U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
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For Immediate Release
Thursday, Sept. 29, 2005

Grassley Seeks Further Refinement of Power Wheelchair Rules

WASHINGTON – Sen. Chuck Grassley, chairman of the Committee on Finance, today urged the Centers for Medicare and Medicaid Services to create a smooth transition to new coverage and payment policies for power wheelchairs. These new rules appear to be overly restrictive, confusing, and impossible to successfully implement in the proposed time frame – fueling fraud, waste and abuse in the Medicare program.

The text of Grassley's letter to the Health and Human Services secretary and director of the Centers for Medicaid and Medicaid Services follows.

September 29, 2005

Via Electronic Transmission
Original via USPS Mail

The Honorable Michael O. Leavitt
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW Room 339G
Washington, DC 20201

Dear Secretary Leavitt and Administrator McClellan:

Since the Committee on Finance (Committee) held its hearing entitled, *Taking Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program*, I have urged the Centers for Medicare and Medicaid Services (CMS) to strengthen its oversight and program integrity efforts, while maintaining beneficiary access to medically necessary devices. As Chairman of the Committee, I have a number of concerns regarding CMS's revised coverage and payment policies for power mobility devices

(PMDs).

In FY 2003 Medicare paid $1.2 billion for PMDs. In light of the historical fraud, waste, and abuse surrounding this benefit, CMS must get the PMD policy right the first time and ensure a transparent and seamless transition to new coverage and payment policies. CMS has made considerable efforts since the Committee's hearing, including streamlining beneficiary access for medically necessary wheelchairs, publishing an interim final rule, creating a National Coverage Determination (NCD), and revising the Healthcare Common Procedure Coding (HCPC) system. For this, I am grateful. However, it appears that in the sprint to publish these requirements, CMS may have added an unnecessary degree of subjectivity to this process.

Accordingly, I request that CMS carefully consider the following concerns:

A. SCRIPTED PRESCRIPTION WITH ATTESTATION

Elimination of the Certificate of Medical Necessity (CMN) without a scripted form may open the door to fraud, confusion, and subjectivity. Therefore, CMS should consider a scripted prescription or similar form with open-ended questions that directly link to the NCD. Under the proposed rule, a treating practitioner will need to sort through the NCD, Mobility Assisted Equipment (MAE) tool, patient chart, and other educational documents to determine what is appropriate to include in the prescription. The new Local Coverage Determination (LCD) alone is approximately 18 pages in length. Practitioners are already pressed for time, without having to read and comprehend an 18 page LCD. In the interim final rule, CMS stated that the CMN was eliminated because "suppliers better know how to properly evaluate and document a beneficiary's medical condition and appropriately prescribe PMDs." This statement is at odds with the confusion and lack of understanding voiced by suppliers at the open door forum last week.

Please state whether or not CMS has considered creating a scripted prescription to walk the treating practitioner through the mobility algorithm. A one-page scripted prescription or similar form may help the treating practitioner document the medical record and understand the NCD in a clear and concise manner, as opposed to promoting an 18-page LCD. This script could also include an open space for the treating practitioner to explain the coverage decision and link MAE questions to HCPCS codes. Most importantly, CMS should include an attestation certification with reference to the False Claims Act to strengthen program integrity efforts.

B. TIMELINE

In addition, the October 25, 2005, effective date of the interim-final rule appears to be unrealistic. Given that most practitioners are unaware of the rule changes, LCD, and revised HCPCS codes, CMS may want to reconsider this timeline. In fact, final comments on the LCDs are not due until October 31, 2005, and the Durable Medical Equipment Regional Carriers (DMERCs) will not finalize these coverage decisions until the end of November. Carriers will not even be able to implement the new codes until April 2006. It seems as if CMS is trying to finish a puzzle with some essential pieces missing. Postponing the effective date of the rule will provide CMS with time to fully educate providers and suppliers and ensure a transparent and smooth transition to the new PMD coverage and payment guidelines. Indeed, as eager as I am to see this rule implemented, I am equally committed to ensuring that we do this right the first time – with all the pieces of the puzzle intact.

C. CONSISTENCY

CMS should also consider working with contractors to decrease subjectivity and ensure consistency as the four DMERCs work to develop their LCDs. In the past, CMS retracted coverage decisions because of inconsistent interpretations of "bed or chair confined." The new NCD is equally ripe for inconsistent interpretation and application across the four DMERCs.

Chapter 13 of CMS's Program Integrity Manual states, "The contractor shall ensure that all LCDs are consistent with all statutes, ruling, regulations, and national coverage, payment, and coding policies." CMS should not abandon this important task to the contractors, but have an active role in the oversight of LCDs. With CMS's lack of oversight, there is already confusion and uncertainty. For example, one LCD requires a beneficiary who needs a "specific use or high activity specific use power wheelchair" to have a face-to face comprehensive evaluation by a RESNA (Rehabilitation Engineering & Assistive Technology Society of North America) Assistive Technology Partner (ATP). However, six states have only five or fewer ATP's and in Iowa, there are only 17 ATPs. Moreover, not all 17 ATPs in Iowa are even licensed to conduct a power wheelchair exam. This current policy is jeopardizing access for beneficiaries not only in Iowa, but across the Nation. CMS should meticulously review the LCDs to ensure consistency and to ensure that beneficiaries in rural areas have access to medically necessary PMDs.

At the very least, CMS must not only clarify the NCD, but also provide additional guidance on the 30-day rule and the home assessment provisions. After all, CMS must not only protect the PMD benefit from fraud, but also ensure that beneficiaries have access to medically necessary PMDs in a timely manner.

In light of the aforementioned concerns, as Chairman of the Committee, I request that CMS respond to the following questions by October 11, 2005.

1. CMS estimates the add-on G-code payment will cost the Medicare program approximately $5 million annually. However, it appears this estimate only includes payment for prescribed scooters and power wheelchairs. If a physician conducts the full examination, documents the medical record, and determines a lightweight manual wheelchair is medically appropriate; will the physician receive the add-on payment? If not, why?

2. If the beneficiary meets with the nurse practitioner and the physician, will CMS provide the add-on payment to both providers or will CMS provide one payment per prescription? Will CMS provide the nurse specialist and physician the same amount for the add-on G-code payment?

3. Provide a crosswalk from the 49 codes released on February 2005 to the 63 codes released on September 14, 2005. Include a detailed explanation of each change along with any new testing requirements.

4. Provide the number of manual wheelchairs, POVs, and power-wheelchairs prescribed and reimbursed from January 1, 2003, to current. Include a collective summary per DMERC.

5. Please explain how the competitive bidding program and new quality standards for DMEPOS will affect the PMD benefit.

Thank you in advance for your assistance on this matter. I would appreciate a response to the enumerated request and concerns raised in this memo no later than October 11, 2005.

Sincerely,

Charles E. Grassley
Chairman