have stated that Medicaid provides benefit for prostheses when they are "surgically implanted." Federal OBRA '89 required state Medicaid Programs to provide medically necessary services under the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) whether or not the requested service is a benefit of the Medicaid Program. As a consequence, Colorado and other states began providing prostheses and orthoses to eligible Medicaid clients under the age of 21 years, when determined to be medically necessary. However, because of statutory requirements, adults needing external prostheses and orthoses continued to be ineligible for receipt of such devices.

During the 1997 Legislative session, HB 97-1063, the 1997 Medicaid Omnibus Bill, provided for the addition of a new optional service under Section 26-4-302(1)(f), C.R.S. The authorized service would provide prosthetic devices, including medically necessary augmentative communication devices, to eligible adult Medicaid clients. HB 97-1063 amended the statute to read as follows:

> 26-4-302. Basic Services for the categorically needy - optional services. (1) The following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:
> *... (f) Prosthetic devices, including medically necessary augmentative communication devices; except that non-surgically implanted prosthetic devices shall be included only after July* I, 1998, *and only if the general assembly approves appropriations for these devices as new benefit.*

Funding, in the amount of $978, 994, of which $481,469 was General Funds, was appropriated in the Fiscal Year 1998-99 Long Bill to implement the statute effective with the first day of Fiscal Year 199&-99.

The Medical Services Board passed amended regulations, effective July 1, 1998, and a change to the Colorado Medicaid State Plan was submitted to the Health Care financing Administration on September 30, 1998, effective July 1, 1998. It was approved by HCFA on December 9, 1998.

PROGRAM DESCRIPTION

Prosthetic Devices are defined in Department regulations as "replacement, corrective, or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:

1. Artificially replace a missing portion of the body;
2. Prevent or correct physical deformity or malfunction; or
3. Support a weak or deformed portion of the body."

This definition, which is identical to the Federal statutory definition, covers the medically y accepted definitions for both prostheses and orthoses. By medical definition, a prosthesis replaces a missing body part, and an orthoses corrects a physical deformity or malfunction, or supports a weak or deformed portion of the body. Prostheses would include artificial limbs and augmentative communication devices. Orthoses would include braces, specially constructed shoes, splints, and medically necessary specialized eating utensils or other medically necessary activities-of-daily living aids.

The Colorado Department of Health Care Policy and Financing Staff Manual Volume 8, in Section 8.593.01 Q, indicates that prosthetic and orthotic devices, including but not limited to the following, are a benefit for clients of all ages:

1 Artificial limbs;
2 Facial prosthetics;
3 Ankle-foot/knee-ankle- foot orthotics;
4 Recumbent ankle positioning splints;
5 Thoracic-lumbar-sacral orthoses (TLSO);
6 Lumbar-sacral orthoses (LSO);
7 Rigid and semi-rigid braces;
8 Therapeutic shoes for diabetics;
9 Orthopedic footwear, including shoes, related modifications, inserts, and heel/sole replacements when a medically necessary and integral part of a leg or ankle brace;
10 Specialized eating utensils and other medically necessary activities of daily living aids; and augmentative communication devices and communication boards.

Determinations of appropriate benefit are being made through the utilization of guidelines and criteria developed by Medicare for use in its prosthetic and orthotic program. The Department determined that utilization of such guidelines was advisable due to the limited amount of experience staff has in dealing with prostheses and orthoses for adults. Medicare guidelines are specific regarding devices which are appropriate and allowable for particular medical and health conditions. For example, using Medicare guidelines, benefit would be allowed for coverage of a lower limb prosthesis when the client:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the client's functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and ordering physician, considering factors including, but not limited to:

- The client's past history, including prior prosthetic use, if applicable;
- The client's current condition including the status of the residual limb and the nature of other medical problems; and
- The client's desire to ambulate.

