

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-19

Subject: Reclassification of Complex Rehabilitation Technology
 (Resolution 117-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
 (John Montgomery, MD, MPH, Chair)

1 At the 2018 Annual Meeting, the House of Delegates referred Resolution 117-A-18, “Supporting
2 Reclassification of Complex Rehabilitation Technology (CRT),” which was introduced by the
3 Texas Delegation. The Board of Trustees assigned this item to the Council on Medical Service for
4 a report back at the 2019 Annual Meeting. Resolution 117-A-18 asked that our American Medical
5 Association (AMA) “advocate for the Centers for Medicare & Medicaid Services (CMS) to
6 reclassify CRT as a separate and distinct payment category to improve access to the most
7 appropriate and necessary equipment to allow individuals with significant disabilities and chronic
8 medical conditions to increase their independence, reduce their overall health care expenses and
9 appropriately manage their medical needs.”

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11 In this report, the Council explains complex rehabilitation technology, discusses legislation that has
12 impacted funding for CRT, summarizes competitive bidding in this context, and highlights relevant
13 AMA policy. The Council concurs with the intent of Resolution 117-A-18, and recommends
14 minimal modifications to avoid potential unintended consequences of the reclassification.

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16 BACKGROUND

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18 Resolution 117-A-18 identifies challenges with the current classification of CRT within the broader
19 category of durable medical equipment (DME) under Medicare’s payment rules. The resolution
20 explains that the DME category used by CMS does not distinguish technological differences
21 between CRT and other DME. CRT is often required for optimal ongoing mobility at home as well
22 as in daily living activities for individuals with debilitating chronic illnesses. The resolution also
23 notes that long-term care facilities may not provide medically necessary CRT due to the cost or
24 lack of experience with CRT configuration.

25
26 CRT can include specialized devices and services that meet the needs of beneficiaries with
27 complex, long-term or permanent, mobility and other impairments. CRT consists of individually
28 configured manual and power wheelchairs, seating and positioning systems, and other adaptive
29 equipment such as standing devices and gait trainers. The specialization inherent in CRT contrasts
30 with the far less complex mobility devices under the DME benefit, which typically serve a
31 short-term, post-hospitalization beneficiary population in need of DME while recovering in the
32 home. In 2014, CRT power wheelchairs and accessories accounted for two percent (about 13,000)
33 of all Medicare wheelchair utilization and 22 percent (about \$69 million) of wheelchair
34 expenditures.¹

1 COMPETITIVE BIDDING

2

3 The Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)
4 Competitive Bidding Program was enacted with the Medicare Prescription Drug, Improvement,
5 and Modernization Act of 2003 (MMA), which required Medicare to implement a competitive
6 bidding process for selected DMEPOS items to reduce beneficiary out-of-pocket expenses and save
7 the Medicare program money.²

8

9 Under competitive bidding, suppliers compete in established competitive bidding areas by
10 submitting bids for selected products. Not all products or items are subject to competitive bidding.
11 Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price.
12 Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable
13 quality and financial standards. Contract suppliers must agree to accept assignment on all claims
14 for bid items and will be paid the single payment amount.

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16 Notably, CRT power wheelchairs, but not other CRT products, were excluded from competitive
17 bidding with the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) of
18 2008. An exceptionally costly unanticipated expense, such as for CRT, can consume a large portion
19 of the budgets of CRT device and service vendors, creating price pressures and/or potentially
20 hindering beneficiary access. A July 2018 GAO report³ found that competitive bidding of DME
21 reduced payment levels substantially, with average reduction of 46 percent across the top 53 items.
22 Rural areas are largely excluded from coverage in the bidding areas. DME vendors can compete in
23 those non-bid areas and also refuse to provide services and products to those areas.

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25 MIPPA acknowledged that complex rehabilitative power wheelchairs were unique and different
26 from standard DME. However, the law did not establish a separate benefit/payment category for
27 these wheelchairs and is limited in scope to apply only to certain complex rehabilitative power
28 wheelchairs. Legislation would be needed to require that CMS create a separate and distinct
29 classification for all products and services that are classified as CRT.

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31 RELEVANT AMA POLICY AND ADVOCACY

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33 Policy D-330.907 strongly encourages CMS to refrain from implementing policies that would
34 curtail access to CRT wheelchairs and accessories by applying competitively bid prices to these
35 specialized devices. If CMS does not refrain from implementing policies limiting access to CRT
36 wheelchairs, the policy states that the AMA will encourage Congress to support legislation
37 (e.g., HR 3229) that would provide a technical correction to federal law to clarify that CMS cannot
38 apply Medicare competitive bidding pricing to CRT wheelchairs.

