August 15, 2006

POWER MOBILITY DEVICES – RESPONSE TO COMMENTS

Basic Coverage Criteria

Allow consideration of in-home activities of daily living (ADLs) other than the five that are stated

- Allow mobility for mobility sake

Response: The Local Coverage Determination (LCD) has been modified to reflect the National Coverage Determination (NCD) in stating that the specific mobility-related ADLs (MRADLs) that are listed are not all-inclusive of those that may be considered in determining the need for a power mobility device (PMD) in the home. Although mobility is not specifically listed, it is understood that mobility is required for the patient to perform or participate in MRADLs in customary locations in the home – e.g., bathroom, kitchen, etc. Mobility must be considered in the context of the activity that it purports to support, and is not sufficient in and of itself.

Revise criterion N to say "Use of the power wheelchair will improve the patient's ability to participate in MRADLs in the usual and customary locations within the home. The fact that the device will be used solely to reach the usual and customary location for the related MRADL (independently or dependently) fulfills this requirement. Additionally, the patient will use the device on a regular basis in the home."

Criterion N says: "Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home."

Response: The additional wording does not change the intent of this criterion and is not needed.

Disagree with the in-the-home restriction

- Either the beneficiary will use device in inappropriate locations or will be confined to the home
- Use of a wheelchair in inappropriate locations will result in increased number of repairs
- If the in-the-home restriction is maintained, allow for add-on features that are useful outside the home
- If the in-the-home restriction is maintained, then for those beneficiaries who need a wheelchair in the home, allow payment for a power wheelchair that allows full mobility outside the home

Response: The in-the-home limitation of coverage of durable medical equipment is a statutory issue and may not be changed by the Durable Medical Equipment Program Safeguard Contractors (DME PSCs).

Make it clear that patients with severe cognitive and/or physical impairments may not be able to accomplish an MRADL without the assistance of a caregiver

Response: Criterion N has been revised to clarify that point.

Delete noncoverage for short term, reversible conditions

- Mandate rental instead of purchase in these situations
- Cover rental as part of a trial where feasible/practical

Response: Use of a power wheelchair in such situations (e.g., when a patient is nonambulatory during recovery from lower extremity surgery) is not standard practice. In those situations, use of manual wheelchair operated by the patient or a caregiver would be considered for coverage.

Modify criterion J (and other parts of the policy) to make it clear that the capabilities of the caregiver will be considered if the beneficiary cannot operate the power wheelchair) WC (similar to criterion K)

Response: Criterion K has been modified to make it clearer that it applies when the patient is unable to operate a PWC.

Role of caregiver should not determine Mobility Assistive Equipment (MAE) eligibility

If there is a caregiver who can push a patient in a manual WC, a power WC should still be covered

Response: We agree. The abilities of the patient are the primary determinant of the item that is covered. Criterion C states that the inability of the patient to propel a manual WC him/herself is the criterion to be met before coverage for a PMD can be considered. The role of the caregiver is considered only when the patient is unable to operate a manual wheelchair or any type of power mobility device.

<u>Downcoding to Standard Use</u>

Note: The code names and coding guidelines have been revised since the draft policy was published. In this and other sections, the responses will reflect the new terminology and guidelines.

Oppose downcoding of other WC bases to Standard for the following reasons:

- Intended for intermittent use (e.g., at the mall)
- Don't provide posture support
- Can't be modified to meet individual patient's seating and positioning needs

- Can't accommodate varying surfaces – e.g., carpet, tile
- Can't accommodate obstacles

Response: We agree. These concerns have been addressed in the code changes. In the current code set, Group 1 power wheelchairs (PWCs) have performance and durability characteristics (e.g., obstacle height capability, dynamic stability on an incline, and fatigue and drop cycle testing requirements) that allow the WC to perform well inside the home and on most hard surfaces outside the home. Patients who require pressure reduction and/or positioning seat and/or back cushions qualify for coverage of Group 2 PWCs which are designed to accommodate those items.

Standard Use chair is not appropriate for patient with a neurological disability who weighs less than 220# and doesn't require alternate drive control, power seating, or a ventilator

Response: We agree. Patients who meet the coverage criteria for a power wheelchair and who have a neurological disability which renders them unable to stand and pivot to transfer from a chair to a wheelchair will qualify for a Group 3 PWC in the new code set.

