

Proposal to Create a Separate Benefit Category for Complex Rehab Technology

January 2011



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a Separate Benefit Category
for Complex Rehab Technology**

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Proposal to Create a Separate Benefit Category for Complex Rehab Technology

Executive Summary

Complex Rehab Technology (CRT) products and associated services include medically necessary, individually configured devices that require evaluation, configuration, fitting, adjustment or programming. These products and services are designed to meet the specific and unique medical, physical, and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. For purposes of this document, CRT refers to individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems and other mobility devices.

Significant challenges threaten access to CRT products and the supporting services that are used by individuals with disabilities and medical conditions. These individuals deal with physical, functional and cognitive challenges every day and utilize CRT to maximize their function and minimize the extent and costs of their medical care. Threats to these products and services stem from coding, coverage, and payment problems. These challenges have increased over the past several years and, without meaningful change to these policies, will only become greater in the future.

A primary factor responsible for these challenges is that this group of individually configurable products does not have a distinct category, but instead is classified by Medicare within the broad category of Durable Medical Equipment (DME). DME is defined as an item that is able to withstand repeated use, i.e., could normally be rented and used by successive patients. This basic premise that exists within the DME benefit category prevents adequate differentiation when it comes to establishing coding, coverage, payment policies, and quality standards for the range of CRT. In order to rectify this fundamental problem, an initiative is underway to secure a Separate Benefit Category within the Medicare program to recognize the specialized nature of CRT products, the required supporting processes and services, the credentials and competencies needed by the providing companies and critical staff, and the related costs involved.

The issues that require a Separate Benefit Category for CRT manifest themselves in a variety of situations. Here are some examples:

- The Medicare program currently applies a restrictive interpretation of language in the Social Security Act regarding equipment coverage. Under this interpretation, Medicare will only pay for medical equipment that is medically necessary for use “in-the-home”. As a result, Medicare does not cover technology that is required to access the community for returning to work or school, going to the doctor or other medical services, grocery shopping or other activities associated with independent self-care or care of other dependents such as young children or aging parents. These activities are part of the daily lives of individuals living with disabilities on Medicare.

- Currently certain coverage policies are “diagnosis driven”, meaning that a person qualifies for the technology solely based on their medical diagnosis. Moreover, coverage policies within the Medicare program are primarily targeted at the typical Medicare beneficiary; individuals over age 65 and primarily with chronic disease. A diagnosis based policy leaves no means for functional criteria to qualify a person for appropriate and necessary CRT. While individuals may present with medical and functional needs similar to that seen with one of the diagnoses listed in the coverage policy, they are relegated to a lower level, less appropriate alternative simply because they do not have the listed diagnosis.
- For the past decade, codes under the HCPCS coding system (which is used to bill items and services) have become more generic and code descriptors like “any type” have been adopted. This causes a wide range of technology with different clinical applications and widely differing costs to be grouped into the same code. Couple this with a pricing methodology that utilizes a median price, and the result is that the more costly complex rehab technology cannot be provided at the Medicare fee schedule amount. For the individual requiring complex rehab, this results in either greater out of pocket costs to the beneficiary, or receiving less than appropriate technology which can lead to further medical and functional complications.
- Currently Medicare Part B does not cover the purchase of CRT in long term care facilities even when the provision of CRT would enable them to return to a home or community setting. The lack of this coverage prevents individuals who otherwise would have the ability to return home or to a community setting from doing so.

The stated purpose of a Separate Benefit Category is “to improve and protect access to CRT products and services for individuals with significant disabilities and medical conditions”. The targeted changes revolve around these five objectives:

- 1.) Develop clearer and more consistent coverage policies that appropriately address the unique needs of individuals with complex disabilities.
- 2.) Establish stronger and more enforceable Supplier Standards to promote appropriate clinical outcomes and consumer protection.
- 3.) Obtain formal recognition of the product-related services and costs involved to allow for appropriate funding.
- 4.) Provide future payment stability to ensure continued access to medically necessary products and services and an environment that encourages product innovation and technological solutions.
- 5.) Produce an improved coverage and payment system that can serve as a model for Medicaid and other payers to follow.

The required changes have been developed under four headings: Products and Coding, Coverage and Documentation, Payment, and Supplier Quality Standards. The following is a summary of the primary proposed changes:

- Proposed Changes Relating to Products and Coding-

1. Existing HCPCS codes, as appropriate, will be classified as CRT codes and will only be available through accredited CRT companies.
 2. New codes will be created where existing codes contain both CRT products and non-CRT products in order to segregate CRT products from DME.
 3. New codes will be created for “uncoded” CRT products that are routinely provided but currently do not have an assigned code.
 4. Product quality standards will be established for CRT products that will be provided to beneficiaries under the CRT Benefit Category.
- Proposed Changes Relating to Coverage and Documentation-
 1. Coverage criteria for CRT will be based on a determination of the beneficiary’s functional abilities and limitations, rather than specific diagnoses or other highly prescriptive and limiting criteria.
 2. A pathway will be established to require that beneficiaries who are seeking wheeled mobility and have certain diagnoses and/or clinical presentations go through a CRT Evaluation to ensure they receive the most appropriate equipment.
 3. Medicare’s “in-the-home” restriction, which ignores a beneficiary’s needs outside the home environment, will be eliminated for CRT.
 4. The primary weight for clinical documentation will be shifted from the physician to the Occupational Therapist and/or the Physical Therapist.
 5. CRT will be covered in Skilled Nursing Facilities for beneficiaries who could transition into the community if provided with these assistive products.
 6. Documentation requirements will be appropriate and clearly defined to help reduce unreasonable administrative burdens.
 - Proposed Changes Relating to Payment-
 1. Only accredited CRT companies would be able to provide and bill CRT products.
 2. All CRT products would be exempt from any competitive bidding programs.
 3. The current Gap Filling pricing methodology as it is applied to CRT HCPCS codes would be modified. CRT codes would be re-priced under Gap Filling with the re-pricing process to include the annual CPI index increases awarded to Orthotics and Prosthetics since 2000. The new fee schedule amount for each code resulting from the re-pricing would be limited to a floor of the current fee schedule and a ceiling of 10% above the current fee schedule.
 - Proposed Changes Relating to Supplier Quality Standards-
 1. The CRT Company (CRTC) must have the capability to service and repair all equipment it supplies.
 2. At the time of evaluation, the CRTC must provide the beneficiary with written information about how the beneficiary will receive service and repair after delivery of the equipment.
 3. The CRTC must provide or arrange for interim rental equipment or components while beneficiary-owned manual wheelchair or power wheelchair equipment is being repaired. The CRTC will be able to bill for interim rental equipment or components.
 4. The CRTC must employ at least one qualified rehab technology professional (RTP) per location and this individual will be required to show additional evidence of

competency in the provision of seating and mobility. A reasonable transition period will be provided to allow individuals to secure this new qualification.

