National Coalition For Assistive & Rehab Technology

March 15, 2023

Centers for Medicare & Medicaid Services

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Re: CAG-00461N- Proposed National Coverage Determination for Power Seat Elevation on Power Wheelchairs

To Whom it May Concern:

The National Coalition for Assistive and Rehab Technology (NCART) 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).

Introduction

The National Coalition for Assistive and Rehab Technology (NCART) is a national non-profit organization of suppliers and manufacturers of Complex Rehab Technology (CRT) products and services used by individuals with disabilities and chronic medical conditions. NCART seeks to ensure these individuals have access to CRT products and supporting services. In pursuit of that goal, NCART works with consumers, clinicians, and physicians along with federal, state, and private policymakers to establish and protect appropriate coverage, coding, funding, and supplier standards policies.

We strongly support Medicare coverage of this important technology to establish critical access for Medicare beneficiaries with disabilities and complex medical needs as detailed in the formal September 2020 coverage request submitted by the ITEM Coalition, and in our comments submitted to the Centers for Medicare and Medicaid Services (CMS) on September 14, 2022. Power seat elevation is an essential component of a complex rehab power wheelchair (PWC) that allows people to perform or participate in the mobility-related activities of daily living (MRADLs) in the home.

The need for and benefits of a power seat elevation system not only improves transfers, but it also improves beneficiary access to the vertical environment for reach and line of sight requirements to safely and effectively engage in one's MRADLs. This is supported in the research, by subject matter expert consensus, patient-centered outcomes data, and is recognized by national disability and medical professional organizations. It is also supported by third-party payors such as state Medicaid programs, commercial payers, and the Veterans Administration that already provide coverage under their programs. We strongly believe it is time for the Medicare Program, as the single largest health care insurer in the nation, to provide coverage for this enabling technology in the same manner as well.

Request

We recommend that Nationally Covered Indications for Power Seat Elevation Equipment on Power Wheelchairs proposed in Appendix B be revised as follows:

Effective for services performed on or after [Month/XX] [20XX], power seat elevation equipment is reasonable and necessary for individuals using complex rehab power wheelchairs with a medical or functional need for vertical movement to allow the beneficiary to perform or obtain assistance to participate in MRADLs in the home when condition 1, 2, and 3 are met and, for Group 2 complex rehab power wheelchairs condition 4 is met, and for Group 3 and above complex rehab power wheelchairs, condition 4, 5, and/or 6 is met:

1. **The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Device 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.**
4. **The individual performs transfers to/from the power wheelchair while in the home, using their upper extremities and/or their lower extremities. Transfers may be accomplished with or without caregiver assistance and/or the use of any type of assistive equipment (e.g., cane, crutch, walker, sliding /transfer board, transfer assist handles, trapeze, transfer/pivot disk, sit-to-stand device, *patient lift/transfer system,* etc.).**
5. **The individual is at high risk for repetitive strain injury or has limited range of reach of the upper extremities, which prohibits performance of or participation in one or more MRADLs from a static seat height due to limited upper extremity strength, limited upper extremity range of motion, deformity, and/or short stature, and**
    a. **The beneficiary does not have sufficient balance, strength, range of motion, and/or endurance to stand and participate in or perform their MRADLs; and**
    b. **The beneficiary is able to participate in or perform their MRADLs from a seated position in the home with the provision of a power seat elevation system.**
6. **The individual has limitations in vision, neck range of motion and/or posture induced neck reflex activity, and cervical hyperextension of the neck:**
    a. **Prohibits the performance of or participation in one or more MRADLs from a static seat height; or,**
    b. **Results in the beneficiary losing contact with their alternative drive input device to operate their power wheelchair and/or power seat functions from a static seat height; and,**
    c. **The beneficiary is able to operate their power wheelchair, and power seat functions to participate in their MRADLs from a seated position in the home with the provision of a power seat elevation system.**

We also recommend CMS consider our recommended revisions to the National Coverage Determination for Mobility Assistive Equipment to support the NCD for Power Seat Elevation Equipment, as originally proposed in the ITEM Coalition's NCD Request for Reconsideration in September 2020.

