Open Meeting: Power Mobility Devices and Wheelchair Options/Accessories

Meeting Date & Time: March 25, 2026, 10 am ET
Location: Virtual Meeting

Nicole Gunnarson: All right. Welcome, everyone. It is 10 A.M. Eastern, so we're going to officially open the open meeting today. So good morning, everyone. Thank you so much for joining us to discuss the proposed updates to the Power Mobility Devices and Wheelchair Options and Accessories LCDs. We have four stakeholders registered to speak today. We have divided up the available time to speak and each speaker will have 15 minutes to present their comments. Just as a reminder to speakers, once it's your turn to speak, we will unmute your line, and we ask that you also make sure you have unmuted yourself on your end. Now I'd like to turn the meeting over to Dr. Sunil Lalla.

Dr. Sunil Lalla: Good morning. Thank you everyone for attending, and welcome to our virtual open meeting. Today we'll be soliciting public comments regarding the proposed Power Mobility Devices and Wheelchair Options and Accessories Local Coverage Determinations.

I'm Dr. Sunil Lalla. I'm with CGS Administrators, the Jurisdiction B, DME MAC, and also from CGS is my colleague, Dr. Robert Hoover with Jurisdiction C. Representing Noridian Healthcare Solutions are Dr. Smitha Ballyamanda and Dr. Angela Jenny with Jurisdictions A and D, respectively. We look forward to your comments regarding the proposed LCD updates. Please do submit these comments in writing and send them to us via e-mail at pmdrecon@noridian.com for the Power Mobility Devices LCD or wcoarecon@noridian.com for the Wheelchair Options and Accessories LCD. Remember that comments which address more than one proposed LCD must be submitted to each respective LCD e-mail address for which comments are being made. Again, please remember that we can respond only to comments that are written. The comments are due by Saturday, April 4th, 2026, when the comment period closes. Also, we will be recording the meeting today, and this will be posted on the DME MAC websites. By attending this meeting, you are giving your consent to use your recorded voice and comments by signing into this meeting. Also, as a reminder, please be careful about sharing any personal health information in your verbal comments. We allow only registered speakers to speak at today's meeting, but anyone can submit written comments to the e-mail addresses mentioned earlier. For our speakers today, we ask that you introduce yourself, the organization that you represent, and please do remember to point out any potential conflicts of interest that you may have with this topic. For those who are listening, please remember to mute your phone line and computer if applicable. Speakers should be prepared to begin their comments immediately after being called upon. Now, let's review and talk a little bit about the proposed LCDs.

For the Power Mobility Devices, the DME MACs are proposing a not reasonable and necessary determination for Group 2 power wheelchairs with seat elevation systems. That's K0830 and K0831. And this is based on the best available evidence. Per the National Coverage Determination, NCD 280.16, Seat Elevation Equipment (Power Operated) on the Power Wheelchairs, coverage of Group 2 power wheelchairs with seat elevators would be determined at the MAC's discretion.

For Wheelchair Options and Accessories LCD, the DME MACs are proposing a not reasonable and necessary determination for the use of seat elevation added onto non-complex power wheelchairs, which is also based on the best available evidence. The proposed LCD proposes to include in the coverage criteria for power tilt and/or reclined seating systems examples of conditions that limit the beneficiary's ability to perform a functional weight shift. Per the National Coverage Determination, 280.16, the Seat Elevation Equipment (Power Operated) on Power Wheelchairs, coverage of power seat elevation equipment for individuals who use Medicare-covered power wheelchairs other than complex rehab power-driven wheelchairs would be determined at the MAC's discretion.

Please do remember these are proposed LCDs, so don't take any actions until we receive all the comments and determine if we will be finalizing the policy in the near future based on comments that we received during the open comment period.

Now I'll turn it back over to our moderator, Nicole Gunnarson, to introduce our speakers for today, Nicole.

Nicole Gunnarson: Thank you, Dr. Lalla. Our first speaker today is Peter Thomas. We're going to unmute your line now. Peter, are you there? Peter, are you there?

Peter Thomas: I am here. Can you hear me?

Nicole Gunnarson: Yes, I can hear you. Thank you. You have 15 minutes, and your time begins now.

Peter Thomas: Excellent. Thank you very much. Good morning, everyone. We appreciate the opportunity to speak with you about LCD, yeah, LCD 33789 today. We're going to withhold comments for our written comments to LCD 33792.

