

*Via email to dmerc.pol@palmettogba.com
Via first class mail*

October 31, 2005

Stacey V. Brennan, M.D.
Medical Director, DMERC Region C
Palmetto GBA
P.O. Box 100141
Mail Stop AG- 250
Columbia, South Carolina 29223

Re: **DMERC Draft LCD and Policy Article for Power Mobility Devices**

Dear Doctor Brennan:

The American Occupational Therapy Association (AOTA) represents approximately 35,000 occupational therapy professionals, many of whom provide services to Medicare beneficiaries. We appreciate the opportunity to comment on Palmetto GBA's (Palmetto's) draft local coverage determination (LCD) and policy article for Power Mobility Devices (PMD) dated September 14, 2005 (referred to hereinafter as "draft LCD"). AOTA's comments on the draft LCD are organized by topic area below.

1. ATP Requirement for Comprehensive Evaluations

The draft LCD currently will only cover tilt and other high-end PMDs if a RESNA-certified Assistive Technology Practitioner (ATP) has conducted a comprehensive evaluation. This draft policy is problematic in its reliance on the recommendation of competency by only one membership organization. By merely relying upon this group's certification, Palmetto has failed to identify for stakeholders the skills and experience that it has determined is necessary to conduct these evaluations. *AOTA recommends that Palmetto explicitly identify the skills and knowledge that it expects of individuals who are evaluating beneficiaries for tilt and other high end PMDs.*

The draft policy excludes coverage for these PMDs when occupational therapists without the ATP credential conduct the comprehensive evaluation. Occupational therapists are qualified to provide both basic and comprehensive PMD evaluations by virtue of the education and training they obtain through their educational programs, employment opportunities, and continuing education opportunities. Therefore, this draft policy restricts beneficiary access to evaluations conducted by equally competent therapists who are not ATPs, particularly in many locations nationally that do not have any (or have very few) RESNA-certified ATPs. *AOTA strongly opposes the ATP-only requirement. AOTA urges Palmetto*

to recognize that all licensed occupational therapists may have the requisite skills to conduct comprehensive evaluations.

In addition, the draft LCD requires that the ATP who conducts the comprehensive evaluation “may not be an employee of the supplier or have any financial relationship with the supplier.” This is a potentially burdensome and inappropriate requirement for occupational therapists and would significantly limit beneficiary access to a comprehensive assistive technology assessment conducted by an occupational therapist, especially in rural areas. Occupational therapists should participate in the PMD evaluation process independently exercising their professional clinical judgments and professional clinical viewpoints. The LCD should include a requirement for the clinical independence of the occupational therapist, rather than addressing the financial relationship. State laws, professional standards, and ethics requirements mandate that occupational therapists provide services to patients only where appropriate circumstances and their professional qualifications ensure their competency. It would be inappropriate for a financial relationship between a supplier and occupational therapist to be contingent on a (good) referral for a PMD. Palmetto would be accomplishing the same goal of deterring inappropriate financial relationships, while recognizing professional ethical and legal constraints, by focusing on the importance of independent clinical judgment. *AOTA strongly recommends that Palmetto revise the draft LCD to require occupational therapists to conduct comprehensive evaluations utilizing their clinical independence in all settings in which they evaluate Medicare beneficiaries for PMDs.*

2. Documentation of Medical Necessity

The draft LCD appears to implement provisions in CMS’ draft interim final rule concerning the requirement that physicians must conduct a face-to-face examination of the patient for a PMD, and that the supplier must receive from the treating physician a written order for a PMD within 30 days after the face-to-face examination. However, the timing of a draft LCD following a draft interim final rule is confusing, problematic, and premature.

A. Evaluation

While AOTA supports the increased role of physicians in the evaluative process for PMDs, neither the interim final rule nor the DMERC draft LCD specifically mentions the role of occupational therapists in the treatment and evaluation process. This ignores the potential for a more appropriate determination of medical necessity if an occupational therapy evaluation is part of the data reviewed by the physician and DMERC. Physicians and suppliers are typically not the only entities with an active role in the beneficiary evaluation process. In fact, occupational therapists are typically consulted by physicians or suppliers to conduct beneficiary PMD evaluations and assessments in the normal course of treatment.

Specifically, occupational therapy evaluations involve a multifaceted evaluation of the individual's physical seating needs, functional abilities, limitations (visual, sensory, motor function, judgment, etc.) and home and community access needs. Occupational therapists are able to effectively evaluate and identify impairments and limitations that need to be addressed to enable safe transfers, weight shifts for pressure relief and skin protection, wheelchair features required to enable maximum function, access for transfers to toilet, bath and bed. Additionally, once the equipment is delivered, occupational therapists train the individual in how to use the wheelchair to be safe in their home and in their community. Occupational therapists are particularly trained to do this type of work.

Under the draft LCD, it remains unclear whether occupational therapists will be permitted to conduct evaluations for PMDs and, if they are permitted to conduct the evaluations (including preparing the extensive documentation frequently involved), whether they will be reimbursed for these services. The draft policy article that accompanies the LCD only adds to the confusion by stating:

The physician may refer the patient to a licensed/certified medical professional, such as a physical therapist or occupational therapist, to perform **part of** this face-to-face evaluation. . . . Once the physician has received and reviewed the written report of this evaluation, the physician must see the patient and perform **any additional evaluation** that is needed. The report of the physician's visit should state concurrence or any disagreement with the other evaluation. In this situation, the **physician must provide the supplier with a copy of both evaluations within 30 days** after the face-to-face examination with the physician (emphasis added).

