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For Immediate Release

PMC CONCERNED ABOUT NEW CMS INTERIM FINAL RULE FOR PMDs *Codification of Status Quo Without Clear Guidance Could Do More Harm*

(Washington, DC) - The Power Mobility Coalition (PMC), a nationwide association of manufacturers and suppliers of motorized wheelchairs and power operated vehicles, expressed concerns with the recently released interim final rule for payment of power mobility devices issued by the Centers for Medicare and Medicaid Services (CMS).

PMC members expressed initial concern about ambiguity in the new interim rule. PMC Director Eric W. Sokol explains, "The PMC is concerned that the new rule appears to essentially preserve the chaos and ambiguity of the status quo because the new rule does not set objective and reliable documentation standards that can help avoid second-guessing of physicians."

In their interim final rule, CMS establishes new procedures for prescribing, supplying, and billing for power mobility devices (PMDs). In addition, the rule reflects changes codified in the Medicare Modernization Act (MMA), including expanding the types of health professionals who may order certain types of PMD, and requiring a face-to-face examination of the patient by the prescribing physician or treating practitioner before PMD may be prescribe.

"The PMC agrees with CMS that the treating physician is in the best position to assess the need for a PMD, but is concerned that, in order to fully succeed, CMS and its contractors will have to conduct a comprehensive review of the benefit for physicians," stated PMC Counsel Stephen M. Azia. "Physicians may not be fully aware of the analytical standards that will be applied to claims, let alone which of the 49 new product codes most appropriately meets beneficiary needs."

Specifically, CMS calls for eliminating the Certificate of Medical Necessity (CMN) to substantiate Medicare power wheelchair claims, instead requiring suppliers to submit a prescription and additional clinical documentation. In addition, suppliers will be required to have access to additional documentation if the prescription and supporting documentation are deemed by CMS or its contractors to be insufficient to determine medical necessity.

Moreover, the PMC has concerns that physicians may feel the reimbursement add-on allowed for in the interim final rule will not be enough to fully compensate them for these new administrative burdens. As a result, prescriptions and required documentation can be filed, but then denied upon review if the physician fails to chart properly because he or she fails to fully comprehend the new functional ambulation standard and complex algorithmic formula set out in the new National Coverage Determination.

The PMC also has concerns over the thirty day timeframe for submission of a PMD claim after a physician face-to-face visit. Given the extensive documentation requirement suppliers, especially those in rural areas, may find the thirty day timeframe too tight to obtain and submit all relevant parts of the medical record, as well as the necessary supporting documentation. In comments on the proposed rule for the face-to-face requirement, the PMC suggested a 90-120 day timeframe.

The PMC looks forward to working with CMS, beneficiary groups and physician organizations to help alleviate these concerns, as well as finding solutions that will provide consistency and fairness to the PMD claims process.

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