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40 Policy H-185.963 (1) urges public and private third party payers to increase access to health
41 insurance products for adults with congenital and/or childhood diseases that are designed for the
42 unique needs of this population; and (2) emphasizes that any health insurance product designed for
43 adults with congenital and/or childhood diseases include the availability of specialized treatment
44 options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of
45 an adequate number of physicians specializing in the care of this unique population.

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47 Policy H-330.955 states that the AMA (1) continues to voice its objection to CMS and other
48 insurers regarding onerous requirements for the prescription of durable medical equipment; (2)
49 advocates that additional members of a physician-led health care team be permitted to complete the
50 certification of medical necessity form for durable medical equipment, according to their
51 education, training and licensure and at the discretion of the physician team leader, but require that

1 the final signature authorizing the prescription for the durable medical equipment be the
2 responsibility of the physician; (3) calls for CMS to revise its interpretation of the law, and
3 advocates for other insurers, to permit that the physician's prescription be the only certification of
4 medical necessity needed to initiate an order for and to secure Medicare or other insurer payment
5 for durable medical equipment; and (4) calls on physicians to be aware of the abuses caused by
6 product-specific advertising by manufacturers and suppliers of durable medical equipment, the
7 impact on the consumers of inappropriate promotion, and the contribution such promotion makes
8 to unnecessary health care expenditures.

9
10 Policy H-390.835 supports: (1) additional reimbursement for evaluation and management services
11 for patients who require additional time and specialized equipment during medical visits due to
12 severe mobility-related impairments; (2) that no additional cost-sharing for the additional
13 reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law;
14 (3) that primary and specialty medical providers be educated regarding the care of patients with
15 severely impaired mobility to improve access to care; and (4) additional funding for payment for
16 services provided to patients with mobility related impairments that is not through a budget neutral
17 adjustment to the physician fee schedule.

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19 In accordance with Policy D-330.907, the AMA submitted a letter to the Secretary of Health and
20 Human Services on June 9, 2016, urging CMS to revoke the application of competitive bidding to
21 complex rehabilitation wheelchairs.

22 23 DISCUSSION

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25 Referred Resolution 117-A-18 is consistent with AMA policy and past advocacy urging the CMS
26 to rescind the decision to apply the competitive bidding pricing program to CRT wheelchairs and
27 wheelchair accessories and instead develop alternative approaches that consider beneficiary access.

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29 Accordingly, the Council recommends the essence of Resolution 117-A-18, while noting that
30 accomplishing the request of the resolution will require legislation and regulation. Because CMS
31 cannot enact legislation, the Council recommends supporting reclassification without referring to
32 CMS as the necessary change agent. Once legislation is enacted, the Council's recommended
33 policy statement of support for reclassification would direct the AMA to advocate for CMS
34 implementation. The Council also recommends supporting the efforts of Federation partners to
35 accomplish adequately funded CRT reclassification.

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37 If CRT is categorized as a distinct category it should be adequately funded. In addition, to address
38 concerns that prices for CRT products and services could increase significantly within a distinct
39 category, the Council believes that it would be appropriate for CMS to develop additional
40 requirements and/or regulations beyond those that currently exist for the fitting and prescribing of
41 CRT under DME regulations. Such possible requirements/regulations could include, but not be
42 limited to competitive bidding of CRT, coverage policies, and quality standards.

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44 Finally, the Council encourages the ongoing involvement of appropriate stakeholders to
45 accomplish the adequately funded reclassification of CRT, such as pain physicians, physical
46 therapists, occupational therapists.

47 48 RECOMMENDATIONS

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50 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
51 117-A-18, and the remainder of the report be filed:

- 1 1. That our American Medical Association (AMA) support the reclassification of complex
2 rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment
3 category to improve access to the most appropriate and necessary equipment to allow
4 individuals with significant disabilities and chronic medical conditions to increase their
5 independence, reduce their overall health care expenses and appropriately manage their
6 medical needs. (New HOD Policy).
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- 8 2. That our AMA support state medical association and national medical specialty society efforts
9 to accomplish adequately funded reclassification of CRT. (New HOD Policy)
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- 11 3. That our AMA support, upon reclassification of CRT as a distinct category, the development
12 by the Centers for Medicare & Medicaid Services of additional requirements and/or regulations
13 specific to CRT, beyond those that exist under the broad category of durable medical
14 equipment. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ US Government Accountability Office. "Medicare: Utilization and Expenditures of Complex Wheelchair Accessories." June 1, 2016. Retrieved from <https://www.gao.gov/assets/680/677602.pdf>. Accessed February 19, 2019.

² Centers for Medicare & Medicaid Services. DMEPOS Competitive Bidding. Retrieved from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html>. Accessed February 20, 2019.

³ US Government Accountability Office. "Medicare Fee-For-Service: Information on the First Year of Nationwide Reduced Payment Rates for Durable Medical Equipment." July 2018. Retrieved at <https://www.gao.gov/assets/700/693412.pdf>. Accessed on February 21, 2019.