The activities necessary to obtain a Separate Benefit Category for CRT are ongoing. Input and support continues to be sought and received from the consumer community, the clinician community, suppliers, and manufacturers regarding problem areas and the changes that are needed. The support of consumers with disabilities, their advocacy groups, physicians, physical therapists, occupational therapists, and other clinicians will be critical in communicating the issues and needed resolution to Congress and the Centers for Medicare and Medicaid Services (CMS). It will only be through these combined efforts that the ultimate goal of improving and protecting access to CRT products and services for individuals with significant disabilities and medical conditions will be achieved.

Objectives

The Project Steering Committee (see Exhibit 7) has adopted the following statement of purpose: "The purpose of a Separate Benefit Category is to improve and protect access to CRT products and services for individuals with significant disabilities and medical conditions". The targeted changes and improvements will be developed with this statement in mind and the following five objectives have been adopted:

- 1.) **Develop clearer and more consistent coverage policies that appropriately address the unique needs of individuals with complex disabilities** - Currently there are provisions within medical coverage policies that inappropriately limit the availability of certain products to people with disabilities. In addition, the current coding system does not differentiate the full breadth of available technology. Policies and coding must allow for a proper matching of an individual's medical, physical and functional needs to appropriate CRT products.
- 2.) **Establish stronger and more enforceable Supplier Standards to promote appropriate clinical outcomes and beneficiary protection** - The complexity of CRT warrants tailored quality standards and professional credentials to ensure that beneficiaries' needs are matched with appropriate products through a professional process and to ensure that there is an adequate system in place to provide for ongoing service and repair needs. These must be enforceable through the accrediting agencies and claims processing edits.
- 3.) **Obtain formal recognition of the product-related services and costs involved to allow for appropriate funding** - An adequate reimbursement system must recognize both the cost of the product and the cost to assess, provide and support the technology. To produce an equitable payment system, the significant product costs and product-related service costs must be recognized and factored in when establishing reasonable fee schedules.
- 4.) **Provide future payment stability to ensure continued access to medically necessary CRT products and services and an environment that encourages product innovation and technological solutions** - The CRT available today that provides function and independence for individuals with disabilities is the result of research and innovation that

has occurred over a number of years. For this consumer-centric product development to continue there must be a business and regulatory environment that fosters these activities and promotes access through appropriate coverage and payment.

- 5.) **Produce an improved coverage and payment system that can serve as a model for Medicaid and other payers to follow** - Many state Medicaid agencies and other third-party payers follow the policies of the federal Medicare program. Once this new system is adopted by the Medicare program it can be easily adopted by other payers and thereby improve access to CRT for individuals enrolled in other funding systems.

Activities to Date

The Separate Benefit Category initiative was formally started in September 2009 with the formation of a broad based Steering Committee and the subsequent establishment of focused Work Groups. Since that time a great deal of time and resources have been spent on meetings, conferences, research, webinars, and other related activities focused on creating awareness, gathering input, and obtaining support. The following are some of the highlights:

March 2010 and September 2010 Discussion Papers-

In March 2010 a Separate Benefit Category "Discussion Paper" was published for review and comment. This initial Discussion Paper was distributed to allow individuals and organizations within the CRT industry and profession, along with other interested parties, to engage in more detailed discussions regarding the pursuit of a Separate Benefit Category, the related elements of implementation, and its potential impact on stakeholders. The document was widely circulated and outlined suggested key concepts and potential changes. As a follow up, based on comments received an updated Discussion Paper was published and widely circulated in September 2010 to a broader group of CRT stakeholders. Input and suggestions were received and related modifications have been made and are reflected in the contents of this January 2011 Proposal.

Congressional Outreach-

In April 2010 the CRT message was taken to the halls of Congress as part of the NRRTS/NCART Continuing Education and Legislative Advocacy (CELA) Conference held in Washington, DC. There were over 220 in-person Congressional office meetings and handouts were delivered to another 20 offices. The CRT advocates included industry professionals, clinicians, and over 50 consumer representatives. The objectives of the visits were to create awareness and support of CRT issues and begin to lay the groundwork for legislation supporting the Separate Benefit Category.

Ensuring Consumer Access to CRT – Requirements for Maximizing Outcomes-

A document outlining the requirements necessary to ensure consumer access to CRT and to maximize related outcomes (see Exhibit 2) was developed under the leadership of Paul Tobin, President of United Spinal Association (www.unitedspinal.org) and a Steering Committee member. The purpose is to formally outline the required components that must exist to create an accessible system for appropriate coverage and payment of CRT, taking into account the needs of consumers, clinicians, and suppliers. This document presents those needs and allows CRT stakeholder organizations and other interested parties to endorse it, showing their agreement with the identified requirements. The document will be shared with policymakers in the federal, state, and private sectors.

Consumer Groups' Endorsement-

The Separate Benefit Category initiative has received the endorsement of the ITEM Coalition (www.itemcoalition.org) (see Exhibit 3). ITEM is a consumer-led coalition of over seventy distinct organizations. These include a diverse set of disability organizations, aging organizations, other consumer groups, labor organizations, voluntary health associations, and non-profit provider associations. ITEM's focus is to:

- Raise awareness about the importance of assistive devices, technologies, and related services in enhancing the function, independence, health status, and quality of life of people with disabilities and chronic conditions of all ages; and
- Identify the barriers to access to necessary devices and technologies under Medicare and Medicaid as well as other federal health programs and private plans; and
- Build support for broad-based legislative and regulatory changes to address the problems of inadequate access to assistive devices, technologies and related services.

Technical Consultation-

Avalere Health, a Washington D.C. based health care policy research firm, was engaged to deliver a report identifying the recommended regulatory and legislative roadmap. The report has provided guidance and direction regarding the next steps. As part of the engagement Avalere also developed the legislative specifications to provide a starting point for writing the required legislation.

Legislation Development-

As a follow up to the legislative specifications prepared by Avalere Health, a Washington D.C. law firm was engaged to prepare the specific legislative language needed to create a Separate Benefit Category within the Medicare program. The draft legislative language will be shared with interested Congressional offices and other stakeholders to begin the process of finalizing the legislative language and having a bill introduced in Congress for passage.

Products and Coding

The Healthcare Common Procedure Coding System (HCPCS) serves as the foundation for coverage and payment. Over the past five years, there has been a significant increase in HCPCS code descriptors using the words "any type". The thought that items addressing the position of a particular portion of the body could be grouped together into a single code for purposes of coverage and payment is the antithesis of CRT. This flaw in the coding system has had a negative impact on access. In addition, despite numerous attempts to obtain appropriate HCPCS codes to represent Complex Rehab Technologies, significant coding issues continue to plague suppliers, payers and ultimately consumers. The level of sales required to obtain a unique HCPCS code almost guarantees that wheelchair accessories and positioning items intended for individuals with severe disabilities will remain "uncoded" causing claims processing to be more costly and the length of time to process prior authorizations with non-Medicare payers to be lengthy.

The following are key changes that will be sought under the Separate Benefit Category relating to Products and Coding:

- 1.) Modify existing HCPCS code definitions to clearly distinguish CRT products from standard DME items.