General Use or High Activity WCs may offer additional features that are helpful
- Adjustable seat-to-back angle
- More seat size and back height options
- Adjustable frame size to accommodate future size (patient weight) change
- Expandable electronics – helpful for patients with progressive conditions

Response: In the new code set, Group 1 and 2 PWCs include models which have adjustable seat-to-back angles and different seat sizes and back heights.

Pediatric WC codes have adjustable frames to accommodate growth. It is not standard for adult power wheelchairs to have adjustable frames to accommodate for weight change.

Expandable controllers are available on some Group 2 and 4 PWCs and all Group 3 PWCs. These controllers can accommodate alternate drive input controls or a combination tilt and recline power seating system for patients who require them.

Establish specific coverage criteria for each category of PMD

Response: We agree. Specific coverage criteria have been established for Group 2 and 3 power wheelchairs.

Similar concerns for downcoding Power Operated Vehicles (POVs) to Standard Use POVs

Response: Group 1 POVs have performance and durability characteristics that allow them to perform well inside the home and on most hard surfaces outside the home. There are also a variety of seating and other options to meet individual patient needs.

Downcoding will restrict access to most products on the market and will constrain physician and beneficiary decision-making

Response: Now that unique coverage criteria have been established for Group 2 and Group 3 PWCs, a beneficiary's needs can be matched to a PWC's capability. As a result, there will be less downcoding. However, downcoding remains an integral part of the policy. The fundamental principle is that Medicare will only pay for the level of equipment that meets both statutory coverage criteria and the medical needs of the beneficiary. There is an option for a beneficiary to obtain an upgraded item if the beneficiary or some other third party payer is willing to pay the additional amount.

Not clear which products will be downcoded to which codes

Response: Until the fee schedule allowances for the individual codes have been established, it is not possible to make those determinations. After the publication of the allowances, the DME PSCs will develop an article that provides additional information on this subject.

Downcoding is contrary to the principle of establishing multiple unique codes for specific technologies

Response: We disagree. Codes are established based on differences in technology. Downcoding is a Medicare coverage determination based on statute and national and local policies. Coding and coverage are not always linked.

Downcoding will limit payment to products without sufficient durability, speed, and range to allow patients to get outside the home

Response: We disagree. Even Group 1 PWCs have performance and durability characteristics (e.g., obstacle height capability, dynamic stability on an incline, and fatigue and drop cycle testing requirements) that allow the WC to perform well on most hard surfaces outside the home. However, the medical policy is based on the national policy which says that, as with all durable medical equipment, wheelchairs are covered only if they are needed for use in the home. Therefore, payment is made for features that are necessary in the home.

Downcoding a power wheelchair to a POV is contrary to the NCD

Response: We disagree. The NCD defines a stepwise progression of medical necessity and coverage. If a PWC is provided and if a POV would

meet the patient's mobility needs, it is appropriate to pay for the PWC comparable to a POV.

Specific Use

Touch pads and mini-proportional or compact joysticks should be considered alternative drive control interfaces

Response: We agree. The revised Coding Guidelines section indicates that all drive control interfaces other than standard proportional joysticks are considered "alternative" controls.

Insufficient numbers of independent Assistive Technology Practitioners (ATPs) with wheelchair specialty

- Many ATPs don't specialize in WCs (e.g., speech language pathologists, engineers)
  - Limit to evaluations performed by ATP-credentialed physical therapists (PTs) and occupational therapists (OTs) in a practice that is able to bill the Medicare program for the assessment
- Some are employed by suppliers or manufacturers
- Long travel for beneficiaries in rural areas
- RESNA (Rehabilitation Engineering & Assistive Technology Society of North America) certification requires 2 years of experience – but if Medicare won't consider evaluations done by them during this period, no one will hire them to get this experience
- Consider other options
  - Phase-in period – 5 years
  - Licensed PT/OT with additional training/experience
  - RESNA certified Assistive Technology Supplier (ATS) plus a qualified PT/OT

Response: We agree that at the current time there are not sufficient numbers of RESNA-certified ATPs to meet the needs of Medicare beneficiaries. However, we believe that beneficiaries who need special rehab wheelchairs (i.e., those that require alternative drive controls and/or power tilt/recline systems) would be best served by the participation of a practitioner with special training and expertise. We believe that is best assured by accreditation through a nationally recognized organization. Therefore, we are establishing this requirement for rehab power wheelchairs that are provided on or after April 1, 2008. The 18 month transition will provide sufficient time for practitioners who currently have the necessary education and experience to obtain ATP certification.

We agree that this should be limited to ATP-credentialed PTs and OTs.