Clinical assessments of a client's rehabilitation potential, or his/her functional ability, are used in the determination of medical necessity and the potential for successful use of a prosthesis, are based on the following classification levels:

Level 0:	Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
Level l:	Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
Level 2:	Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
Level 3:	Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
Level 4:	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation ski1ls, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

PRIOR AUTHORIZATION PROCESS

Prior authorization is required for all prosthetic and orthotic benefits. The Department has contracted with the Colorado Foundation for Medical Care (CFMC) to provide medically professional review of adult prior authorization requests. Reviewers use the Medicare guidelines in their review process.

In addition to the Medicare guidelines, the Department developed two questionnaires to be submitted with the Request for Prior Authorization. One must be submitted with requests for prostheses or orthoses, and another is requested to be submitted with requests for augmentative communication devices. The questionnaires were developed to assist the reviewers with determining the degree to which each request meets the Medicare criteria. They are also used to provide an estimation of the medical impact, both before and after receipt of the requested device. However, the questionnaires have evolved during the first year of the new benefit, with occasional changes needed as staff developed more experience and understanding of the complexities of the adult program. The current questionnaires requests less information about anticipated fiscal impact than did the original, as reviewers found that neither the physicians nor the providers of the requested services, were able to assign a fiscal value to previous medical services, or to potential future services. Copies of the two questionnaires are attached to this report as "Attachment B" and "Attachment C."

ADVISORY COMMITTEE

The Department has solicited the help of an advisory committee to assist with the implementation of this new adult benefit. The Prosthetic and Orthotic Advisory Committee is comprised of certified prosthetists and orthotists, augmentative communication specialists, CFMC staff, fiscal agent claims processors, and Department staff. It is anticipated that staff from the Department of Human Services, Division of Rehabilitation, will participate in the Advisory Committee in the future.

The Committee began by meeting at approximately two-month intervals. Beginning with the October, 1999 meeting, the Advisory Committee plans to meet at a standing quarterly meeting to allow members to schedule meeting dates, rather than attempting to find a date meeting everyone's needs.

Committee members not employed by the Department or its contractors have provided the Program with information regarding devices, which are unnecessarily high in cost, ineffective, duplicative, etc. Consultation has also been provided regarding the process of amputation and the development of an appropriate prosthesis.

The Department has utilized the Advisory Committee to review limited and selected Requests for Prior Authorization, which are questionable. Such requests (without client or provider identified) have been submitted to three of the providers serving on the Committee. The committee members have provided

recommendations regarding additional information needed and other devices that

STATE FISCAL YEAR 1998-1999 UTILIZATION AND EXPENDITURES

The Colorado Medicaid Adult Prosthetic and Orthotic Program has been operational since July 1, 1998. It was slow in its start up phase, while word of the new benefit was circulated among both providers and clients. However, the pace of implementation picked up following both the passage of time and the production of an official Medicaid Bulletin announcing the new benefit

A review of c1aims paid for services provided since July 1, 1998, indicates the following claims breakdown. Claims include those paid for dates of service between July 1, 1998, and June 30, 1999; claims submitted between July 1, 1998, and October 3O, 1999 (the last date for which a claim for a date of service within fiscal year 1998-1999 could be billed).

Prostheses

Distinct count of clients	52		
Total Payments	$241,310.63	Total numbers of prosthetic units	876
Single client high cost	$13,229.59	Number of diagnoses represented	15
Average cost per client	$4,640.59	Single client low cost	$26.00
Average units per client	16.85	Average cost per unit	$275.47

As indicated in the table below, 49.2% of the prosthetic units, and 44.5% of expenditures were utilized by female clients. Males utilized 50.8% of units and 55.5% of expenditures.

Gender	Number of Prosthetic Units	Paid Amount
Female	431	$ 107,489.67
Male	445	$ 133820.96
TOTAL	876	$ 241,310.63

The table below itemizes utilization by aid category. Clients in the Aid to the Needy Disabled (AND) category utilized the majority of services with 71.9% of units and 76.7% of expenditures.

Aid Category	Number of Prosthetic Units	Paid Amount
Old Age Pension - Class A	91	$ 27,023.82
Old Age Pension - Class B	101	$18,422.14
Aid to Needy Disabled, S81, SSI Medicaid	630	$185,086.85
Aid to Needy Disabled, State Only	54	$10,777.82
TOTAL	876	$241,310.63

The most common diagnoses indicating the need for a prosthesis were those relating to traumatic amputation of some limb. Traumatic amputation accounted for 80% of all units utilized, and for 84% of prosthetic expenditures. A complete itemized list of all diagnoses indicated on claims for prosthetic services can be found in Attachment A.