- 2.) Designate specific HCPCS codes as CRT and limit these codes to being billed only by accredited CRT companies.
- 3.) Obtain new HCPCS codes to represent CRT products which are currently inappropriately grouped in the same code with DME items or are non-coded (such as positioning items, configurable manual wheelchairs grouped under K0004, etc.).
- 4.) Obtain new HCPCS codes for accessories related to certain coded items (such as stander accessories).
- 5.) Establish product quality standards for CRT products that will be provided under the CRT Benefit Category. Product quality standards will ensure a minimum level of product integrity and performance and create an important consumer protection safeguard. Currently, Medicare has in place performance standards for a limited range of products, including power wheelchairs and seat cushions. Medicare should recognize existing industry product standards established by the Rehabilitation Engineering and Assistive Technology Association of North America (RESNA) and the American National Standards Institute (ANSI). Only those products that meet established RESNA and ANSI standards would be deemed to meet the appropriate HCPCS code. Obtaining a CRT HCPCS code designation would require the product to meet these specific standards.
- 6.) Revise coding to mitigate Medically Unlikely Edits (MUE) limitations, for such items as removable or swing-away hardware.

The attached Exhibit 6 contains a list of current HCPCS codes that will be classified as CRT (Section A) and a list of other current HCPCS codes that contain both CRT products and non-CRT products (Section B) that will require modifications or additions to segregate CRT products from DME products. Additional work in this area will also include identifying needed codes for “uncoded” CRT items that are routinely provided but currently do not have an assigned code. Further analysis and planning is being undertaken by an industry Coding Work Group.

Coverage and Documentation

Appropriate coverage policies and documentation requirements are critical components in establishing a system that ensures that beneficiaries with significant disabilities and medical conditions have proper access to CRT. The following are key changes that will be sought under the Separate Benefit Category relating to Coverage and Documentation:

- 1.) Create a new National Coverage Determination (NCD) for CRT products that would include, but not be limited to, Complex Rehab manual wheelchairs, Complex Rehab power wheelchairs (including power assist), Complex Rehab wheelchair seating, Complex Rehab wheelchair options and accessories, gait trainers and alternative positioning systems. As needed, new Local Coverage Determinations (LCDs) would be created to align with the coverage and policy changes. Wheelchairs, wheelchair seating, and wheelchair options and accessories that are not considered to be CRT will remain under the current DME NCDs and respective LCDs.

- 2.) Base the coverage criteria in the new LCDs for CRT on the functional and medical needs of the beneficiary, rather than on specific diagnosis codes, specific categories of diagnoses, or other highly prescriptive criteria. Creating such a functional pathway for decision-making will help to ensure access for the subset of beneficiaries who require these CRT products due to their more complex medical, postural and functional needs and co-morbidities but who are currently denied access due to lack of a specific diagnosis. This will also allow clinicians to follow a best practice model in which products are chosen based on the results of an appropriate clinical evaluation and technological assessment which identifies a beneficiary's capabilities, limitations and goals. Through this system, recommendations will be based on the beneficiary's individual functional needs as opposed to a particular diagnosis.
 - a. The model used as an example to create the foundation for these new LCDs is the Lower Limb Prosthesis LCD. This LCD provides a hierarchy of functional levels against which the beneficiary's abilities are measured in order to determine the appropriate device. Once the beneficiary meets the basic criteria for any lower limb prosthesis, he/she qualifies for a specific type of prosthesis based on which functional level he or she meets. The beneficiary's functional level is identified by the treating clinician and prosthetist. The functional levels are based on a person's ability to ambulate with a prosthesis at a certain activity level and throughout certain environments.
 - b. New LCDs for CRT products will similarly establish a hierarchy of functional levels for Complex Rehab manual wheelchairs and a hierarchy of functional levels for Complex Rehab power wheelchairs based on the person's mobility abilities and limitations. However, because Complex Rehab mobility devices might also provide some positioning capabilities through frame features, adjustments and modifications, additional criteria will be established for each HCPCS code. These criteria will be based on positioning needs of the beneficiary that can be met through the mobility base. Coverage criteria for each HCPCS code would then be based on the achievement of specific functional levels, as well as the additional criteria specific to that particular type of product. This new system of functional levels for Complex Rehab mobility will have clear lines of demarcation from one functional level to another and clear correlation to products that meet these needs.
- 3.) Provide a pathway such that beneficiaries who are seeking wheeled mobility and meet specific criteria are required to go through a CRT Evaluation to ensure that those who require CRT products receive appropriate equipment and services. This pathway, or decision tree, is a series of 3 questions that would be applied to all beneficiaries who have a permanent need for wheeled mobility (see Exhibit 4). Based on the answers, the beneficiary would either be directed straight to the policies outlined in the DME LCDs or would be required to go through a CRT Evaluation performed by the physician and/or physical or occupational therapist members of the CRT Team (see Exhibit 1). The resulting recommendations of this evaluation could be either DME or CRT depending on current needs and the clinical judgment of the physician and/or physical or occupational therapist. By virtue of this CRT Evaluation, beneficiaries who have conditions or

presentations which would necessitate CRT either now or in the future will be directed to these products and services in the most appropriate and cost-effective manner.

The requirements for each step of the decision tree will be sufficiently clear and distinctive such that any licensed practitioner/clinician can answer the questions and arrive at the appropriate conclusion. The three sequential questions of the decision tree are as follows:

1. Does the beneficiary have a PERMANENT (lifetime) need for wheeled mobility?
 - **If “yes” continue to question 2.**
 - **If “no”, a CRT Evaluation is not required.**

2. Does the permanent need for wheeled mobility result from one of the following primary diagnoses?
 - a. Amyotrophic Lateral Sclerosis
 - b. Multiple Sclerosis
 - c. Muscular Dystrophy
 - d. Progressive Muscular Atrophy
 - e. Spinal Muscular Atrophy
 - f. Spinal Cord Injury
 - g. Traumatic Brain Injury
 - h. Post-Polio Syndrome
 - i. Cerebral Palsy
 - j. Spina Bifida
 - k. Arthrogyrosis
 - l. Osteogenesis Imperfecta
 - m. Friedreich’s Ataxia
 - n. Multiple Extremity Amputations
 - o. Guillain Barre
 - p. Huntington’s Disease
 - **If “yes”, beneficiary must go through a CRT Evaluation.**
 - **If “no”, continue to question 3.**

3. Does the beneficiary have one or more of the following postural presentations which hinders the person’s ability to perform ADLs (activities of daily living) or IADLs (instrumental activities of daily living) effectively, safely and efficiently from a seated position or places the beneficiary at risk for physical, medical or functional complications?
 - a. Inability to sit unsupported (hands-free) while maintaining a balanced, midline upright seated posture; or
 - b. Reducible or non-reducible postural deformity(ies) or asymmetry(ies) which cannot be self-corrected due to physical or cognitive limitations; or