Lastly, we strongly recommend CMS work with the DME MACs and stakeholders to take the additional steps required to establish coverage criteria necessitated by the National Coverage Determination for Power Seat Elevation Equipment in the Power Mobility Device and Wheelchair Options/Accessories Local Coverage Determinations (LCDs) and their associated Policy Articles to effectuate this change accordingly.

Further comments supporting these recommendations are provided below.

I. NCA – Seat Elevation Systems as an Accessory to Complex Rehab Power Wheelchairs (Group 3 and above)

We agree with CMS' proposal to allow power seat elevation equipment on Group 3 power wheelchairs both at initial issue and as a modification to a beneficiary-owned power wheelchair upon implementation of the policy.

We recognize it is CMS' current policy that Group 4 PWCs have added capabilities that are not needed for use in the home and if provided they will be denied as not reasonable and necessary (CMSa, 2015). However, we contend Group 4 power wheelchairs serve a medical purpose for certain individuals with disabilities, and/or in certain environments of use. Therefore, we request consideration for power seat elevation equipment to be extended to Group 4 PWCs if the base is deemed a necessary upgrade.

We also recognize that CMS has specific criteria for coverage of a Group 5 (pediatric) power wheelchair that must be met for it to be considered a covered benefit (CMSa, 2015). We contend that power seat elevation equipment serves in a special developmental capacity, similar to a seat to floor or standing system (CMSb, 2015), and request CMS to recognize seat elevation systems as an accessory to power wheelchairs that include Group 5 as well.

II. Seat Elevation Systems are Durable Medical Equipment

We agree with and support CMS's determination that power seat elevation equipment on power wheelchairs falls within the benefit category for durable medical equipment (DME) and are pleased that this enabling technology has been determined to serve a medical purpose. However, we assert that the medical purpose of power seat elevation extends beyond the limited scope of transfers for some Medicare beneficiaries, and as supported by the clinical evidence presented to CMS in the formal NCD Reconsideration Request submitted by the ITEM Coalition in September 2020.

III. Seat Elevation Systems are Reasonable and Necessary if Certain Conditions are Met

As a threshold matter, we agree with and support CMS's determination that power seat elevation equipment on power wheelchairs should be deemed reasonable and necessary if established conditions are met. We support, in part, the proposed National Coverage Determination language changes detailing these conditions, as outlined in appendices B and C of the proposed decision memo but respectfully request consideration of our recommended changes, as discussed in this letter.

IV. Seat Elevation Systems Serve a Medical Purpose for All Transfers

While we support CMS' efforts to establish medically necessary criteria for seat elevation systems, we have concerns with the criteria set forth in the NCD with regard to the proposed criteria for "non-level (uneven)" and "weight-bearing" transfers.

1. We are concerned that individuals who perform non-level (uneven) transfers would be precluded from coverage of a seat elevation system even if the safest, or most effective transfer is performed utilizing a downhill, gravity assisted method. We agree with the Paralyzed Veterans of America that the transfer surfaces should be either at equal height *or downhill*, as uphill transfers are known to increase forces in the upper limb (PVA, 2005), which is supported extensively in the research. We strongly recommend striking the words "non-level (uneven)" from the proposed condition that must be met for coverage consideration.
2. We are concerned the term "weight-bearing transfers" lacks clarity, may be misinterpreted, and has different implications depending on the transfer technique, level of assistance, and equipment used. We are seeking clarification to the proposed criteria that a weight-bearing transfer 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, *patient lift/transfer system*, etc.
3. We are also concerned that the criteria as written would eliminate coverage for a small sub-section of the disability population that would medically benefit from the use of a power seat elevation system for the safe execution of their transfers. We encourage CMS to consider coverage of a seat elevation system for individuals who are transferred using a patient lift system (E0625, E0630, E0635, E0639, E0640) or a multi-positional patient transfer system (E0636) who would not perform a weight-bearing transfer, as outlined in 2d above. Such inclusion would permit coverage for individuals with permanent disabilities such as, but not limited to ALS, Muscular Dystrophy, Multiple Sclerosis, Spinal Cord Injury (high-level tetraplegia), Spinal Muscular Atrophy, etc. who may require a mechanical lift system to safely transfer. A seat elevation system is medically necessary to transfer in these cases for the following reasons:

a. Beneficiaries who require a mechanical lift transfer sit on a sling while being transferred to their chair but must have the sling removed to fully complete the execution of the transfer, so they are able to take advantage of the skin protection and/or positioning properties of their wheelchair seat cushion. Remaining in a seated position on the sling throughout the day would be deemed an incomplete transfer, eliminates the medical benefits derived from the wheelchair seat cushion, and places the beneficiary at heightened risk for the development of a pressure injury and secondary medical complications.
b. For individuals with significant trunk weakness, poor balance, and/or postural control challenges as a result of a neurological condition, myopathy, or congenital skeletal deformity it is necessary to change the seat height for beneficiary safety and minimize beneficiary fall risk when removing or placing the sling. For example, the seat may be elevated to one height for a 5-foot-tall caregiver to remove their sling following the transfer to the chair and then elevated to a different height, for a different caregiver who is 6-feet tall to place the sling under the beneficiary at the start of the transfer out of the wheelchair.
c. Once a complete transfer is executed to the chair, and the beneficiary is provided the necessary stability afforded by their wheelchair cushion, back, and postural support components, there is medical benefit for a seat elevation system in maintaining shoulder, spine, and neck integrity for reach and line of sight requirements to perform or participate in their MRADLs.

Recommendation: For these reasons, we recommend that the criteria for coverage of transfers be considered as follows:

- **The individual performs transfers to/from the power wheelchair while in the home, using their upper extremities and/or their lower extremities. Transfers may be accomplished with or without caregiver assistance and/or the use of any type of assistive equipment (e.g., cane, crutch, walker, sliding /transfer board, transfer assist handles, trapeze, transfer/pivot disk, sit-to-stand device, *patient lift/transfer system*, etc.).**

V. Seat Elevation Systems Serve a Medical Purpose for Safe Reach and MRADLs

In addition to transfers, seat elevation systems serve the medical purpose of reaching in a way that minimizes the risk for pain and injuries while completing one's MRADLs. In particular, individuals that may not use their upper or lower extremities to transfer could use a seat elevation system to permit adequate range of reach and perform their medically necessary MRADLs. We respectfully request CMS review the peer reviewed research related to the application of power seat elevation systems for reach that were submitted with the original request by the ITEM Coalition in September 2020 and deemed complete in November 2020. Further, we request CMS take into consideration subject matter expert consensus, patient-centered outcomes data, and the numerous comments supporting the use of power seat elevation for the purpose of reaching the vertical environment to allow beneficiaries to perform or

participate in their MRADLs submitted during the initial open comment period August 14 – September 15, 2022 as well as the comments on this subject during this comment period.

Power wheelchairs provide 360° of movement in a horizontal, 2-dimensional plane, but we live in a 3-dimensional world. The Power Mobility Device Local Coverage Determination (L33789) provides the criteria for coverage of the power wheelchair to allow the beneficiary to get from point A to point B, and the Proposed Decision Memo has stated that power seat elevation is reasonable and necessary for individuals using power wheelchairs who perform transfers to be able to get in their wheelchair at point A. However, the proposed criteria in the decision memo falls short of meeting the needs of beneficiaries with permanent disabilities and complex medical needs while in their wheelchair, once they get to point B. Based on the peer reviewed research, subject matter expert consensus, and patient-centered outcomes data, this ignores three of the key questions in the National Coverage Determination for Mobility Assistive Equipment (CMS, 2005), which ask:

- Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?
- If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
- Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?
    - The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
    - The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of the power wheelchair.

One of the "other conditions" that limit the beneficiary's ability to participate in their MRADLs is the height of the surfaces they need to reach in the home. The inability to safely reach items can be ameliorated or compensated for adequately by the addition of a power seat elevation system for those individuals who must perform their MRADLs from their wheelchair in a seated position. For example, a home assessment, as required by the Power Mobility Device Local Coverage Determination (L33789) prior to or at the time of delivery of the power wheelchair, would verify that the beneficiary can adequately utilize the power wheelchair with the seat elevation system in the home, considering the physical layout and surface heights, to significantly improve their ability to perform or obtain assistance to participate in one or more MRADL.

