Submitted Electronically via Medicare Coverage Database (Copy and Pasted to a Form)

Re: Comments on CMS Proposed Decision Memo: Seat Elevation Systems as an Accessory to Power Wheelchairs (Group 3)

Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members include manufacturers and suppliers of manual and power wheelchairs, including complex rehab power wheelchairs. Complex rehab technology (CRT) devices include medically necessary and individually configured manual and power wheelchairs, seating and positioning systems, and other adaptive equipment such as standing devices and gait trainers. Our members are proud to be part of the continuum of care that assures beneficiaries and other patients receive cost effective, safe, and reliable home care products and services.

AAHomecare strongly supports Medicare's proposed coverage of seat elevation as detailed in the formal September 2020 coverage request submitted to CMS by the ITEM Coalition. Seat elevation is critical to mobility-related activities of daily living (MRADLs) in the home. Seat elevation improves transfers and reaching, reduces falls, and reduces or eliminates neck and spine injuries from power wheelchair use. Seat elevating systems provide medical and functional benefits while reducing health care costs by decreasing falls, skin breakdowns, muscle contractures and other avoidable medical complications of long term or permanent wheelchair use.[i] Power seat elevation systems have been available for years and are covered by most other payers, besides the Medicare program. It is high time for the Medicare Program, as the largest health care insurer in the country, to provide coverage for these important systems.

AAHomecare is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS') Proposed Decision Memo on Seat Elevation Systems as an Accessory to Power Wheelchairs (Group 3). Seat elevation systems allow for wheelchair bound patients to safely participate in activities of daily living with or without additional assistance, allowing them to live a more independent life. Being able to safely perform or participate in activities of daily living would minimize potential serious injuries, which would, in turn, reduce the frequency of emergency department visits or hospitalizations.

CMS' Proposed Decision

CMS is proposing that power seat elevation equipment on Group 3 power wheelchairs falls within the benefit category for durable medical equipment (DME). CMS is proposing that the evidence is sufficient to determine that power seat elevation equipment is reasonable and necessary for individuals using power wheelchairs when the following conditions are met:

- The individual performs weight bearing transfers to/from the power wheelchair while in the home, using either their upper extremities during a non-level (uneven) sitting transfer and/or

their lower extremities during a sit to stand transfer. Transfers may be accomplished with or without caregiver assistance and/or the use of assistive equipment (e.g., sliding board, cane, crutch, walker); and,

- The individual has undergone a specialty evaluation by a practitioner who has specific training and experience in rehabilitation wheelchair evaluations, such as a physical therapist (PT) or occupational therapist (OT), that assesses the individual's ability to safely use the seat elevation equipment in the home.

We support and agree with CMS' determination that seat elevation systems meet all the legal criteria to be durable medical equipment (DME): (1) can withstand repeated use; (2) has an expected life of at least three years; (3) is primarily and customarily used to serve a medical purpose; and (4) generally is not useful in the absence of an illness or injury (42 C.F.R. §414.202).

Summary of Comments

AAHomecare urges CMS to finalize the National Coverage Determination as follows:

1. Finalize the proposed Benefit Category Determination holding that power seat elevation systems are primarily medical in nature and are considered durable medical equipment under the Medicare benefit; and finalize the proposed coverage determination holding that these systems are reasonable and necessary for Medicare beneficiaries who use Group 3 and above CRT power wheelchairs in order to perform transfers for the purpose of performing or participating in mobility related activities of daily living (MRADLs);
2. Include coverage for Medicare beneficiaries who need seat elevation to improve their reach and line of sight to support shoulder, upper spine, and neck integrity while performing or participating in MRADLs;
3. Include coverage of seat elevation for Medicare beneficiaries who use Group 2 CRT power wheelchairs in the final NCD; and
4. Provide important clarifications to the proposed NCD, including further detail regarding "weight-bearing transfers," beneficiaries using patient transfer devices, and the specific criteria for specialty evaluations.

Medicare Coverage for Power Seat Elevation Systems Should Be Comprehensive and Not Limited to Non-Level Transfers

AAHomecare supports CMS' proposed benefit category decision that recognizes power seat elevation systems as primarily medical in nature. There are, however, several issues with CMS' proposed decision summary. We strongly support the ITEM Coalition's Comments submitted, responding to CMS' Proposed Decision as they provide significant clinical support and detailed rationales for CMS to modify and improve its coverage decision for power seat elevation systems.

AAHomecare recommends that CMS modify and improve its final coverage decision as follows:

a. Seat elevation systems serve a medical purpose for all transfers, not just un-level transfers.

b. In addition to transfers, seat elevation systems serve the medical purpose of reach ~~in~~ in a way that minimizes the risk for pain and injuries while completing MRADLs. We refer CMS to the peer review research related to the application for power seat elevation system for reach that were submitted with the ITEM Coalition's original September 2020 request to CMS.