- c. Atypical body dimensions or anatomical anomalies (e.g., dwarfism, gigantism, leg length discrepancies). Obesity alone would not require a CRT evaluation.
 - **If “yes”, beneficiary must go through a CRT Evaluation.**
 - **If “no”, a CRT Evaluation is not required unless prescribed by a physician.**
- 4.) Place appropriate weight on the clinical evaluation, the technological assessment, and the expertise and judgment of the CRT Team. Under this proposal, it will be the clinical and technological judgment of experienced and knowledgeable team members that identifies the beneficiary’s functional level, which is then used as justification for the appropriate products recommended. This places greater emphasis on the CRT Team’s assessments, as opposed to basing medical justification primarily on the exam and documentation of the physician. Again, this has precedence in both the lower limb prosthesis LCD, as well as the current LCD for speech generating devices. Appropriate checks and balances will be established in the policy to prevent overutilization of higher cost products.
- 5.) Shift the primary responsibility for the clinical documentation from that of the physician to that of the other clinicians on the CRT Team. The physician will be required to concur with the clinical and technological findings and provide the written order. However, the face-to-face process would be modified to retain the beneficiary protection aspects while alleviating some of the specific requirements of the physician documentation.
- 6.) Medicare’s “in-the-home” restriction for DME, which ignores a beneficiary’s needs outside the home environment, will be eliminated for CRT. There is precedence for this within the coverage of lower limb prostheses and speech generating devices. This will eliminate the issues with the current coverage criteria in which access to appropriate CRT for many Medicare beneficiaries is obstructed. Their daily lives extend well beyond the four walls of their residence and their environments of typical use are varied. These individuals might be able to function within the home with a less complex piece of equipment, however they require another level of product to function outside the home in order to perform such activities as going to medical appointments, attending religious services, voting, participating in community and family events, performing volunteer work, grocery and other shopping, attending school, getting to work, and functioning within the workplace.

Basing coverage criteria on functional levels that include mobility and activities in all environments of typical use would also bring the coverage criteria for CRT more in line with other legislation passed by Congress including the Rehabilitation Act, Americans with Disabilities Act, Ticket to Work and Work Incentives Improvement Act, and New Freedom Initiative Act. These all encourage people with disabilities to return to the community and the workplace.

- 7.) Develop coverage criteria that would allow appropriately identified residents of Skilled Nursing Facilities to access CRT in order to transition into the community. In these cases, CRT would be covered in the Skilled Nursing Facility under Medicare Part B similar to orthotics and prosthetics.

- 8.) Establish coverage criteria for new HCPCS codes that are created to reflect the technological range and complexity of CRT products (such as Complex Rehab manual wheelchairs, seating components, options and accessories, and repair/replacement components).
- 9.) Remove any redundancies from the current DME LCDs for manual and power wheelchairs, wheelchair seating, and wheelchair accessories which will continue to include standard DME seating and mobility products.
- 10.) Documentation requirements will be clearly defined to eliminate second guessing, confusion and potential omissions or errors. This would relieve some of the administrative burden of documentation collection by the CRT company.

Payment

Reimbursement for CRT has been eroded to a crisis level due to a number of policy changes and funding cuts. These include a decade of fee schedule freezes (which alone cost the CRT industry over 29 percent when compared to what reimbursement would have been had annual CPI updates been applied) along with other significant fee reductions. The other significant reductions resulted from coding changes that produced reduced fee schedules; code descriptor changes that now state “not billable at initial issue”, “for replacement only”, or “any type”; policy changes that created basic equipment packages “included in the base price” without adjustments to the base item fee schedule to cover the now “included options and accessories”; and other fee schedule cutbacks.

In order to maintain access to CRT, the following are key changes that will be sought under the Separate Benefit Category relating to Payment:

- 1.) Only accredited CRT companies will be able to provide and bill CRT products.
- 2.) All CRT products and services will be exempt from competitive bidding.
- 3.) All CRT products and services will be exempt from application of competitively bid pricing to the fee schedule.
- 4.) Payment methodology will be included in the legislative language for the Separate Benefit Category. This would mitigate the risk of obtaining a Separate Benefit Category yet ending up with all the same payment problems. The changes would include a modification to the Gap Filling pricing methodology in its application to CRT HCPCS codes. The identified CRT codes would be re-priced under Gap Filling with the re-pricing process to include the annual CPI index increases awarded to Orthotics and Prosthetics since 2000. The new fee schedule amount for each code resulting from the re-pricing would be limited to a floor of the current fee schedule and a ceiling of 10% above the current fee schedule.

- 5.) The new fee schedule would be developed to cover technology related services, including but not limited to, technology assessments, trials, simulations, fittings (initial and subsequent), modifications, adjustments, programming and training.
- 6.) All CRT products would be classified in the “purchase” category.

Supplier Quality Standards

Given the complexity of properly providing CRT it is critical that only appropriately qualified suppliers be allowed to provide these products and services. While there are currently some requirements in place, these must be strengthened in key areas in order to better safeguard the interests of beneficiaries and to improve outcomes. The following are key changes that will be sought under the Separate Benefit Category relating to Supplier Quality Standards:

- 1.) Relating to Service and Repair Requirements
 - a. The CRT Company (CRTC) must have the capability to service and repair all equipment it supplies.
 - i. At the time of the evaluation/technology assessment, the CRTC must provide the beneficiary with written information about how the beneficiary will receive service and repair after delivery of the equipment. For example, this requires the CRTC serving national and regional rehab facilities to present information about service and repair in the beneficiary’s local area.
 - ii. For sales to beneficiaries residing within the CRTC’s sales and service area, the CRTC must provide service and repair either through its own internal capability or through a written contractual arrangement with another accredited CRTC that agrees to provide service and repair in accordance with its own standard service and repair policies. This internal capability would require the capacity to provide service and repair at either the company’s facility, or in the beneficiary’s home, or another alternative location. (Note - this obligation does not apply to beneficiaries who move out of the CRTC’s sales and service area or for whom funding is not available.)
 - iii. For sales to beneficiaries residing outside the CRTC’s sales and service area, or in cases where a beneficiary moves out of the selling CRTC’s sales and service area, the CRTC must use its best efforts to locate an accredited CRTC in the beneficiary’s home area that will provide future service and repair.
 - b. The CRTC must provide or arrange for interim rental equipment while beneficiary-owned manual wheelchair or power wheelchair equipment is being repaired.
 - i. A mobility base must be offered as interim rental equipment if necessary to prevent the beneficiary from being bed or chair confined.
 - ii. The CRTC will be able to bill for interim rental equipment or components.
 - iii. Note- Current Medicare DMEPOS Quality Standards (October 2008) require that the supplier shall: “Provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for

orthotics and prosthetics; and.....". To recognize the unique nature of the systems provided by CRT companies, similar to orthotics and prosthetics, CRT would be added to the exceptions in Section II, Subsection B. 1. of the DMEPOS Quality Standards as follows: "Provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for **complex rehab technology equipment and** orthotics and prosthetics;"