While AOTA appreciates the stated inclusion of occupational therapists in the evaluative process here, there are several problems with including the role of the occupational therapist only in a policy article. First, local coverage policy articles are not legally binding, rather the articles are only interpretive guidance from the DMERCs. Second, occupational therapists may not be able to locate the policy article on the DMERC or CMS website and are less likely to review the policy article than they are to review the LCD. Third, the statement in the policy article about the role of occupational therapists is unclear and gives no guidance to occupational therapists as to which part of the face-to-face-evaluation occupational therapists will be permitted to perform evaluations, nor in what setting such services will be permitted. Including occupational therapists in the policy article does nothing to clarify the role of occupational therapists in the evaluation and documentation process. Most physicians refer to occupational therapists to conduct the function-based evaluation because this is an area in which few physicians are specialists. Physicians also rely upon occupational therapists to consider the requirements of the National Coverage Determination (NCD) as part of the evaluation.

AOTA urges Palmetto to include in the body of the draft LCD the specific role of occupational therapists in the treatment and evaluation process by explicitly recognizing the team approach that may be involved with evaluating beneficiaries for PMDs, and the participation of therapists in that team approach. Including language about the role of occupational therapists in the LCD is critical to ensure appropriate, cost-efficient issuance of PMD.

For all these reasons, AOTA strongly urges Palmetto to explicitly state in the draft LCD that an occupational therapy evaluation of the beneficiary for a PMD is a covered service, reportable separately through CPT code. Further, it is essential that Palmetto clearly states that the occupational therapy evaluation of the beneficiary's need for a PMD will be considered evidence in the medical record of medical necessity in addition to the physician's face-face evaluation.

B. Prior Occupational Therapy Services

The DMERC should consider evidence in the medical record of previous rehabilitation services, including occupational therapy, as contributing to the demonstration of medical necessity for the PMD.

Whether a beneficiary previously received such services focused on maximizing function is relevant to whether a PMD is required. *AOTA recommends that Palmetto consider evidence in the medical record of previous rehabilitation services, including occupational therapy, as contributing to the demonstration of medical necessity for PMDs.*

3. Restrictive Definition of Mobility Related Activities of Daily Living (MRADLs)

Under the section *Basic Coverage Criteria (A)*, the draft LCD states the following: “the MRADLs to be considered in this and all other statements in this policy **are** toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.” However, the final NCD for mobility assistive equipment (MAE) states that “MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) **such as** toileting, feeding, dressing, grooming, and bathing in customary locations within the home.” AOTA asserts that this change in language from the final NCD (“such as”) to the draft LCD (“are”) represents a critical inconsistency between the two coverage determination policies. The language used in the draft LCD would have the impact of further restricting access to PMDs for individuals with disabilities by disallowing clinical consideration of other activities involving mobility during assessment. This is not the intent of the interim final rule and consequently should not be the aim of the draft LCD.

Occupational therapists work with beneficiaries to improve a significantly wider range of MRADLs beyond those listed in the draft LCD (e.g., toileting, feeding, dressing, grooming, and bathing). For example, a beneficiary with an upper spinal cord injury may never have the ability to cook for herself or bath herself independently even with the use of a mobility device. However, with the appropriate mobility device, the beneficiary may be able to move herself from the bedroom to the computer room where she might be able to engage in activities that are meaningful to her and contribute to her motivation to engage in ADLs/IADLs such as reading an online newspaper, participating in online classes, or pursuing home based employment. She may be able to travel to the kitchen to answer the telephone, move to the bookcase to read a book, move to the front door to pick up the mail, travel to the living room to watch television or move to a patio to visit with a friend. None of these improvements in function are currently recognized by the draft LCD and every one of them is an example of the basic functional needs of most beneficiaries with mobility impairments. The interim final rule appears to contemplate coverage of a broader range of MRADLs and should likewise be included in the LCD.

*AOTA opposes the DMERCs’ choice to definitively define MRADLs as toileting, feeding, dressing, grooming, and bathing and strongly urges the DMERCs to revise the draft LCD’s definition of MRADLs to be consistent with the NCD language as follows, “PMDs are reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) **such as** toileting, feeding, dressing, grooming, and bathing in customary locations within the home.”*

Finally, AOTA strongly objects to the draft LCDs’ omission of “mobility” itself in the document’s definition of MRADLs. By definition, “mobility assistance equipment” and “power mobility devices” are equipment used to aid in mobility. One’s capacity to improve mobility, whether or not it improves one’s ability to perform some other task, should be considered in the coverage determination process for mobility devices.

4. Problematic Timing of Implementation

The timing of implementation for the draft LCD relative to the interim final rule is confusing and unclear. AOTA has advocated to CMS that it postpone the implementation of the interim final rule. AOTA strongly recommends that Palmetto coordinate the effective date of the LCD to be consistent with the implementation of the final rule to provide both entities with adequate time to fully educate providers and suppliers on both policies and to ensure a smooth transition.

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AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on this LCD. We look forward to a continuing dialogue with Palmetto on these issues as they apply to occupational therapy. Should you have any questions or comments, please contact me at (301) 652-2682 ext. 2863 or via email at ssandhu@aota.org.

Sincerely,



Sharmila Sandhu, Esq.
Regulatory Counsel