November 3, 2006

Dr. Mark Schaefer
Director of Medical Policy
State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Re: CMS Power Mobility Device (PMD) Local Coverage Determination (LCD) and HCPC Coding

Dear Dr. Schaefer:

On behalf of NEMED, CT rehab equipment providers and the CT Disability Collaborative, I am writing to you to provide information regarding the negative impact CMS's local coverage determination and payment reductions will have on access to appropriate PMD's for those with disabilities requiring power seating & mobility equipment. As the NEMED group has relayed in previous meetings with DSS, CMS has been working on a new LCD and expanded HCPC coding policy for some time. As you may be aware, utilization and Medicare spending for PMD's has increased dramatically over the past 10 years fueled largely by national consumer advertisers, catering to the basic consumer PMD client. Payment for PMD's has been restricted to primarily 4 HCPC codes with one code (K0011) being most prevalent.

Providers whose primary business focuses upon the "complex rehab" segment of the patient population supported CMS's efforts to group patients into functional categories which more appropriately address the broad range of technology, as well as, direct and indirect costs associated with various patient groups and medical conditions. The complex rehab industry applauded the creation of four category groupings, along with 64 PMD codes for coverage of power mobility devices. The industry anticipated significant reimbursement reductions in the Group I basic category, however, never anticipated the **drastic reductions** ranging from 20% to as much as 35-40% for the Group II & III categories. In addition, the Group IV category, generally defined by CMS as the most complex patient, will not be reimbursed by Medicare (automatic downcoding to Group III) leaving the burden of payment for upgraded equipment on the Medicare patient, secondary payers such as Medicaid, or the potential supply of inferior and potentially unsafe equipment for the most highly disabled beneficiaries.

The LCD policy, scheduled to go into effect on 10/1/06 was delayed by CMS until 11/15 based upon significant issues relayed to CMS by many interested parties including clinician groups,

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disability advocacy organizations, consumers, providers, manufacturers and legislators. Positive changes have been introduced to the LCD policy, however, significant restrictions remain which will have a definite impact on the provision of appropriate equipment for the elderly and severely disabled if unchanged. Industry "insiders" working with CMS were informed that the industry would be "pleased" with reimbursement rates in the higher category groupings, see moderate reductions, and potential increases in some cases. What resulted was reimbursement reductions ranging from a minimum of 20% to as much as 35-40%; a restrictive LCD policy that will limit or deny beneficiary access to appropriate seating and PMD equipment; and an industry "scratching its head" on how they will be able to continue to service Medicare beneficiaries. Once again, CMS utilized, by their own past admission, a "flawed" gap filling formula to establish PMD rates. CMS has the authority to move outside the gap filling methodology and establish rates that are appropriate relevant to current technologies, medical criteria, and market forces. We believe there is a reasonable likelihood that CMS may further delay the implementation of the LCD and payment rates, however, the LCD and payment policies may go into effect 11/15/06.

Many national, regional and local providers of "complex rehab" equipment have acknowledged publicly that they will not service Medicare beneficiaries in the supply of PMD's if these drastic reductions and restrictive policies remain. CT rehab equipment providers, as well as the disability advocacy community, are very concerned about the ability to continue to service Medicare PMD clients, as well as, other payers who further reduce reimbursement from Medicare reimbursement rates.

We bring this matter and relevant history of these policies to your attention to relay the seriousness of this issue and intent to work with CT Medicaid to implement policies that will allow complex rehab providers in CT to continue to supply appropriate PMD equipment to Medicaid beneficiaries. I have enclosed the following reference information for your review:

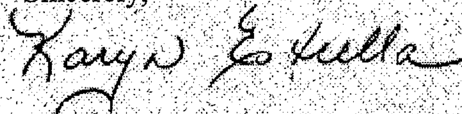
- ITEM (Independence Through Enhancement of Medicare and Medicaid Coalition) letter to Secretary Michael Leavitt, U.S. Dept. of Health and Human Services. This organization, including national associations such as the Paralyzed Veterans of America, United Spinal Association and numerous others oppose specific criteria relating to both the LCD and reimbursement reductions.
- Preliminary fiscal analysis of "complex rehab" PMD wheelchair configuration and rates
- NCART Position paper – National Coalition for Assistive and Rehabilitation Technology
- Senator Specter and Santorum's letter to Michael Leavitt

We will know more regarding the implementation of this policy over the next two weeks and communicate our concerns to you. We would ask that you consider delaying implementation of the new LCD and Medicare rates if implemented and unchanged by CMS. In working with other New England State Medicaid programs, MA Medicaid's DME program manager, Lynda Scully, has stated that "MA will not implement the new Medicare rates until she is certain that they are reasonable and at that time will adopt 100% of Medicare rates." Other NE states are considering this policy.

We would also ask that NEMED have the opportunity to meet with you to sit at the table and discuss the serious issues our members and the disability community face prior to implementing these codes and LCD policy. It is the opinion of NEMED Rehab Members that the new coding and pricing from CMS will make the supply of these products very difficult, especially to the more complex labor intensive clients. As they stand, the 64 new codes and product/diagnosis groupings will automatically provide substantial savings in power mobility device reimbursement of 20-40%. To arbitrarily implement an additional 15% reduction on top of the enormous reductions proposed by CMS will create an access issue. CT rehab providers will simply not be able to service Medicaid beneficiaries in the supply of PMD's without consideration of appropriate reimbursement.

If you have any questions regarding any of this information, we would appreciate receiving them in advance of our meeting. Thank you for your consideration. I look forward to hearing from you soon.

Sincerely,



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Cc: Deputy Commissioner Michael Starkowski
Stan Kosloski – CT Disability Collaborative
CT NEMED Rehab Providers