2.) Relating to Key Personnel Requirements

- a. The CRTC must employ (as a W-2 employee) at least one qualified rehab technology professional (RTP) per location. The use of the acronym RTP is not intended to create a new title, certification or credential. It is intended to designate, for discussion purposes, the individual (as opposed to the company) involved in the CRT service delivery process. A qualified RTP is defined as an individual who has:
 - i. Successfully completed the RESNA ATP exam; and
 - ii. After a to-be-determined transition period following the establishment of a Separate Benefit Category for CRT, has achieved an additional designation that demonstrates the individual's competencies and experience outlined in the attached Exhibit 5 "CRT Service Delivery Matrix".
 - iii. Note- The next steps in the process of developing an additional designation that demonstrates the RTP's competencies and experience in the area of seating and mobility are (1) further define the responsibilities and required knowledge, skills, and experience outlined in the attached Exhibit 5 "CRT Service Delivery Matrix" into the specific skills, experience and knowledge needed for each task; (2) establish the criteria for determining how various pathways (education/credentialing/ certification programs) will be evaluated to be recognized as qualifying pathways; and (3) identify specific pathways and organizations that will be recognized to provide this additional designation.
- b. In the event that an RTP leaves the employ of the CRTC and there is no employed RTP at the CRTC location, the CRTC:
 - i. Must notify its accrediting body of the vacancy within 30 days from the date of separation.
 - ii. Is allowed a 180 day grace period from the date of separation to fill the vacancy during which time:
 1. The CRTC is allowed to deliver and bill for all outstanding orders with evaluations completed by the previous RTP.
 2. The CRTC is allowed to contract with an interim RTP, not to exceed the 180 day grace period, for new evaluations, fittings, etc. and is allowed to bill for the products delivered, providing proper notification has been given to their accrediting body.
 - iii. Must notify their accrediting body and provide documentation once the vacated position has been filled.

- iv. If the vacancy is not filled with a W-2 employed RTP and the required documentation is not provided within 180 days from the date of separation, the CRTC will be excluded from providing CRT products to Medicare beneficiaries until the vacancy is filled and documentation provided.
- c. Certain CRT service delivery activities may be delegated to a qualified CRT Technician with direct oversight by the RTP. A CRT Technician is deemed qualified by meeting all of the following:
 - i. Factory trained by manufacturers of the products supplied by the CRTC.
 - ii. Experienced in the assembly, fitting and programming of CRT products (e.g., on the job training, familiarity with CRT clients, related disabilities, products and services).
 - iii. Has completed at least 10 hours annually of continuing education specific to the assembly, fitting, and programming of CRT products.
 - iv. Has demonstrated competency in assembling and programming sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.
- d. The CRTC must employ at least one qualified service technician per location who is qualified to service the variety of CRT products supplied to beneficiaries by the CRTC. (Note- for smaller locations, the role of the qualified service technician may be filled by a qualified RTP as long as the individual possesses these additional qualifications.) A service technician is deemed qualified by meeting all of the following:
 - i. Factory trained by manufacturers of the products supplied by the CRTC.
 - ii. Experienced in the field of CRT product repair and service (e.g., on the job training, familiarity with CRT clients, products and services).
 - iii. Has completed at least 10 hours annually of continuing education specific to the repair and service of CRT products.
 - iv. Has demonstrated competency in programming and repairing sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.

Moving Ahead

CRT is dramatically different in many ways from standard DME. The consumers' needs are far more complex, requiring more extensive evaluation and fittings compared to standard DME. The products and equipment involved are intended to meet the unique medical and functional needs of individuals with a permanent need for CRT and therefore require a more detailed matching of their identified needs to the technology as compared to that required for standard DME. The service/delivery model and the skill set, knowledge and experience of the professionals who provide the services are very different from standard DME. A Separate Benefit Category for CRT will provide the best opportunity to address these differences in a meaningful way that will benefit not only Medicare beneficiaries with disabilities and significant medical conditions, but the Medicare program as a whole.

Activities around obtaining a Separate Benefit Category for CRT are ongoing. Input and support continues to be sought and received from the consumer community, the clinician community, suppliers, and manufacturers to provide details and insights into what additional fixes and changes are needed. The support of consumers with disabilities, their advocacy groups, physicians, physical therapists, occupational therapists, and other clinicians will be critical in communicating the issues and needed resolutions to Congress and the Centers for Medicare and Medicaid Services (CMS). It will only be through these combined efforts that the ultimate goal of improving and protecting access to CRT products and services for individuals with significant disabilities and medical conditions will be achieved.

Contacts for Additional Information

Please contact any member of the Separate Benefit Category Steering Committee:

- **Don Clayback**, Executive Director, NCART
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- **Gary Gilberti**, ATP, President, Chesapeake Rehab Equipment
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- **Walt Gorski**, Vice President, American Association for Homecare
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Exhibit 1 – Complex Rehab Technology Overview

The Products

Complex Rehab Technology (CRT) products and associated services include medically necessary, individually configured devices that require evaluation, configuration, fitting, adjustment or programming. These products and services are designed to meet the specific and unique medical, physical, and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. For purposes of this document, CRT refers to individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems and other mobility devices.

The Person

These products and services are designed to meet the specific and unique medical and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. The primary diagnoses that can require CRT include:

- Spinal Cord Injury; or
- Traumatic Brain Injury; or
- Cerebral Palsy; or
- Muscular Dystrophy; or
- Spina Bifida; or
- Osteogenesis Imperfecta; or
- Arthrogyrosis; or
- Amyotrophic Lateral Sclerosis; or
- Multiple Sclerosis; or
- Demyelinating diseases; or
- Myelopathy; or
- Myopathy; or
- Progressive Muscular Atrophy; or
- Anterior horn cell diseases; or
- Post-Polio Syndrome; or
- Cerebellar degeneration; or
- Dystonia; or
- Huntington's disease; or
- Spinocerebellar disease; or
- Certain types of amputation; or
- Paralysis or paresis; or
- Other disability or disease that is determined through individual consideration to require the use of such individually configured products and services

The Process

In establishing a person's need for CRT products and services, consideration is always given to the person's immediate and anticipated medical and functional needs. These needs include, but are not limited to, activities of daily living (ADLs), instrumental activities of daily living (IADLs), functional mobility, positioning, pressure redistribution, and communication. CRT is used to address these needs and enable the individual to accomplish these tasks safely, timely, and as independently as possible in all environments the individual is expected to encounter.

The provision of CRT consists of two interrelated components:

- The clinical component of providing CRT includes the physical and functional evaluation, treatment plan, goal setting, preliminary device feature determination, trials/simulations, fittings, function related training, determination of outcomes and related follow-up. The clinical team is responsible for the prescription and supporting medical documentation.

- The technology-related component of providing CRT includes, as appropriate: accessibility survey of the home environment; transportation assessment; technology assessment; equipment demonstration/trial/simulation; product feature matching to identified medical, physical, and functional needs; system configuration; fitting; adjustments; programming; and product related training and follow-up.

