

**Bottom Line:** *CMS Power Wheelchair Policies Will Harm Medicare Beneficiaries With Mobility Needs, These Policies Must be Fixed, and Implementation Must be Delayed Until they are Fixed.*

**Three Major Problem Areas –**

- **LCD** released on August 15<sup>th</sup> will push the majority of beneficiaries with mobility needs into lightweight/portable wheelchairs or power operated vehicles (POV, or scooter) codes not designed for more than 2-3 hours of daily usage.
- **Coding & Pricing** guidelines posted on August 7<sup>th</sup>/10<sup>th</sup> contained numerous classification errors that will, in turn, produce pricing reductions for certain codes upwards of 40 percent. Methodology used to calculate payments is antiquated and needs to be revisited – CMS even acknowledged this in previous rulemaking this year (e.g., DME competitive bidding proposed rule)
- **Documentation Requirements** have placed a substantial burden on both the supplier and provider to demonstrate medical necessity. A general lack of awareness and clarity could result in a reduction in beneficiary access to power wheelchairs. When claims are denied, suppliers do not get paid, while the beneficiary retains their chair. Manufacturers have never taken these away – simply file numerous appeals – an arduous, multi-year process.
- Physicians have also expressed frustration regarding the time-consuming and burdensome nature prescribing a power wheelchair. CMS maintains this will only take 10 minutes; surveys indicate significantly longer.

**Impact:**

- New Medicare coverage rules will reduce the type and performance of power wheelchairs available in the future, force major manufacturers to reevaluate Medicare business, and place tremendous financial burden on beneficiary to maintain independence.
- Industry is willing to obtain necessary documentation, but new requirements are challenging for suppliers to meet and physicians to understand. Ambiguity can potentially lead to more fraud & abuse rather than less. We request a “benchmark of completeness” in order to ensure total compliance with these policies. CMS could also work with the industry to develop a simple form that would ease the paperwork and time burden for doctors and demonstrate medical necessity.
- Ultimately, October 1<sup>st</sup> is CMS scheduled (not mandated) date of implementation and suppliers did not see final decisions on these policies until mid-August. 45 days is not enough time to prepare systems and inform providers of these changes.