TOTAL EXPENDITURES FOR NEW ADULT BENEFIT

Distinct count of clients	381	Total numbers of units	1545
Total Payments	$373,964.50	Number of diagnoses represented	195
Single client high cost	$13,229.59	Single client low cost	$4.58
Average cost percent	$981.53	Average cost per unit	$ 245.34
Average units per client	4.06		

Type of Service	Number of Units	Paid Amount
Prostheses	876	$241,310.63
Prosthetic eyes	8	$10,540.90
Augmentative Communication Devices	24	$23,658.63
Orthoses	638	$98,454.34
TOTAL	**1,546**	**$373,964.50**

FISCAL YEAR 1999-2000 ESTIMATED UTILIZATIONIZATION AND EXPENDITURES

Although a Medicaid Bulletin was published, announcing the new benefit for adults, the Department continues to receive requests for confirmation that prostheses and orthoses are now considered a regular benefit of the Medicaid program. Both clients and providers do not fully understand that a service not offered for 30 years is now available as a regular benefit Because of that lack of understanding, and a continuing increase in the number of prior authorization requests for prosthetic and orthotic services, staff of the Department believes that growth in utilization for previously unmet needs will continue into the new fiscal year. Consequently, based upon experience of the prior authorization reviewers and the advisory committee membership, it is estimated that expenditures for Prostheses during state fiscal year 1999-2000 will be approximately $ 485,669. This amount reflects an estimated utilization growth factor of 3 0%.

The 30% growth in utilization has been applied evenly across all prosthetic and orthotic services, particularly since it is an estimate. Anticipated utilization therefore appears to be as follows:

Type of Service	Units	Amount
Prostheses	1139	$ 313,760.00
Prosthetic Eyes	10	$13 176.00
Augmentative Communication Devices	31	$30,427.00
Orthoses	829	$127,931.00
TOTAL	**2,009**	**$485,294.00**

POTENTIAL SAVINGS

The provision of prostheses and orthoses to adult Medicaid clients results in a variety of benefits, some of which are fiscal in nature; some of which are more related to quality of life issues, which are less measurable.

It had been the intent of the Department to identify and quantify some of the areas of potential client improvements anticipated or experienced by clients newly able to obtain medically necessary prostheses and orthoses. The information was to be provided by the two questionnaires used as part of the prior authorization process. However, although experience with the questionnaires proved to be useful in determining medical necessity, those portions of the questionnaires which asked physicians to speculate on the physical and/or quality-of-life improvements to be anticipated were often incomplete, and therefore invalid for quantifying such improvements. Physicians, in completing the forms, were unwilling or unable to forecast such anticipated outcomes.

While not able to quantify anticipated physical/quality-of-life changes, it is believed that the long-term effects of newly available prostheses and orthoses wilt be a reduction in pain, decreased dependence on caretakers, and reduced chance of diabetic-related infection leading to limb amputation. Savings in overall medical costs experienced by clients utilizing the new adult prosthetic and orthotic benefit were identified. Clients were selected who had utilized the new adult benefit, and who had a full six months of potential medical services available to them, and billed, following receipt of their prosthetic or orthotic. Further, clients were selected who had also received medical services during a comparable six-month period in the previous year.

Medical expenses for each of the 166 clients meeting the above criteria 'were examined for dates of service occurring during the 7th through the 12th month preceding the month in which the client received a prosthetic or orthotic. The costs of medical care received during and in the five months following receipt of the prosthetic or orthotic were also examined and compared to those previous costs. For example, if a client received a prosthetic in October, 1998, the client's medical expenses were examined for the period October, 1997 through March, 1998, and for the period October, 1998 through March, 1999. For the subject group of clients, information

provided does not include a comparison of medical equipment costs. Expenditures for durable medical equipment increased for the subject study group by virtue of the fact that the cost of the prosthetic or orthotic was included in the costs expended for the month of service, and was not an expenditure for the corresponding period, 12-months earlier.