The Professionals

The provision of CRT is done through an interdisciplinary team consisting of, at a minimum, a Physician, a Physical Therapist or Occupational Therapist, and a Rehab Technology Professional (referred to as the CRT Team). The team collectively provides clinical services and technology-related services. An individual's medical and functional needs are identified by the clinical team. These needs are then matched to products and configured into custom designed systems by the Rehab Technology Professional with input from the clinical team.

- The clinical CRT services are provided by a licensed/certified Physical Therapist or Occupational Therapist.
- The technology-related CRT services are provided by a certified, registered or otherwise credentialed Rehab Technology Professional.

The Credentials

CRT products must be provided by individuals who are certified, registered or otherwise credentialed by recognized organizations in the field of CRT and who are employed by a business specifically accredited by a CMS deemed accreditation organization to provide CRT.

Special Note: Other assistive technology devices that require evaluation, configuration, fitting, adjustment or programming and the related provision processes may be added to this definition at a future date.

Exhibit 2 – Ensuring Consumer Access to Complex Rehab Technology Requirements for Maximizing Outcomes

Complex Rehab Technology (CRT) products are defined as medically necessary, individually configured devices that require evaluation, configuration, fitting, adjustment or programming. Examples of CRT include individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems and other mobility devices. These products and services are designed to meet the specific and unique medical, physical, and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma.

CRT is essential for the health and well-being of people with disabilities who require the equipment and services and for their caregivers. The proper access to and provision of CRT products and services is critical for the independence, well-being, and ability of people with disabilities to live, attend school, work, worship and participate in their communities. To ensure there is appropriate access, the following requirements must be incorporated into all applicable policies and practices:

- Consumers require a choice of appropriate quality equipment and services and the opportunity for input during the evaluation, selection, and procurement processes.
- Consumers require access to a thorough evaluation by qualified clinicians and suppliers.
- Consumers require transparency in the funding process and associated decisions, including an option for the consumer to provide supplementary funding above available allowable payment amounts.
- Consumers require adequate customization, integration, fitting, adjustment, and training along with appropriate post-delivery maintenance and timely repair.
- Consumers require that clinicians and suppliers be held accountable to appropriate quality and service standards.
- Consumers require responsiveness from clinicians, suppliers, manufacturers, and payers along with timely complaint resolution and consumer recourse.
- Consumers require that physicians, case managers, social workers, discharge planners, and other referral sources be provided a clear and concise process for making a referral for prescribed CRT.
- Consumers require that physicians, other prescribing medical professionals, clinicians and suppliers be provided a clearly defined set of coverage and payment policies with reasonable, consistent, and explicit documentation requirements regarding medical necessity.
- Consumers require that policies recognize the services and support systems necessary to evaluate, research, simulate, assemble, fit, educate and maintain the prescribed CRT.
- Consumers require that payers establish adequate payment schedules that are appropriate given the product and service costs involved.
- Consumers require replacement of prescribed CRT when the cost of repair exceeds 50% of the cost of replacement, regardless of the length of time it is in use.
- Consumers require that payers allow the option for suppliers to obtain prior funding approval for uncertain coverage situations.

In recognition of these stated requirements, the undersigned CRT stakeholders and supporters request that federal, state and local policymakers and agencies incorporate these into all related coverage, payment, and quality standards policies to ensure appropriate access to prescribed CRT products and services for people with disabilities.

Exhibit 3 – ITEM Coalition Letter of Support



November 30, 2010

RE: Ensuring Medicare Patient Access to Complex Rehab Technology (CRT)

Dear Senators and Representatives:

The Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition requests that Congress establish a separate benefit category for complex rehab technology within Medicare to ensure beneficiary access to critical assistive devices for beneficiaries with disabling conditions. The current benefit structure presents serious and often insurmountable obstacles for individuals who need to access Complex Rehab Technology (CRT) to achieve high levels of function in order to achieve good health outcomes, live independently, be employed where possible, care for their loved ones, engage in civic functions, and perform everyday activities.

CRT entails a broader baseline of services than those that are currently referred to under the Medicare program as “durable medical equipment” or “DME.” CRT is prescribed and customized to meet the specific medical and functional needs of individuals with disabilities and medical conditions such as, but not limited to, Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis, Spinal Cord Injury, Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease), and Spina Bifida. However, because CRT is currently coupled with the more general DME benefit, these patients face a series of challenges trying to access the appropriate and necessary technologies and services. These challenges include:

- Hindrance of the pairing of an individual’s needs to the appropriate products and technology due to coverage policies that are based on diagnosis instead of a person’s functional needs;
- Severe limitations on devices to be used outside of the home and in the community, due to Medicare’s restrictive interpretation of the “in the home” requirement for DME;
- Threats to patient access by the inclusion of CRT products in Medicare’s DME Competitive Bidding program, a program that could threaten patient access to

specialized technology. (While Group 3 complex rehabilitation wheelchairs were exempt from competitive bidding, other items such as configurable manual wheelchairs, tilt-in-space wheelchairs and custom seating and positioning items are still at risk);

- Lack of access to local CRT suppliers and long delays for repairs and maintenance for CRT due to insufficient reimbursement for these specialized devices and services; and
- Reductions in coverage for CRT when State Medicaid programs cut DME benefits.

Congress recognized the difference between DME and CRT when it exempted complex rehabilitation wheelchairs from DME competitive bidding in the Medicare Improvements for Patients and Providers Act (MIPPA). CRT was exempted from this program to preserve access to these specialized technologies for a patient population that is vulnerable and at-risk. Our proposal to break out a new CRT benefit from the existing DME benefit under the Medicare program would build on that Congressional recognition.

The ITEM Coalition urges Congress to establish a new and separate benefit category for Complex Rehab Technology products and services that recognizes the customized nature of the technology and the range of services necessary to meet the unique medical and functional needs of people with disabilities and complex medical conditions. For more information, please contact Peter Thomas, ITEM Coalition Counsel, at (202) 466-6550.

