American Association for Homecare
Caring that Feels Right at Home

April 22, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., S.W., Room 445-G
Washington, DC 20201

RE: Reinstate Beneficiary Access to Payment for Reasonable and Necessary Power Mobility Devices

Dear Dr. Berwick:

On behalf of the American Association for Homecare, we are writing to request that the Centers for Medicare and Medicaid Services (CMS) address an unintended consequence related to the elimination of the "least costly alternative" payment determinations for Durable Medical Equipment (DME) claims. The Power Mobility Device (PMD) Local Coverage Determination (LCD) and its associated Policy Article have removed a Medicare beneficiary's right to upgrade to certain Group 2 and Group 4 power mobility devices (PMDs). The revised policy now in place has turned this previously workable system on its head and forces the Medicare beneficiary to incur the entire cost of certain medically necessary power wheelchairs and scooters, which include additional features deemed not necessary for use in the home.

In the past, when a Medicare beneficiary was prescribed a Group 4 power wheelchair, a Group 2 power wheelchair with a seat elevator or a Group 2 power operated vehicle, Medicare downcoded these items to the "least costly, medically necessary item" for payment. If the beneficiary selected the power mobility base and/or accessories prescribed by a physician that were not covered by the Medicare program, or were deemed "convenience" items, Medicare paid for the medically necessary base code and allowed Durable Medical Equipment suppliers to furnish the patient with an Advanced Beneficiary Notice of Noncoverage (ABN). This appropriate use of the ABN allowed beneficiaries to make an informed consumer decision about receiving items with additional features that may not be medically necessary, for which they may have to pay out-of-pocket, or through supplementary insurance and be more active participants in their own health care treatment decisions.

It is the Association's view that when an item or service is medically necessary and covered under the Medicare program, and the beneficiary prefers an item with deluxe features, additional components or upgrades that are not medically necessary, coverage and payment should be based on the amount for the item normally used to meet the intended purpose. The elimination of payment for these items will force some beneficiaries into utilizing a product that may not meet their needs or allow safe, independent negotiation of their environment.

Rationale:
Group 2 POVs (K0806-K0808), Group 2 PWCs (K0830-K0831) and Group 4 PWCs (K0868 – K0886) clearly meet the definition of DME under the Medicare program. In addition,

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1. They are presumptively medical, do not meet the definition of presumptively non-medical, are not identified as presumptively non-medical, do not serve a comfort or convenience purpose and are not physical fitness equipment, first-aid or precautionary equipment, a self-help device or training equipment;
2. They are reasonable and necessary for the treatment of an illness or injury, or to improve the function of a malformed body member;
3. May be deemed to be substantially more costly than a medically appropriate and realistically feasible alternative or serve essentially the same purpose as equipment already available to the beneficiary; and,
4. The "added capabilities that are not needed for use in the home" do not preclude the use of the PMD within the beneficiary's home.

Furthermore,

1. The DMEPOS Quality standards require a supplier to ensure that the beneficiary can use the equipment safely and effectively in the settings of anticipated use;
2. Statutory coverage of DME requires that it be needed for use inside the home. However, if that requirement is met, the item may be used outside the home; and,
3. An ABN allows beneficiaries to make an informed consumer decision about receiving upgraded items or services that may include an excess component, which is in addition to, or is more extensive and/or more expensive than the item that is reasonable and necessary under Medicare's coverage requirements.

Recommendations:
AAHomecare recommends the following immediate action be taken so that Medicare beneficiaries can elect to upgrade HME or select additional features and accessories if the underlying item is covered by Medicare:

1. Continue to allow beneficiaries to elect an upgrade for these items, as outlined in Section 1834 (42 U.S.C 1395m)(a)(19) of the Social Security Act, which has been available via the appropriate use of an Advanced Beneficiary Notice of Noncoverage (ABN) since the new power mobility device codes were implemented in 2006.
2. Issue an immediate rescission of the interpretation published by National Government Services on March 14, 2011, allow Medicare beneficiaries to continue to utilize the upgrade provision and allow payment for a power mobility device that is consistent with what is reasonable and medically necessary to serve the intended purpose of the prescribed power mobility device. This recession should be retroactive to February 4, 2011.
3. Engage in discussions with stakeholders, including appropriate consumer, clinician, and supplier groups, to develop LCD and Policy Article language for Power Mobility Devices that is consistent statute and will not result in a negative impact to a beneficiary's access or ability to engage in their own heath care decisions.

We appreciate your consideration of this issue and welcome the opportunity to discuss this further. Please feel free to contact Walt Gorski, Vice President, Government Affairs at (703) 535-1894 or waltg@aahomecare.org.

Sincerely,

Tyler J. Wilson
President
American Association for Homecare