c. The evidence base on reach and line of sight supports the medical nature of power seat elevation for these purposes. The recommendation to expand the coverage criteria to include reach is consistent with criteria ~~for~~ under the following nine state Medicaid programs:
    a. California **(**Power seat elevator is covered when there is documentation that other methods to achieve mobility related ADLs or IADLs without a power seat elevator have been exhausted).
    b. Colorado (The client has limited range of reach of the upper extremities due to limited joint mobility, limited active range of motion, congenital deformity, and/or short stature, which prohibits independent performance of ADLs or IADLs in the home and/or community; the client does not have a full-time care giver who can provide assistance with ADLs or IADLs in the home and/or community; and provision of a power seat elevator enables the client to accomplish independent performance of ADLs or IADLs in the home and/or community.)
    c. Idaho - Power seat elevation features are a covered benefit under Idaho Medicaid for participants under the age of 21 with limited reach and range of motion that prohibits the ability to perform MRADL's independently.
    d. Iowa (To allow the member to independently reach items that are needed to complete activities of daily living (ADL's) which cannot be completed without the use of the power lift. (ADL's include dressing, grooming, toileting, and personal hygiene.))
    e. Minnesota (The seat elevation feature has been demonstrated to allow the member to independently access areas in the home necessary for completion of activities of daily living (ADLs) (cupboards, closets, etc.)
    f. New York (Power seat elevation allows the member to independently perform MRADLs that cannot be performed independently without the addition of power seat elevation.)
    g. North Carolina Power seat elevation is covered for beneficiary's ages 0 through 20 years only, when the beneficiary … requires seat elevation to perform MRADL's.
    h. South Dakota (The seat elevation feature has been demonstrated to allow the recipient to independently access areas in the home necessary for completion of activities of daily living (ADLs) (cupboards, closets, etc.))
    i. Tennessee (The Enrollee has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and the activities for which the accessory will be used are conducted primarily in the enrollee's home.)
    j. Texas (The client has limited reach and range of motion in the shoulder or hand that prohibits independent performance of MRADLs (such as, dressing, feeding, grooming, hygiene, meal preparation, and toileting))
    k. Wisconsin (Use of a power seat elevation system will allow the member to independently perform activities of daily living (ADL) and reduce caregiver dependency.)

AAHomecare recommends that CMS clarify and define that its proposed coverage criteria of "weight-bearing transfers" includes:

a. Any transfer in which the beneficiary bears weight on their upper and/or lower extremities during the execution of the transfer;
b. May be performed with or without the assistance of a caregiver;
c. May be performed with or without the use of other mobility assistive equipment such as, but not limited to canes, crutches, walkers, etc.; and,

d. May be performed with or without the use of a transfer assist device such as, but not limited to a sliding/transfer board, transfer assist handles, trapeze, transfer/pivot disk, sit-to-stand device.

Coverage when Used with a Group 2 Power Wheelchair

CMS asked for comments as to whether power seat elevation equipment on Group 2 power wheelchairs primarily and customarily serves a medical purpose and thus also falls within the benefit category. We strongly recommend that CMS include power seat elevation on Group 2 power wheelchairs for certain users.

Some Medicare beneficiaries who meet the criteria for a power wheelchair, but do not meet the criteria for coverage of a Group 3 power wheelchair (e.g., lower extremity acquired Absence of Limb(s), Lupus, Inclusion Body Myositis, Myasthenia Gravis, (Poly)Neuropathy, Rheumatoid Arthritis, Scleroderma, and/or an advanced stage of one or more chronic medical condition) may benefit from having a Group 2 power wheelchair with a seat elevation system to transfer. For Medicare beneficiaries who are deemed a high fall risk or have fallen while in a standing position, with attempts to stand, or during a transfer the seat elevation system improves transfer biomechanics, safety and independence, and will reduce the number of fatal and non-fatal falls for individuals over 65.

Power Seat Elevation System as a Power Seat Function

AAHomecare strongly urges CMS to determine that a power seat elevation system is considered a power seat function, similar to power tilt and power recline, and require the same level of beneficiary protections as the other two power seat functions. Specifically, we recommend the coverage criteria for power seat elevation be revised to require:

1. The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Device Local Coverage Determination (LCD); and
2. A specialty evaluation was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs. The PT, OT, or practitioner may have no financial relationship with the supplier; and
3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

We strongly urge CMS to deem a PWC with either power tilt only, power recline only, or power seat elevation only as a single power option base and that any combination of power tilt and recline, power tilt and seat elevation, power recline and seat elevation, or power tilt, recline and seat elevation be deemed a multiple power option base. This is because the engagement of any of these three power seat functions alone or in combination change the center of gravity of the unit when they are engaged, affecting the dynamic stability of the power wheelchair base. It is, therefore, imperative that power wheelchairs with a power seat elevation system be required to pass all ANSI/RESNA testing specifications

for dynamic stability where the dealer adjustments are set to the least stable configuration in which the PMD drives in full speed. Further, if the PMD's speed is reduced (creep mode) after the power seat elevation system is engaged it must pass the additional dynamic stability driving tests (forward stability, rearward stability, and lateral stability) on a ramp in the least stable configuration in which the chair drives at the reduced speed.

Any power wheelchair with a seat elevation of at least 6" must be tested as a single or multiple power option base, with the seat elevation system included, by an independent test lab for PDAC code verification.

Conclusion

A wheelchair consumer's ability to securely transfer, perform and participate in MRADLs, ability to reach and retrieve objects, and facilitate his/her line of sight necessary to navigate and perform MRADLs are all equally important medical needs offered by seat elevation systems. As detailed in the comments of the ITEM Coalition, available scientific literature supports the benefits and clinical significance of seat elevation systems. Medicare coverage of this important technology will improve the safety and quality of the life for wheelchair consumers.

AAHomecare supports CMS' proposed benefit category decision that recognizes power seat elevation systems as primarily medical in nature, but we urge CMS to modify the decision to incorporate reach and line of sight, and improve its coverage decision to include our recommendations, as well as those of ITEM Coalition. Thank you for the opportunity to comment. Please contact me at kimb@aahomecare.org for further information.

Sincerely,

Kim Brummett
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American Association for Homecare

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[i] ITEM Coalition Request Letter. Page 3.