Sincerely,

ACCSES

American Academy of Physical Medicine and Rehabilitation

American Association of People with Disabilities

American Association on Health and Disability

American Congress of Rehabilitative Medicine

American Music Therapy Association

American Therapeutic Recreation Association

Amputee Coalition of America

Association of Assistive Technology Act Programs

Association of University Centers on Disabilities

Blinded Veterans Association

Brain Injury Association of America

Christopher and Dana Reeve Foundation

Disability Health Access, LLC

Disability Rights Education and Defense Fund

Easter Seals

Harris Family Center for Disability and Health Policy

Hearing Loss Association of America

National Association of County Behavioral Health and Developmental Disability Directors

National Association of State Head Injury Administrators
National Council on Independent Living
National Disability Rights Network
National Down Syndrome Society
National Multiple Sclerosis Society
National Rehabilitation Hospital
National Spinal Cord Injury Association
Paralyzed Veterans of America
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
TASH
The Arc
United Cerebral Palsy
United Spinal Association
VetsFirst

**Exhibit 4 – CRT Evaluation Requirement Decision Tree
For Beneficiaries Seeking Wheeled Mobility**

<p>1. Does the beneficiary have a PERMANENT (lifetime) need for wheeled mobility?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, go to question #2. If no, a CRT Evaluation is not required.</p>
<p>2. Does the permanent need for wheeled mobility result from one of the following primary diagnoses?</p> <ul style="list-style-type: none"> a. Amyotrophic Lateral Sclerosis b. Multiple Sclerosis c. Muscular Dystrophy d. Progressive Muscular Atrophy e. Spinal Muscular Atrophy f. Spinal Cord Injury g. Traumatic Brain Injury h. Post-Polio Syndrome i. Cerebral Palsy j. Spina Bifida k. Arthrogryposis l. Osteogenesis Imperfecta m. Friedreich’s Ataxia n. Multiple Extremity Amputations o. Guillain Barre p. Huntington’s Disease 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, beneficiary must go through a CRT Evaluation. If no, go to question #3.</p>
<p>3. Does the beneficiary have one or more of the following postural presentations which hinders the person’s ability to perform ADLs or IADLs effectively, safely and efficiently from a seated position or places the beneficiary at risk for physical, medical or functional complications?</p> <ul style="list-style-type: none"> a. Inability to sit unsupported (hands-free) while maintaining a balanced, midline upright seated posture; or b. Reducible or non-reducible postural deformity(ies) or asymmetry(ies) which cannot be self-corrected due to physical or cognitive limitations; or c. Atypical body dimensions or anatomical anomalies (e.g., dwarfism, gigantism, leg length discrepancies). Obesity alone does not require a CRT Evaluation. 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, beneficiary must go through a CRT Evaluation. If no, a CRT Evaluation is not required unless prescribed by a physician.</p>

Exhibit 5 – CRT Service Delivery Matrix

Complex Rehab Technology Service Delivery Activities with Related Complex Rehab Technology Company (CRTC) and Rehab Technology Professional (RTP) Responsibilities				
	Complex Rehab Technology (CRT) Activities In The Service Delivery Process	CRTC Responsibility- Fiduciary responsibility to individual client and payer	Required RTP Knowledge/ Skills/Experience- Responsible for all technology related services of the CRT service delivery process	Can activity be performed by someone other than RTP?
1	Perform initial intake gathering appropriate information on the individual	Responsible to assure this step occurs	Not Applicable	Yes
2	Identify trial equipment as needed for evaluation purposes	Responsible for providing adequate inventory or assuring availability of trial equipment to meet the needs of the individuals served	Requires knowledge, skill and experience to choose appropriate equipment for trial based on individual's diagnosis and symptomatology	RTP Required
3	Assemble, deliver, and fit trial equipment for evaluation purposes	Responsible to assure this step occurs	Requires knowledge, skill and experience to assure fit and function of trial equipment	Yes **
4	Evaluate outcome of equipment trials	Responsible to assure this step occurs	Requires knowledge, skill and experience to assess trial results in collaboration with treating therapist and to document appropriately	RTP Required
5	Participate in CRT Evaluation Process	Responsible to assure this step occurs	Requires knowledge, skill and experience to actively participate as part of the CRT Team (physician, therapist, others)	RTP Required

6	Perform Technology Assessment	Responsible to assure this step occurs	Requires knowledge, skill and experience to complete and appropriately document Technology Assessment matching specific equipment to unique needs of individual	RTP Required
7	Conduct home accessibility survey or obtain home accessibility report from other appropriate source	Responsible to assure this step occurs	Requires knowledge, skill and experience to conduct and document home accessibility survey	Yes **
8	Identify and document equipment recommendations and specifications	Responsible to assure this step occurs	Requires knowledge, skill and experience to translate Technology Assessment and equipment trials into specific equipment recommendations (manufacturers, models, accessories)	RTP Required
9	Prepare price quotation and obtain required funding documentation	Responsible to assure this step occurs	Requires knowledge, skill and experience to provide pricing quotation and potential funding documentation requirements	Yes
10	Submit prior approval requests in a timely manner as needed	Responsible to assure this step occurs	Not Applicable	Yes
11	Provide additional information as requested by the funding source	Responsible to assure this step occurs	Requires knowledge, skill and experience to provide additional information regarding technology selected	Yes
12	Order, receive, and assemble equipment according to manufacturer guidelines and individual's specifications	Responsible to assure this step occurs	Not Applicable	Yes

13	Deliver, fit, program, and adjust equipment to individual to maximize positioning and function	Responsible to assure this step occurs	Requires knowledge, skill and experience to properly fit, program, and adjust equipment to maximize positioning and function	Yes **
14	Provide training in equipment operation and maintenance	Responsible to assure this step occurs	Requires knowledge, skill and experience to provide training in safe operation and ongoing maintenance	Yes **
15	Provide on-going service and repair	Responsible for providing timely service and repair by qualified service technician	Not Applicable	Yes
16	Perform required billing and collections activities, including supplying additional information and pursuing appeals	Responsible to assure this step occurs	Not Applicable	Yes

**** These activities are the direct responsibility of the RTP. If these activities are performed by someone other than the RTP, the person to whom they are delegated must have the required knowledge, skills, and experience to perform them in a competent and professional manner. The RTP retains oversight and responsibility.**

Exhibit 6 – CRT HCPCS Codes

This Exhibit is segregated into two Sections: **Section A** is an initial list of existing HCPCS codes that will be classified as Complex Rehab Technology (CRT). Some codes may need to be adjusted or expanded in order to properly distinguish the technology within. In some cases components and accessories for these products may also need new codes. **Section B** is an initial list of other existing HCPCS codes that contain both CRT products and non-CRT products. These codes will require modifications and creation of new codes to segregate CRT products from DME products. Further analysis and recommendations in this area will be the responsibility of the Coding Work Group.

Section A

This section is an initial list of existing HCPCS codes that will be classified as CRT. Some codes may need to be adjusted or expanded in order to properly distinguish the technology within. In some cases components and accessories for these products may also need new codes.

