

As a former medical director of one of this nation's four regional DMERCs, I feel it necessary to bring to your urgent attention an incredible action by the DMERCs that will affect millions of patients' welfare, threaten your members' own reimbursement status for services to Medicare patients (aside from dme concerns), and which may even pose the threat of your members' liability for repayment of Medicare funds from past years of service rendered in good faith. I urge you to read the attached Word file (copied below), disseminate it to your members, and encourage their emailed comments to those indicated with all dispatch. Every day allowed to pass with these unprecedented actions going unchallenged will likely result in rendering these disastrous changes more permanent and the agencies responsible, more intractable to rescinding them.

Thank you,
Paul D. Metzger, M.D.

Dear Medicare Provider Organization:

As a recently retired Medicare Medical Director of the Durable Medical Equipment Regional Carrier (DMERC) for Region C, I am issuing the following alert to your organization's members about an action Medicare is currently implementing that will seriously affect your Medicare beneficiaries (your members' patients) and potentially, your members' Medicare reimbursements, as well as introduce liability for their previous Medicare payments.

Because of some pockets of fraudulent billing activity for power wheelchairs by a few unscrupulous, fraudulent suppliers, the DMERCs and CMS are now over-reacting by attempting to restrict access to wheeled mobility across the board using bulletin issuances in an effort to avoid and eliminate any opportunity for public comment. Furthermore, the DMERCs are making these policy restrictions RETROACTIVE! They claim to be "clarifying" existing policy in order to avoid the essential opportunity for your members to offer comments to the clinical advisability of policy restriction. Their "clarifications" involve going back to the strict language of "bed or chair confined," and removal of cardiopulmonary conditions that should be considered as reasonable and necessary conditions requiring powered mobility.

For the last 7-8 years, the DMERCs have been informing beneficiaries, informing suppliers, and paying for manual wheelchairs if the patient needed them to perform activities of daily living within the confines of the home (even though the national and regional medical review policies include antiquated language about having to be completely bed or chair confined to qualify). That the more liberal application of policy with respect to "bed or chair confined," and inclusion of cardiopulmonary conditions has been in effect for all this time is evidenced by the wording of the DMERCs'

Certificates of Medical Necessity (CMNs), which use both these expanded parameters in their questions on patient functionality, to which the physician prescribing these items attests, and until now, if answered positively, would have qualified the patient for the manual or powered wheelchair. These changes will render the CMN questions a meaningless exercise, wasting the physician's time (as no answer will now qualify the patient for wheeled mobility) and a cruel disappointment for the patient.

Normally, as part of the local medical review (LMRP) development process, Medicare contractors circulate proposed drafts of any restrictive changes, inviting Medicare stakeholders such as your organization's members, to present comments, which will be considered and help reflect standards of community medical practice in the final published LMRP. Claims are then processed to pay or deny based upon the coverage criteria contained in those LMRPs. Without the comment process, the entire nation's Medicare reimbursement for all durable medical equipment would reflect the opinions of only four (currently three) DMERC medical directors. Once implemented, there should always be an effective date for dates of service, AFTER WHICH the new criteria will be applied.

In absolute disregard of the due process established by CMS and the DMERCs themselves for changing medical review policies, they have stated the following: ANY PATIENT WHO CAN TAKE MORE THAN ONE STEP, EVEN WITH THE ASSISTANCE OF A CANE, CRUTCH, OR WALKER, TO TRANSFER FROM A BED TO A CHAIR, WILL BE CONSIDERED "AMBULATORY," AND WILL THEREFORE *NOT* QUALIFY FOR A MANUAL WHEELCHAIR. ANY PATIENT WHO HAS CONDITIONS OTHER THAN MUSCULAR OR NEUROLOGICAL WEAKNESSES IN THE UPPER EXTREMITIES, WILL NOT QUALIFY FOR A POWERED WHEELCHAIR.

What You Must Do:

Ironically, while the DMERCs have not invited comment on these drastic changes that will affect the lives of millions of disabled and elderly patients, there is nothing stopping your organization from issuing comments anyway. Please distribute news of this incredible attempted bureaucratic coup before it can be further implemented and allowed to quietly become, by default, the new standard of LMRP development and issuance.

Your timely dissemination of these developments to your members and rapid responses are critical. Please see DMERC and CMS contact information and further details below.

Thank you,

Paul D. Metzger, M.D.
Executive Vice President, Medical Affairs
The SCOOTER Store Inc.

What Does This Mean for Patients:

The following are examples of patients who will no longer qualify for Medicare reimbursed manual wheelchairs:

- Patients who can only walk a few steps, or using a cane or walker, exhaust themselves getting to a bathroom or kitchen, will no longer qualify for wheeled mobility, causing them to require moving to nursing homes prematurely, or relying totally on care-givers, and incurring fractures through falls with all the associated morbidity and mortality!
- Patients with progressive neurological diseases such as multiple sclerosis, ALS, or post-polio syndromes, who have waxing and waning symptoms, because of their better days, will no longer qualify for wheeled mobility until they become 100% bed or chair confined!

The following are examples of patients who will no longer qualify for coverage of powered wheelchairs:

- Patients with end-stage congestive heart failure;
- Patients with intractable stage III and IV angina;
- Patients with advanced COPD and restrictive lung diseases;
- Patients with end-stage renal failure;
- Patients with terminal cancer and cachexia.

What Does This Mean for Medicare Providers:

- If the DMERCs are successful in slipping through these changes without using established LMRP development protocol, precedent will be set for other Medicare contractors, such as those issuing policy pronouncements for physician and other health-care provider services, as well as hospitals and other Medicare reimbursed institutions, to autocratically issue restrictive guidelines in knee-jerk fashion, based upon perceived problems of utilization, or to satisfy whimsical politics of the day.
- Precedent will be established to pronounce these restrictive changes to be RETROACTIVE, meaning no effective date – meaning Medicare can impose arbitrary reimbursement recovery actions on service claims going back years, when providers believed they were conforming to established medical policy.
- Hospitals will have to keep patients, who could otherwise have been discharged home with powered mobility to independently accomplish

their activities of daily living, until a nursing home bed can be found, regardless of DRG reimbursement limits.

- Assisted living facilities will have to increase their labor costs to transport previously independently mobile residents to and from the dining area three times per day.

Background:

As you may know, the DMERCs are separate Part B Medicare carriers. The *local* Part B Medicare carriers for each state process claims for physician, laboratory and ambulance services, while Part A Medicare intermediaries process hospital, nursing home and home health agency claims for service. These carriers and intermediaries are insurance companies, which obtain contracts from the Federal agency responsible for administration of the Medicare program - the Centers for Medicare and Medicaid Services (CMS) [formerly known as HCFA]. Frequently, the local carriers and intermediaries adopt techniques for dealing with Medicare stakeholders that are piloted by the DMERCs. The DMERCs process Medicare claims for durable medical equipment used within the home and in assisted living facilities, including manual and power wheelchairs.

Your members may contact the following individuals who are responsible for this action:

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