Supports requirement for ATPs but board certified physiatrists should also be included

Response: We agree. Among physician specialties, that group has the needed training and experience. The policy has been revised to acknowledge that.

Many others are qualified – e.g., all PTs, all OTs, neurologists, etc.

Response: We disagree. All of these individuals do not have expertise in evaluating patients for rehab wheelchairs. If they have the required education and experience, they should obtain the additional certification.

Add a requirement that the supplier be ATS certified or (National Registry of Rehabilitation Technology Suppliers) NRRTS registered

Response: We agree. For dates of service on or after April 1, 2008, we have added the requirement that suppliers who provide wheelchairs with an alternative drive control device and/or power tilt and/or recline seating systems have an ATS certification through RESNA.

POVs

Some who require assistance to transfer may benefit from a POV. Allow if a patient can "safely" transfer. Don't require independent transfer

Response: We agree. We have made this revision to the policy.

Maintain requirement for independent transfer to assure that if beneficiaries are not able to operate a lower level device (e.g., POV) independently but are able to operate a higher level device (e.g., power wheelchair) independently, that the higher level device will be covered

Response: We partially agree. Even though we are modifying the policy to allow coverage of a POV if the patient can safely transfer with assistance, we do continue to say that if a patient meets the general criteria for a power mobility device but is not able to independently transfer, that patient would qualify for coverage of a PWC.

POV may not be appropriate for a patient with a progressive condition

Response: Medicare coverage is based on the patient's medical condition at the time that the item is provided.

Bariatric beneficiary should be able to get a POV if there is one that meets their needs

Response: We agree. The new code set establishes POV codes with weight capacity up to 600 pounds. These will be covered if the criteria are met.

POVs may be problematic for activities involving a table or sink. When a POV's seat is swiveled 90 degrees, the patient's legs dangle which results in instability and may aggravate arthritic, circulatory, or neurological conditions

Response: If a patient meets the requirements for power mobility and is not able to transfer from a chair to a POV independently, he/she would be eligible for coverage of a PWC. If a patient is able to transfer independently, he/she would be able to sit in a regular chair at a table. Having a PWC would not allow the patient to access a sink any better than having a POV.

POVs are not designed for use in the home. Shouldn't downcode a PWC to a POV

Response: We disagree. POVs that are included in the new code categories can be operated in some homes. Suppliers are responsible for assessing whether the beneficiary's home can accommodate a POV.

POVs are not as safe as a power WC

Response: POVs are approved for marketing by the Food and Drug Administration (FDA) and are safe when they are ordered for the appropriate individual. Part of the responsibility of the physician and other practitioners who are performing the face-to-face examination is to determine whether a particular type of mobility device can be safely operated by that beneficiary.

Captain's Chair

Sling seat plus general use cushion shouldn't be downcoded to a captain's seat – allow what is ordered. Disadvantages of captain's seat:

- Too high for transfers
- Environmental access issues (e.g., tabletops)
- Limited sizes, contours
- Limited options for arm supports
- Many don't accommodate swing away leg supports
- Cover material doesn't address heat and moisture management
- Can't change to higher level cushion if patient's condition worsens
- Many don't have adjustable back angle

Response: We disagree. A Captain's Chair serves the same purpose as a general use seat and back cushion. Therefore, the application of the least costly alternative provision is appropriate.

Accessories

Push-rim activated power assist – disagree with criteria – allow the evaluating therapist/physician to decide what is best

Response: We partially agree. A major criterion for coverage of these devices rests on the assessment by a clinician with expertise in evaluating patients who need rehab wheelchairs. We believe that the requirement that the patient has been a manual wheelchair user for at least one year is reasonable. This device may be appropriate for a patient who is a long term manual wheelchair user, is having some problems with arm propulsion, but does not want to use a POV or PWC. For a patient who has not been in a wheelchair and is determined to need power mobility, a POV or PWC is appropriate.

Add-on feature to convert manual WC to a power WC or POV – deny as noncovered, not as not medically necessary

Response: We disagree. These add on devices do meet the definition of DME and therefore we cannot deny them as statutorily noncovered. We are denying them as not medically necessary because they do not have the performance and durability characteristic that are now required for PMDs.

<u>Documentation</u>

Recommend standard documentation tool/form or establish a new CMN

Response: The requirements of the Paperwork Reduction Act make this impractical. Also, our previous experience with the Certificate of Medical Necessity (CMN) revealed significant problems with the use of these sorts of documents in a rapidly evolving line of business.

Forms should be considered part of medical record

Response: The use of a form does not replace the patient's medical record as the primary source of information demonstrating whether the patient meets the coverage criteria.