Manual Wheelchairs:

- E1161 MANUAL ADULT TILT IN SPACE WHEELCHAIR
- E1220 WHEELCHAIR, SPECIALLY SIZED OR CONSTRUCTED, (INDICATE BRAND NAME, MODEL NUMBER)
- E1229 WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED
- E1231 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
- E1232 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM
- E1233 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
- E1234 WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
- E1235 WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
- E1236 WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM
- E1237 WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
- E1238 WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
- K0005 ULTRALIGHTWEIGHT WHEELCHAIR

Power Wheelchairs:

- E1239 POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED
- K0835 POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0836 POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0837 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS

Section A (cont'd)

- K0838 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0839 POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0840 POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0841 POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0842 POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0843 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0848 POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0849 POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0850 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0851 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0852 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0853 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0854 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0855 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0856 POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0857 POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0858 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUND
- K0859 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0860 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0861 POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0862 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0863 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS

Section A (cont'd)

- K0864 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0868 POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0869 POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0870 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0871 POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0877 POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0878 POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0879 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0880 POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS
- K0884 POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0885 POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0886 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0890 POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0891 POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0898 POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED

Wheelchair Accessories:

- E0986 MANUAL WHEELCHAIR ACCESSORY, PUSH ACTIVATED POWER ASSIST, EACH
- E1002 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY
- E1003 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITHOUT SHEAR REDUCTION
- E1004 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION
- E1005 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION
- E1006 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION
- E1007 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION

Section A (cont'd)

- E1008 WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION
- E1009 WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM
- E1010 WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEG REST, PAIR
- E1011 MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)
- E1014 RECLINING BACK, ADDITION TO PEDIATRIC SIZE WHEELCHAIR
- E1228 SPECIAL BACK HEIGHT FOR WHEELCHAIR
- E2209 ACCESSORY, ARM TROUGH, WITH OR WITHOUT HAND SUPPORT, EACH
- E2295 MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES
- E2300 POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM
- E2301 POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM
- E2310 POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND ONE POWER SEATING SYSTEM MOTOR, INCLUDING ALL FIXED MOUNTING HARDWARE ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE
- E2311 POWER WHEELCHAIR ACCESSORY, ELECTRONIC CONNECTION BETWEEN WHEELCHAIR CONTROLLER AND TWO OR MORE POWER SEATING SYSTEM MOTORS, INCLUDING ALL RELATED ELECTRONICS, INDICATOR FEATURE, MECHANICAL FUNCTION SELECTION SWITCH, AND FIXED MOUNTING HARDWARE
- E2312 POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE
- E2313 POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH
- E2321 POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, REMOTE JOYSTICK, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE
- E2322 POWER WHEELCHAIR ACCESSORY, HAND CONTROL INTERFACE, MULTIPLE MECHANICAL SWITCHES, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND FIXED MOUNTING HARDWARE
- E2323 POWER WHEELCHAIR ACCESSORY, SPECIALTY JOYSTICK HANDLE FOR HAND CONTROL INTERFACE, PREFABRICATED
- E2324 POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE
- E2325 POWER WHEELCHAIR ACCESSORY, SIP AND PUFF INTERFACE, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, AND MANUAL SWINGAWAY MOUNTING HARDWARE
- E2326 POWER WHEELCHAIR ACCESSORY, BREATH TUBE KIT FOR SIP AND PUFF INTERFACE

Section A (cont'd)

- E2327 POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE
- E2328 POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE
- E2329 POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE
- E2330 POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, PROXIMITY SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE
- E2331 POWER WHEELCHAIR ACCESSORY, ATTENDANT CONTROL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE
- E2351 POWER WHEELCHAIR ACCESSORY, ELECTRONIC INTERFACE TO OPERATE SPEECH GENERATING DEVICE USING POWER WHEELCHAIR CONTROL INTERFACE
- E2373 POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE
- E2374 POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY
- E2376 POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
- E2377 POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE

Wheelchair Seating:

- E2291 BACK, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE
- E2292 SEAT, PLANAR, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE
- E2293 BACK, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE
- E2294 SEAT, CONTOURED, FOR PEDIATRIC SIZE WHEELCHAIR INCLUDING FIXED ATTACHING HARDWARE
- E2609 CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION
- E2610 WHEELCHAIR SEAT CUSHION, POWERED
- E2617 CUSTOM FABRICATED WHEELCHAIR BACK CUSHION

Section A (cont'd)

Other CRT:

- E0637 COMBINATION SIT TO STAND SYSTEM, ANY SIZE, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS
- E0638 STANDING FRAME SYSTEM, ONE POSITION (E.G. UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
- E0641 STANDING FRAME SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
- E0642 STANDING FRAME SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC
- E1037 TRANSPORT CHAIR, PEDIATRIC SIZE
- E8000 GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS
- E8001 GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS
- E8002 GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS

Section B

This section is an initial list of other existing HCPCS codes that contain both CRT products and non-CRT products. These codes will require modifications and creation of new codes to segregate CRT products from DME products.

Manual Wheelchairs:

- K0004 HIGH STRENGTH LIGHTWEIGHT MANUAL WHEELCHAIR
- K0009 OTHER MANUAL WHEELCHAIR/BASE

Wheelchair Accessories:

- E0950 WHEELCHAIR ACCESSORY, TRAY, EACH
- E0951 HEEL LOOP/HOLDER, ANY TYPE, WITH OR WITHOUT ANKLE STRAP, EACH
- E0952 TOE LOOP/HOLDER, ANY TYPE, EACH
- E0955 WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE
- E0956 WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
- E0957 WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
- E0960 WHEELCHAIR ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, INCLUDING ANY TYPE MOUNTING HARDWARE
- E0967 MANUAL WHEELCHAIR ACCESSORY, HAND RIM WITH PROJECTIONS, ANY TYPE, EACH
- E0978 WHEELCHAIR ACCESSORY, POSITIONING BELT/SAFETY BELT/PELVIC STRAP, EACH
- E0990 WHEELCHAIR ACCESSORY, ELEVATING LEG REST, COMPLETE ASSEMBLY, EACH
- E1015 SHOCK ABSORBER FOR MANUAL WHEELCHAIR, EACH

Section B (cont'd)

- E1016 SHOCK ABSORBER FOR POWER WHEELCHAIR, EACH
- E1028 WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABLE OR REMOVABLE MOUNTING HARDWARE FOR JOYSTICK, OTHER CONTROL INTERFACE OR POSITIONING ACCESSORY
- E1029 WHEELCHAIR ACCESSORY, VENTILATOR TRAY, FIXED
- E1030 WHEELCHAIR ACCESSORY, VENTILATOR TRAY, GIMBALED
- E2205 MANUAL WHEELCHAIR ACCESSORY, HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED) ANY TYPE, REPLACEMENT ONLY, EACH
- E2208 WHEELCHAIR ACCESSORY, CYLINDER TANK CARRIER, EACH
- E2231 MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE
- E2368 POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY
- E2369 POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY
- E2370 POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY
- K0040 ADJUSTABLE ANGLE FOOTPLATE, EACH
- K0108 WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED
- K0669 WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM DME PDAC

Wheelchair Seating:

- E2605 POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
- E2606 POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
- E2607 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH
- E2608 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH
- E2613 POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2614 POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2615 POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2616 POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2620 POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2621 POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE
- E2624 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH (replaced K0736 effective 1/1/11)

Section B (cont'd)

- E2625 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH (replaced K0737 effective 1/1/11)
- K0736 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH (replaced by E2624 effective 1/1/11)
- K0737 SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH (replaced by E2625 effective 1/1/11)

Other CRT:

- E0143 WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT (new codes needed for pediatric specialty walkers)

Exhibit 7 – Work Group Members

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