CMS Can Easily Correct Medicare Policy to Ensure Beneficiary Access to Complex Rehab Wheelchair Accessories

Background

CMS can easily resolve a Medicare access issue relating to accessories used with complex rehab technology (CRT) wheelchairs that are critical to people with significant disabilities and to reflect the intent of Congress in the 2008 Medicare Improvements for Patients and Providers Act (MIPPA). To do so only requires CMS to make a small modification to a CMS December 2014 FAQ document (sub-regulatory guidance) that is posted on CMS' web site.

MIPPA Law: Section 154 of MIPPA 2008 specifically excludes from the Medicare DME competitive bidding program (CBP) CRT power wheelchairs, as well as the accessories that consumers use with those wheelchairs, such as seat/back cushions, recline/tilt systems, and specialty controls. Consistent with that law, Congress did not include those CRT items in Rounds 1 or Rounds 2 of the DME bidding program. CMS also implemented a similar payment policy for accessories used with CRT manual wheelchairs. As a result, CRT wheelchair bases and related accessories have been paid at the traditional fee schedule amount in bid and non-bid areas.

CMS Regulation: In November 2014, CMS issued a final rule ("Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies," 1614-F, 79 *Fed. Reg*. 66119, November 6, 2014) finalizing certain next steps and changes to the Medicare DMEPOS bid program. Specifically, the CMS final rule details how CMS will use information obtained from the Medicare bidding program to adjust the Medicare fee schedules for competitively bid items provided in non-bid areas, beginning January 1, 2016.

CMS FAQ: The November 2014 final rule did not address this CRT accessory payment issue. In December 2014 CMS posted on-line a "Frequently Asked Questions" (FAQ) document stating that starting in January 2016 CMS intended to use bid pricing information obtained from the CBP for standard wheelchair accessories to reduce the payment amounts for CRT wheelchair accessories. This application was not appropriate as these CRT accessories were not included in the CBP per the intent of Congress contained in MIPPA 2008. The issue arises from the fact that many HCPCS codes for wheelchair accessories include a broad array of technology, some of which are provided on standard and some which are provided on CRT wheelchairs. Therefore, while there may be a competitive bid payment amount associated with a HCPCS code, the payment amount is based upon bids for the standard accessory, not the CRT accessory.

Congress: Congress has repeatedly expressed to CMS that it should not apply bid rates to accessories used with CRT wheelchairs. In April 2015, 101 Members of the U.S. House of Representative sent a bipartisan letter to CMS asking it to not apply CBP payment rates to accessories used with CRT wheelchairs. In August 2015, 25 Members of the U.S. Senate sent a similar bipartisan letter. Despite this broad based bipartisan Congressional request, CMS refused to make the change.

Given CMS' refusal to make the needed change, House and Senate bills were introduced to make the needed clarification (H.R. 3229 and S. 2196[i]). Seventy-six national consumer, patient, and clinician organizations wrote to Congress in support of passage of the bills. At the end of 2015, Congress included in the Patient Access and Medicare Protection Act (PAMPA) a 12-month delay (through December 31, 2016) of CMS' planned application of CBP prices based on standard accessories to CRT accessories that share the same HCPCS code. In December 2016, as part of the 21st Century Cures Act, Congress included an additional 6-month delay that will expire on June 30, 2017.

Request to CMS

Congress has repeatedly communicated to CMS that the application of CBP payment rates to CRT Wheelchair Accessories is contrary to its intent in excluding CRT wheelchairs and accessories used with them as part of the MIPPA 2008 law. There is no need for a statutory change. There is no need for CMS to change its current regulation. CMS can simply modify its December 2014 (updated February 18, 2015)[ii] sub-regulatory guidance posted on its web site and instruct its contractors.

Following is the text of the referenced FAQ with the recommended changes needed to resolve this issue noted (suggested additions are in **bold red**, ~~deletions~~ are crossed out):

> 3Q. In some cases, an accessory identified by a Healthcare Common Procedure Coding System (HCPCS) code that can be furnished for use in conjunction with different types of base equipment has been included in CBPs for use with some but not all of the different types of base equipment that are furnished in conjunction with the accessory. Will the fee schedule amounts for the HCPCS code for the accessory be adjusted based on the single payment amounts (SPAs) established for the accessory for use with certain base equipment, and will the fee schedule amounts for the accessory that are adjusted based on the SPAs be used in paying all claims for the accessory, regardless of which type of base equipment the beneficiary is using in conjunction with the accessory?
>
> 3A. In these cases, the fee schedule amounts for the accessory will **not** be adjusted based on the methodologies set forth in the final rule **if such code was used on a complex rehabilitative wheelchair base**. ~~Effective July 1, 2016, after the 6-month phase in period, Medicare will no longer have different fees for the same accessory when used with different types of base equipment if the HCPCS code for the accessory does not limit what type of base equipment the item can be used in conjunction with and if SPAs have been established for the accessory. The fee schedule amounts for the accessory will be the same regardless of what type of base equipment the item is used in conjunction with.~~
>
> For example, certain wheelchair accessories, such as a power seating system, are used with both Group 2 complex rehabilitative power wheelchairs and Group 3 complex rehabilitative power wheelchairs. SPAs were established for many of these accessories under a product category for Group 2 complex rehabilitative power wheelchairs and related accessories. The fee schedule amounts for these accessories will **not** be adjusted based on the SPAs established for these items under CBPs for Group 2 complex rehabilitative power wheelchairs and related accessories. ~~The adjusted fee schedule amounts will be used in paying claims for these accessories when they are furnished for use with either Group 2 or Group 3 complex rehabilitative power wheelchairs. The codes and Medicare allowed payment amounts for the accessories are separate from the codes and Medicare allowed payment amounts for the wheelchairs they are furnished in conjunction with, and the codes for the accessories do not specify that the accessory is only for use with certain types of complex rehabilitative power wheelchairs.~~

List of Attachments:

1. ATTACHMENT 1- Section 154 of MIPPA 2008
2. ATTACHMENT 2- CMS FAQ modified February 18, 2015
3. ATTACHMENT 3- Relevant sections of CMS final rule November 6, 2014
4. ATTACHMENT 4- H.R. 3229 from 2016

---

[i] At the end of 2016, H.R. 3229 had 146 co-sponsors and S.2196 had 25 co-sponsors.

[ii] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/Downloads/2015-DMEPOS-FR-FAQs.pdf