This need extends to individuals who require a mechanical lift to transfer as well. These individuals may benefit from the use of a seat elevation system to reach the vertical environment and perform or participate in their MRADLs in the home once they are seated in their wheelchair with the appropriate cushion, back, and postural support components in place. This beneficiary population is typically seated in their power wheelchair more than 8 hours a day (Sonenblum, et al., 2019), must perform all their MRADLs from a seated position, and requires the seat elevation system to do so.

The evidence supports the need for power seat elevation to facilitate reach biomechanics, safety, and range (Schiappa et al., 2019) for people with mobility limitations that function from a seated position in their power wheelchair. For example, when we look at the Anthropometric Survey of U.S. Personnel: Summary Statistics Interim Report (Gordon et al., 1988), we see that the mean vertical grip reach height for women in sitting positions (n=2208) is 47.73" and for men (n=1774) it is 51.57". When this is compared to the typical height of objects an individual must interact with in the home on a daily basis it falls short of the heights needed to safely perform or participate in many ADLs, even at the top range of the reach. (Schiappa et al., 2019). Examples of this may include, but are not limited to the following MRADLs:

- Dressing:
    - reaching clothing on a clothes rod (66" high), the shelf of a closet (80" high), or in a dresser drawer (up to 54" high)
    - doing laundry (top load washer is 36" high, but you have to be able to reach down inside), stacked washer/dryer is 75" high
- Feeding:
    - preparing a basic meal for nutrition includes access to the counter (36"), upper (54 – 84") and lower cabinets, refrigerator/freezer (50" – 72"), the stove (36") and/or microwave (50" – 66")
    - access to water for hydration (36")
- Grooming:
    - brushing teeth, washing hands (36")
    - brushing/combing hair, shaving, washing one's face (54" – 66")
- Other:
    - access to the thermostat to manage thermoregulatory dysfunction (60")
    - access to light and/or fan switches (48")
    - access to medications (54 – 66")

The recommendation to extend coverage criteria to include reach is consistent with criteria for coverage implemented in whole or in part by the following eleven state Medicaid programs:
California[1] –

- A 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.

Colorado[2] –

- 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.

Idaho[3] –

- 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.

Iowa[4] –

- 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.)

Minnesota[5] –

- 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.)

New York[6] –

- Power seat elevation allows the member to independently perform MRADLs that cannot be performed independently without the addition of power seat elevation.

North Carolina[7] –

- Power seat elevation is covered for beneficiary's ages 0 through 20 years only, when the beneficiary … requires seat elevation to perform MRADL's.

South Dakota[8] –

- 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.).

Tennessee[9] –

- 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.

Texas[10] –

- 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).

Wisconsin[11] –

- Use of a power seat elevation system will allow the member to independently perform activities of daily living (ADL) and reduce caregiver dependency.

Recommendation: Accordingly, we recommend that the first criteria be revised, and a second alternative criteria be added for the purposes of reach in the vertical environment as follows:

- **The individual performs transfers to/from the power wheelchair while in the home, using their upper extremities and/or their lower extremities. Transfers may be accomplished with or**

without caregiver assistance and/or the use of any type of assistive equipment (e.g., cane, crutch, walker, sliding /transfer board, transfer assist handles, trapeze, transfer/pivot disk, sit-to-stand device, etc.), OR

- **The individual is at high risk for repetitive strain injury or has limited range of reach of the upper extremities, which prohibits performance of or participation in one or more MRADLs from a static seat height due to limited upper extremity strength, limited upper extremity range of motion, deformity, and/or short stature, and**
    - **The beneficiary does not have sufficient balance, strength, range of motion, and/or endurance to stand and participate in or perform their MRADLs; and**
    - **The beneficiary is able to participate in or perform their MRADLs from a seated position in the home with the provision of a power seat elevation system.**