Changes in the medical expenditures for the study group of 166 clients are indicated below.

Type of Service	Prior Costs	Subsequent Costs	Difference	Percentage
CO1500 (medical)	$ 399,598	$417,392	$17,794	+ 4.45%
Med Equipment (not including Prosth & Ortho)	$85,551	$60,315	(&25,236)	-29.50%
UB-92 (Hosp, Nursing Fac, and Home Health)	$1,353,013	$824,228	($528,785)	-39.08%
Pharmacy	$152,564	$169,551	$16,987	+11.13%
Total	$1,990,726	$1,633,365	($357,361)	-17.95%

It should be noted that the study group of 166 clients had expenditures in the amount of $ 161,879 not included in the above table. This amount was for the purchase of a prosthetic, orthotic, or augmentative communication device.

Consequently, as indicated by the table, there were gross savings in the amount of $ 357,361. However, discounting the expenditures for the new adult benefit services, there was a net savings realized of$ 195,482, or $ 1,177.60 per client.

If the per client average were to be applied to the 215 prosthetic and orthotic clients not included in the study group, there would be an additional estimated savings for the fiscal year of$ 253,184. Consequently, the estimated net savings for fiscal year 1998-1999, would be $ 448,666 ($ 195,482 + $ 253,184).

Summary

The Medicaid Prosthetic Program for adults was funded in the amount of $978, 994 for Fiscal Year 1998-99. The Joint Budget Committee requested information regarding the anticipated expenditures for the first and second fiscal years.

As part of the implementation of this new benefit, the Department has selected medical criteria for use during reviews of requests for prior authorization. Staff has worked with the provider community to establish an advisory committee to assist with additional protocols for review, in addition to training regarding the complex issue of adult prostheses and orthoses. Questionnaires have been designed and made available to providers to help reviewers conduct a comprehensive review of each request for prior authorization.

Expenditures for the first year have been a total of$ 373,964.50, with 381 clients being served. It is anticipated for fiscal year 1999-2000, that expenditures will increase approximately 30% for a total of$ 485,426. The increase is anticipated due to the fact that not all providers and c1ients seem to be fully aware of the new adult benefit availability, and will therefore be presenting for services during year two, rather than the first year as originally anticipated.

There have been increased expenditures experienced for some types of medical services following provision of a prosthetic to an adult client, and decreased expenditures for others. Net savings documented for one-half of the benefit's first fiscal year are $195,482. Projecting average savings across the balance of the population would result in an estimated net savings of $ 448,666.

In addition to the estimated savings realized, the Department feels that a valuable service is being offered to Medicaid adult clients, that will provide a more pain free, less dependent life for them.

Attachment A

Utilization by Diagnosis

Prostheses:

Principal Diagnosis	Number of Prosthetic Units	Paid Amount
Malignant Neoplasm of the Larynx	3	$75.00
Diabetes Mellitus	21	$3,426.97
Diabetes with peripheral circulatory disorders	17	$0.00
Quadriplegia	3	$135.00
Peripheral vascular disease, unspecified	18	$2,600.98
Chronic airway obstruction, not elsewhere classified	1	$26.00
Impotence of organic origin	1	$335.57
Other ill-defined and unknown causes of morbidity and mortality	2	$90.00
Fracture of facial bones, other facial bones, open	1	$2,500
Traumatic amputation of arm and hand, bilateral, complicated	13	$5,677.35
Traumatic amputation of foot, bilateral without mention of complication	10	$8,901.18
Traumatic amputation of leg(s)	54	$8,812.48
Traumatic amputation of leg(s), unilateral, below knee, without mention of complication	454	$106,640.29
Traumatic amputation of leg(s), unilateral, at or above knee, without mention of complication	137	$66,074.53
Traumatic amputation of leg(s), bilateral without mention of complication	34	$6,033.32
Unknown	107	$29,921.96
TOTAL	**876**	**$241,310.63**