Home assessment

- Don't require on-site home assessment
- There is no funding for this
- Agree with in-home assessment
- Home assessment by the supplier needs to be conducted prior to writing the order

Response: Because of the many factors that may make certain power mobility devices inappropriate for use in a particular patient's home, it is important that there be an in-home assessment by the supplier. Although it is preferable that this assessment be performed before the PMD (especially a rehab power wheelchair) is ordered, we are not making that a requirement. However, the supplier must realize that if they wait until the day of delivery to do the home assessment and if they determine that the device will not allow the patient to function well in the home, then the

supplier must not complete the delivery and must order a another PMD that is appropriate for use in the patient's home.

Allow PT/OT evaluation, not just "patient medical records"

Response: Evaluations by PTs/OTs who are independently practicing or employees of healthcare facilities/practitioners and whose services are eligible to be reimbursed by Medicare are considered to be part of the medical record.

Allow use of PTs or OTs employed by supplier

Response: Because of the potential conflict of interest, personnel employed by a supplier are precluded from performing assessments used to justify the medical necessity for the item.

Agree with requirement that the therapist have no financial relationship with the supplier

Response: That requirement is retained in the final policy.

Medical charts and progress notes are frequently incomplete

Response: The purpose of the required face-to-face examination is to have a visit dedicated to an assessment of the patient's mobility needs. It is expected that the documentation from this visit will provide a clear picture of the patient's condition.

Create an advisory committee to establish documentation guidelines

Response: The comment process for a draft policy provides the opportunity for individuals or groups to offer specific recommendations.

Suppliers should not be forced to make clinical judgments

Response: Suppliers are expected to have sufficient knowledge of the patient's medical condition in order to determine whether coverage criteria have been met for the equipment that they provide. For years, suppliers have been using this level of knowledge to assess whether to obtain an Advance Beneficiary Notice (ABN) on items that they provide.

Recognize that trained supplier employees may play a role in product selection

Response: Although supplier employees may not do the clinical evaluation to determine what type of mobility assistive equipment is medically necessary for a beneficiary, suppliers do play a valuable role in deciding what specific model of a POV or power WC is appropriate for a beneficiary based on the medical necessity determination.

Include information on use of a therapist in the evaluation process in the LCD rather than in the Policy Article

Response: Since the face-to-face examination is a specific statutory provision and not an application of the general medical necessity provision, information about the role of the therapist in the face-to-face exam belongs in the Policy Article rather than the LCD.

Specify that therapist evaluations are covered through a separate CPT code

Response: The DME contractors do not provide advice or instructions concerning the use of CPT codes. That information should be sought from local carriers and fiscal intermediaries.

Previous rehab evaluations should be considered as part of the documentation for a PMD

Response: In addition to the report of the face-to-face examination, physicians are encouraged to provide any additional information from the medical record that helps to describe the patient's condition and mobility needs.

Codes

There were several comments that addressed issues specific to the codes that were proposed in the draft policy. Since there has been a change in the code set, those specific comments are not included in this document.

Miscellaneous

If the codes change, a new draft LCD should be sent out for comment

Response: Although the revised code set made some changes in the performance characteristics that distinguish different categories of power mobility devices, the basic framework of the coding structure did not change significantly. Similarly, the relationship of the codes to the coverage criteria did not change. The comments that were received on the draft policy are equally pertinent to the new code set. Therefore, there is no need to repeat the comment process.

There are problems with funding for PT evaluation

Response: Payment for PT services is not an issue that is under the jurisdiction of the DME contractors.

Need improved education of physician, other clinicians

Response: Although the DME contractors do not have direct responsibility for the education of physicians, we do provide resource material that may be used by suppliers to help educate physicians. We also provide this

information to the local carriers who have the primary responsibility for physician education.

Emergency services and on-going assistance should not be included in allowance – or more clearly define what is meant by those terms

Response: We agree. Those statements have been removed from the policy.

Deny nonqualifying WCs as noncovered rather than as not medically necessary

Response: Durable medical equipment is a defined statutory benefit. If an item meets the general definition of DME but the contractors decide that the particular item is not appropriate for a particular patient, or for any patient, the denial must be a medical necessity denial rather than a "coverage" denial.

Offer the option of prior authorization for all power mobility devices

Response: Items that are considered to be eligible for prior authorization are determined by Centers for Medicare & Medicaid Services (CMS) based on the Medicare statute. The DME contractors do not make that determination.