VI. Seat Elevation Systems Serve a Medical Purpose for Visual Line of Site, Safe Operation of the PWC, and MRADLs

Individuals with a disability that preclude the use of their upper extremities for the performance of MRADLs who have the physical and cognitive capability to safely operate their power wheelchair, and associated power seat functions participate in the MRADLs by actively directing their care. For example, an individual with complete, high-level tetraplegia would meet the criteria for coverage of a Group 3 PWC to get to the customary locations of the home where MRADLs are performed (e.g., bathroom). While the individual would require the assistance of a caregiver to brush his teeth, shave his face and style his hair, access to the vertical environment allows the person to direct his care by having a line of sight in the mirror and fulfil the mandate of the National Coverage Determination for Mobility Assistive Equipment (CMS, 2005) as identified in Section V.

Complex rehab power wheelchairs must be capable of upgrade to alternative [drive] control devices (CMSb, 2015), yet alternative drive control systems are used by a very small subset of Medicare beneficiaries. In fact, the combined Medicare utilization of a head control interface (E2327, E2328, E2329, or E2330), a sip and puff interface (E2325), or a chin control (E2312, E2373) was only 922 units in 2021 (CMS, 2021). However, for individuals with disabilities that use their head, mouth, or chin to drive their power wheelchair, the ability to maintain a neutral neck position is essential to maintain contact or proximity to their drive control interface. For this small subset of Medicare beneficiaries power seat elevation also serves a medical benefit of improved line of sight along the vertical continuum and reduces cervical hyperextension commonly seen in people seated at a typical wheelchair height (Schiappa, et al., 2019).

Recommendation: In addition to the alternative recommendation proposed in Sec. V, we recommend adding to the proposed criteria the following alternative third criteria as follows:

- **The individual has limitations in vision, neck range of motion and/or posture induced neck reflex activity, and cervical hyperextension of the neck, which:**

- **Prohibits the performance of or participation in one or more MRADLs from a static seat height; or**
- **Results in the beneficiary losing contact with their alternative drive input device to operate their power wheelchair and/or power seat functions from a static seat height; and,**
- **The beneficiary is able to operate their power wheelchair, and power seat functions to participate in their MRADLs from a seated position in the home with the provision of a power seat elevation system.**

VII. Seat Elevation Systems Require a Team Approach to the Evaluation and Recommendation Process

We support the proposed condition that 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. However, this is inconsistent with the requirements for the complex rehab base the power seat elevation system will be used on and does not provide the same level of protection for the beneficiary or the Medicare Trust Fund that has been established for the provision of a power tilt and/or power recline system. For example:

1. The proposed condition would not preclude the practitioner, PT, or OT from having a financial relationship with the supplier of the power seat elevation system.
2. The absence of a requirement for the wheelchair to be 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 would permit the seat elevation system to be provided and billed for by any supplier with a Medicare provider number. Without the requirement for a supplier ATP to be directly involved with the beneficiary during the evaluation and recommendation process, there is no beneficiary or Medicare Trust Fund protection in place for situations in which the beneficiary has a change in medical condition and requires a seat elevation system as a modification to a beneficiary owned PWC.
3. The Power Mobility Device Local Coverage Determination (L33789) allows the supplier or practitioner to perform an on-site evaluation of the beneficiary's home to verify that the beneficiary can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces, and there must be a written report of this evaluation available on request (CMSa, 2015). The vast majority of all home environment assessments are carried out by the supplier ATP for the following reasons:
    a. The supplier ATP is the technology expert charged with matching technology recommendations/solutions to the beneficiary's identified medical needs;
    b. The supplier ATP has access to trial and evaluation equipment to verify the recommended equipment can be used in the home; and.
    c. The typical practitioner, PT, or OT with specific training and experience in rehabilitation wheelchair evaluations is often employed by a hospital, rehabilitation facility, or outpatient clinic. As such, leaving their place of employment to conduct an assessment

of the individual's home and their ability to safely use the seat elevation equipment in it is outside their clinical practice parameters.

Recommendation: For these reasons, we recommend that the criteria for coverage for a seat elevation system be consistent with the requirements in place for other power seating systems such that:

- **The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Device LCD; and**
- **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**
- **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.**

VIII. Power Seat Elevation System as a Power Seat Function

In furtherance to the recommendation in Sec. VII, we strongly encourage CMS to acknowledge that a power seat elevation system is considered a power seat function, similar to power tilt and/or power recline, and require the same level of beneficiary protection as the other two power seat functions.

