

August 25, 2006

Mr. Michael Rich  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**VIA ELECTRONIC SUBMISSION**

Dear Mr. Rich:

On behalf of the Power Mobility Coalition (PMC), a nationwide association of manufacturers and suppliers of motorized wheelchairs and power operated vehicles (POVs), we submit the following comments concerning the product classification list and preliminary pricing information that was released by the Centers for Medicare and Medicaid Services (CMS) on August 10th. While the PMC supports CMS' efforts to more accurately align costs with different products, the coding and pricing information that was released by CMS is inaccurate and incomplete. In addition, the PMC has concerns that CMS' gap-filling methodology circumvents stakeholder input, fails to base potential pricing on valid statistical data and, essentially, allows CMS to unilaterally establish prices under these new power mobility device (PMD) product categories.

Specifically, the PMC has the following concerns:

**SADMERC Must Fix Product Categories before Finalizing Codes**

It has come to the attention of the PMC, through its manufacturer members, that the product classification list, which places more than 100 power wheelchairs and scooters into six groups of codes, contains errors and that several products were placed in the wrong category. The PMC recommends that such product classification errors be corrected prior to the implementation of the new codes and corresponding pricing.

**Internet and Wholesale Pricing Fails to Take into Account Cost of Overhead Required of Medicare Suppliers**

With regard to retail or managed care transactions, it is important that valid and reliable data be

used in any usual charge calculation. To be consistent, the terms governing negotiated rates (for the purpose of defining usual charge) must be the same as those required by Medicare. Purchasers who desire to buy only the item offered without delivery and set-up charges would be purchasing a different product package than that required for a Medicare sale. Likewise, a purchaser who offers cash or terms financially more advantageous (which Medicare cannot offer) would also be purchasing a different product package.

Due to the complexity of the Medicare program and the stringent requirements associated with each claim, the time and cost associated with a Medicare transaction is far greater than that of other payors. Unlike other payors, the Medicare allowable for a power mobility item is bundled and thus all components listed below may not be billed to Medicare as a separate cost.

For years, Medicare costs for DME have been compared to DME acquisition costs in other federal health programs and it's clear that such an analysis cannot be based on cost alone. Factoring in the requirements mandated on suppliers, the cost of PMDs to the Medicare program is appropriate. In 2002, the Office of the Inspector General (OIG), testifying before the Senate Committee on Appropriations Subcommittee on Labor, HHS, and Education, provided a summary of 16 durable medical equipment (DME) products (including PMDs) comparing Medicare prices to the Department of Veterans Affairs, Medicaid, Retail and Federal Employee Health Benefit (FEHB) prices.<sup>1</sup> According to the OIG study, the median retail price for a motorized wheelchair is greater than the median Medicare price. Further, the difference between Medicare and FEHB pricing was merely 3.28%.<sup>2</sup> Other DME cited by the OIG were found to have a Medicare allowable of up to 72% higher than a retail transaction and up to 22% higher than that of a FEHP transaction.<sup>3</sup>

The service and cost components involved in a Medicare PMD transaction are numerous and extensive. The following are some of the costs that are unique to the Medicare program:

#### Paperwork/Documentation

The Medicare program has imposed significant paperwork and documentation requirements on power mobility suppliers. First, suppliers must provide CMS with a completed prescription for the PMD that is signed and completed by the patient's treating physician. Upon completion of

---

<sup>1</sup> Hearings to examine fraud, waste and abuse related to Medicare reimbursement for medical equipment and supplies, and ways to improve the process, including creating supplier standards, centralizing claims processing, reducing oxygen reimbursement, and introducing a more competitive bidding process: Before the Subcommittee on Labor, HHS, and Education, Senate Committee on Appropriations, 107<sup>th</sup> Congress, pgs. 2-3 (2002) (Testimony of Janet Rehnquist, Inspector General, Department of Health and Human Services).

<sup>2</sup> Id., pg. 4

<sup>3</sup> Id., pg. 4

the signed prescription, suppliers must then provide CMS a detailed product description, which also must be signed by the physician. In addition, suppliers obtain from (and submit to) beneficiaries a wide range of documentation, including but not limited to: delivery slips, an authorization of benefits form, patients consent to release records, supplier standards, and co-pay information.

CMS regulations also require suppliers to obtain additional documentation from physicians, hospitals, other medical professionals, and beneficiaries. Such documentation might include a physical therapist report, a letter from the treating physician, the beneficiary's chart notes, or even the entire set of medical records for a particular patient. Suppliers incur costs in copying, storing, and administrative personnel.

Since payment is currently predicated upon a subjective claims determination process, suppliers often hire clinicians or nurses to review beneficiary files and make clinical determinations that will help in determining eligibility. Further, Occupational Therapists and Physical Therapists are often employed to supplement the beneficiary's file with a physical assessment and evaluation.