We 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. The foundation for this recommendation is based on the fact that engagement of any of these three power seat functions alone or in combination change the center of gravity of the unit when they are activated, thereby effecting the dynamic stability of the complex rehab power wheelchair it is used on. As such, we feel it is imperative that power wheelchairs with a power seat elevation system pass all ANSI/RESNA testing specifications for dynamic stability where the dealer adjustments are set to the least stable configuration in which the PWC drives in full speed. Further, if the PWC'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.

IX. Power Seat Elevation Equipment on a Group 2 Power Wheelchair Primarily and Customarily Serves a Medical Purpose

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. It is

our position that power seat elevation serves a medical purpose for Group 2 complex rehab power wheelchair users for the following reasons:

- 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), Inclusion Body Myositis, Lupus, 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 complex rehab power wheelchair with a seat elevation system to transfer. According to the Centers for Disease Control and Prevention (CDC, 2023) emergency departments recorded 3 million visits for older adult falls in 2020. This added up to $50 million in medical costs, three fourths (3/4) of which were paid by Medicare and Medicaid. 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 (Schiappa et al., 2019), and may reduce the number of fatal and non-fatal falls for individuals over 65.
- According to the Administration for Community Living, which includes the Administration on Aging, 27% of the population age 65+ (14 million people) live alone (ACL, 2020). For those who use a power wheelchair and are a fall risk this often results in the individual performing or participating in their activities of daily living from a seated position. While falls often occur as a result of an unsuccessful transfer and would be addressed by the addition of a seat elevation system, the seat elevation system on a Group 2 power wheelchair would provide added benefit to facilitate reach biomechanics, safety, and range (Schiappa et al., 2019) in this population, especially for access to nutrition and hydration throughout the day.
- Of the estimated 4.9 million Medicare beneficiaries aged 65 years or older in 2015, approximately 40.5 million (92.4%) reported using eyeglasses with 37.2 million (84.8%) using them for near vision correction (Otte et al., 2018). When performing or participating in one's MRADLs vision correction alone may not allow the individual to see and read labels, thermostats, dials on cooking and cleaning appliances, etc. from a seated position without an accurate line of sight. Beneficiaries who use a Group 2 power wheelchair as their only means of mobility within their home may derive added benefit from the use of a seat elevation system to enhance visual orientation, line of sight, and safety (Schiappa et al., 2019).

Therefore, we recommend CMS extend coverage for seat elevation systems with a height of at least 6", as written in the Wheelchair Options/Accessories Devices Policy Article (CMSc, 2015), for people who have a medical need for a Group 2 power wheelchair to safely transfer to/from their chair. Six inches is recommended to cover the full range of beneficiary heights (i.e., tall beneficiaries performing a stand-pivot transfer), transfer surface heights (i.e., hospital beds 21" – 39" high), and transfer techniques (i.e., down-hill, gravity assisted sitting transfers). This would also allow people who have a medical need for a Group 2 power wheelchair to safely reach overhead and interact with the surfaces and items they need to access in the home to cook, clean, and take care of their hygiene and grooming needs.

However, we also assert that Group 2 power wheelchair users are a different patient population, use of the seat elevation equipment is typically different, and the seat elevation system technology itself is different than those using a Group 3 or higher power wheelchair. While Group 3 power wheelchair users would certainly benefit from the use of seat elevation for transfers, they have different needs due to their neurological conditions, myopathies, and congenital deformities that further necessitate a seat elevation system for reach and line of sight requirements. Accordingly, we propose different criteria for coverage to reflect these users' medical needs and that additional seat elevation product specifications are necessary to address these needs.

If coverage of seat elevation systems is expanded to Group 2 power wheelchairs, we also strongly recommend CMS work with stakeholders and the Alpha-Numeric HCPCS Coding Working Group to develop a new HCPCS code, in addition to E2300 to:

- Reflect the differences in user medical necessity;
- Reflect the differences in minimum product characteristics associated with meeting those needs; and.
- Accommodate the differing applications and technologies associated with Group 2 and Group 3 and higher complex rehab power wheelchairs.