#### *Delivery / Service and Transportation Costs*

Suppliers in the Medicare program must deliver products to beneficiaries and educate beneficiaries on how to use Medicare-covered items safely and effectively. The Medicare allowable covers this entire process, including all transportation costs (and follow up educational costs) associated with each transaction.

With gas prices hovering close to \$3.00 a gallon (more in many places), transportation costs – especially in rural areas – is becoming more significant. Moreover, to deliver products a supplier must lease or own a specially equipped cargo van , perform regular maintenance and purchase commercial insurance.

Home assessment and evaluation are the last steps in deterring fraud and ensuring that the beneficiary qualifies for the PMD, that the PMD is appropriate for the home environment and that the beneficiary can safely use the PMD. Suppliers devote substantial resources to train their in-home personnel to educate beneficiaries, field their questions, ensure the PMD is properly fitted, and the beneficiary can operate the PMD safely within the home.

#### *Medicare Appeals Process*

Suppliers must undergo a costly Medicare appeals process for claims that are denied at the

carrier level. The appeals process currently includes a carrier review and QIC review followed by a hearing before an Administrative Law Judge. It is not unusual for a supplier to wait one or two years for a claim to be completely adjudicated.

### Staff Training

Suppliers incur significant costs to ensure their personnel are compliant with all Medicare rules and guidelines. This includes compliance training, attendance at carrier seminars and constant dialogue with carrier staff. Employees also have to be trained in HIPPA procedures and the recently released quality standards. To limit liability or meet accreditation standards, suppliers often conduct background checks on their employees.

### Certification and Accreditation

Suppliers are now mandated by the Medicare Modernization Act to become certified by a nationally recognized accreditation body. Costs associated with certification are not just limited to the fees paid to accrediting bodies. Suppliers often have to invest in major capitol investments to ensure they meet quality standards and pass muster with the accrediting bodies.

The new quality standards require suppliers to maintain a physical address which must be readily accessible to beneficiaries. Such store fronts must be rented, properly staffed during normal business hours, and large enough to store inventory. Further, Medicare suppliers must be insured, invest in computer systems to track billing and inventory, and have a telephone system so that beneficiaries and employees can contact them.

## **TRANSPARENCY AND SAFEGUARDS ARE NEEDED IN ESTABLISHING PMD PRICING**

CMS gap-filing methodology to determine PMD pricing for the new HCPC codes is a closed process. The comments submitted today, while representing an attempt at stakeholder feedback, are not required under the gap-filing process. Yet, Congress has provided CMS with a methodology to adjust Medicare reimbursement for DME that requires statistical validity and stakeholder participation prior to any change in pricing. This authority, known as inherent reasonableness (IR), permits CMS to adjust reimbursement levels for individual items if the payment levels are found to be grossly deficient or excessive. Under this IR authority, CMS is allowed to make reimbursement adjustments of up to 15 percent in one year so long as the adjustment is based on “valid and reasonable data” and the public is allowed a 60-day comment period prior to any price changes. In determining what is “valid and reasonable,” CMS must

take certain steps, which include:

- Developing written guidelines for data collection and analysis;
- Ensuring consistency in any survey to collect and analyze pricing data;
- Developing a consistent set of survey questions to use when requesting retail prices;
- Ensuring that sampled prices fully represent the range of prices nationally;
- Considering the geographic distribution of Medicare beneficiaries;
- Considering relative prices in the various localities to ensure that an appropriate mix of areas with high, medium, and low consumer prices was included;
- Considering criteria to define populous state, less populous state, urban area, and rural area;
- Considering a consistent approach in selecting retail outlets within selected cities;
- Considering whether the distribution of sampled prices from localities surveyed is fully representative of the distribution of the U.S. population;
- Considering the products generally used by beneficiaries and collecting prices of these products; and
- When using wholesale costs, considering the cost of the services necessary to furnish a product to beneficiaries.<sup>4</sup>

The PMC recommends that CMS adopt IR safeguards to the PMD pricing methodology. Such criteria will ensure that CMS' pricing incorporates valid statistical data in determining reimbursement, as well as stakeholder input to ensure that beneficiary access will not be compromised under new pricing levels.

It is imperative that pricing for the new HCPC codes reflects the true cost of the product to the supplier, including the costs needed to comply with Medicare regulations, certification and overhead. Further, the methodology for determining such pricing should be based on valid statistical data and be subject to meaningful stakeholder input. CMS should not unilaterally establish pricing based on internet pricing or wholesale data that fails to reflect the true costs of supplying PMDs to the Medicare population.

As always, the PMC appreciates the opportunity to comment on these issues and hopes to work with CMS and other PMD stakeholders to establish more accurate pricing for PMDs supplied under the Medicare program.

Respectfully Submitted,

---

<sup>4</sup> 42 CFR § 405.502(g)(4)

Eric Sokol  
PMC Director

Stephen M. Azia  
PMC Counsel