Recommendation: For all the reasons stated above in Sec. IV – VII, we recommend Appendix B be revised as follows:

Effective for services performed on or after [Month/XX] [20XX], power seat elevation equipment is reasonable and necessary for individuals using complex rehab power wheelchairs with a medical or functional need for vertical movement to allow the beneficiary to perform or obtain assistance to participate in MRADLs in the home when condition 1, 2, and 3 are met and, for Group 2 complex rehab power wheelchairs condition 4 is met, and for Group 3 and above complex rehab power wheelchairs, condition 4, 5, and/or 6 is met:

1. **The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Device 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.**
4. **The individual performs transfers to/from the power wheelchair while in the home, using their upper extremities and/or their lower extremities. Transfers may be accomplished with or without caregiver assistance and/or the use of any type of assistive equipment (e.g., cane, crutch, walker, sliding /transfer board, transfer assist handles, trapeze, transfer/pivot disk, sit-to-stand device, *patient lift/transfer system,* etc.).**

5. **The individual is at high risk for repetitive strain injury or has limited range of reach of the upper extremities, which prohibits performance of or participation in one or more MRADLs from a static seat height due to limited upper extremity strength, limited upper extremity range of motion, deformity, and/or short stature, and**
    a. **The beneficiary does not have sufficient balance, strength, range of motion, and/or endurance to stand and participate in or perform their MRADLs; and**
    b. **The beneficiary is able to participate in or perform their MRADLs from a seated position in the home with the provision of a power seat elevation system.**
6. **The individual has limitations in vision, neck range of motion and/or posture induced neck reflex activity, and cervical hyperextension of the neck:**
    a. **Prohibits the performance of or participation in one or more MRADLs from a static seat height; or,**
    b. **Results in the beneficiary losing contact with their alternative drive input device to operate their power wheelchair and/or power seat functions from a static seat height; and,**
    c. **The beneficiary is able to operate their power wheelchair, and power seat functions to participate in their MRADLs from a seated position in the home with the provision of a power seat elevation system.**

We further recommend the National Coverage Determination for Mobility Assistive Equipment be revised as follows:

1. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE**, features or accessories** will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
2. Are the additional features **or accessories** provided by a power wheelchair needed to all the beneficiary to **perform or** participate in one or more MRADLs?
    b. **Access to the beneficiary's vertical environment (i.e., the need for a power seat elevation system) to allow the beneficiary to perform or obtain assistance to participate in MRADLs in the home.**

Recommendation: For all the reasons stated above in Sec. IV - VII, we also recommend Appendix C be revised as follows:

Seat Elevation Equipment (power-operated) on Group <u>2 and higher complex rehab</u> Power Wheelchairs

<u>Conclusion</u>

Clinicians, consumers, manufacturers, and providers all agree Medicare coverage of this important technology will improve the safety and quality of the life for wheelchair beneficiaries. NCART is proud to support CMS' proposed benefit category decision that recognizes power seat elevation equipment as

primarily medical in nature. We urge CMS to modify the proposed coverage decision to incorporate reach and line of sight and improve its conditions for coverage to include our recommendations.

We also believe it is essential for CMS to put safeguards in place to protect beneficiaries, the benefit, and the Medicare Trust Fund such as, but not limited to:

1. Following the clinical evidence that supports coverage for power seat elevation equipment for those Medicare beneficiaries who could medically benefit from access to the technology to more fully participate in their MRADLs;
2. Revising the coverage criteria to mirror the requirements for the provision of a power tilt and/or power recline system, as identified above;
3. Recognizing power seat elevation as a power seat function, for use on complex rehab technology bases with single or multiple power option capabilities; and
4. Requiring independent testing of power wheelchair bases with a seat elevation option that meets the definition of E2300 (at least 6" of elevation) entering the market on or after the implementation date of the policy.

Thank you for the opportunity to comment. Please contact me at wgrau@ncart.us for further information.

Sincerely,

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