My name is Peter Thomas. I'm the managing partner of the Powers Law Firm here in Washington, DC. And I'm also the co-coordinator of the ITEM Coalition, which stands for the Independence Through Enhancement of Medicare and Medicaid Coalition. It's 103 national nonprofit organizations. The mission is to increase and improve coverage of and access to assistive devices and technologies of all kinds to people of all ages with disabilities.

I want to waive my right to HIPAA because I happen to be a person who can benefit from the technology seat elevation in a Group 2 power wheelchair. And I want to relate some specific instances. And I also would say that I have no conflicts of interest. I do represent a number of different companies and mostly associations, but don't own anything related to any company involving seat elevation and would say I have no conflicts of interest.

The steering committee, the ITEM coalition, is comprised of mostly organizations that rely on wheeled mobility, United Spinal Association, the Reeve Foundation, the ALS Association, the Multiple Sclerosis Society, the Spina Bifida Association of America, and the Amputee Coalition.

Now, amputees, people with limb loss, often use prosthetic limbs, but some of them either can't or need some kind of wheeled mobility in their home when they're not using their limbs. And so they, too, routinely use wheeled mobility.

Frankly, all the organizations, who I just mentioned and many others that are in the coalition, rely on DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) especially wheeled mobility to perform reach activities, transfers, perform mobility-related activities of daily living in the home.

I must say that we strongly oppose the proposed LCD, which states that Group 2 power wheelchairs without complex rehab technology are not reasonable and necessary and therefore not covered for Medicare beneficiaries with certain conditions.

We strongly urge you to withdraw this LCD. We're happy to continue working with you, but we really strongly oppose this LCD and find it to be not only in conflict with the letter, but certainly with the spirit of the National Coverage Determination and the National Coverage Analysis, that was published in May of 2023.

This policy, this draft policy, impacts individuals with limb loss, pressure ulcers, COPD, congestive heart failure, or I should say congestive heart disease, myositis, rheumatoid arthritis, and other disabling conditions that required wheeled mobility in the home to perform MRADLs.

The proposal represents a significant and deeply concerning departure from the NCD and NCA. If finalized, this proposed LCD will restrict access to medically necessary technology, increase risks for beneficiaries, decrease functional abilities and status of individuals who use Group 2 power chairs, and ultimately will drive higher costs elsewhere in the Medicare program.

So why is this proposal so problematic? First, I need to recount some history of how we came to this point. For years, seat elevation has been on the market and available to those who could afford it or whose payers were willing to cover it. Medicare considered this a convenience or a luxury for years. The ITEM Coalition strongly opposed that. We went in and met with CMS on numerous occasions, in the 1990s, the 2000s, the 2010s, and teens. Multiple ALJ hearings were held. Individuals won them, and they were often then denied access to seat elevation by the Medicare Appeals Council, who determined that this was not a DME benefit because it did not serve a medical purpose and was not medically necessary.

We met numerous times with CMS until finally we decided we would put forward a National Coverage Determination reconsideration request. The ITEM Coalition cobbled together its membership. We developed multiple subcommittees. We submitted a comprehensive NCD request in September of 2020. In August of 2022, CMS finally opened an NCA process for seat elevation. They bifurcated the standing systems portion of our NCD request and ultimately issued

a preliminary NCD and NCA in February of 2023.

That was a fairly limited view of seat elevation, and we fought that, we were glad that they had decided that seat elevation was in fact durable medical equipment and did serve a medical purpose, that was a major step forward, one that was long overdue in our estimation.

But they also determined that there were limits to the seat elevation coverage. A massive grassroots campaign resulted in thousands, I believe over 8,000 comments to that original preliminary policy, and ultimately, a final NCD was issued in May of 2023.

It was extremely favorable. It was much broader and much more relevant for people with disabilities than the preliminary LCD. And it was strongly supported by the disability community. We came out publicly and thanked CMS profusely. We appreciated being heard. And frankly, the disability community rejoiced. We were very pleased.

The NCD said a few things that I want to quickly quote. “Similar to individuals with Medicare who use Group 3 power wheelchairs, some individuals who use Group 2 power wheelchairs face the same obstacles with non-level transfers.

While the majority of non-Group 3 wheelchair users have medical conditions that still permit full weight-bearing activity, some users may have conditions that require them to use their devices as the primary means of mobility in their homes.

It is expected that they will use their upper extremities to bear weight and face the same obstacles as those patients in Group 3 power wheelchairs.”

I’ll continue, quoting from the NCA. “There are also Medicare-covered power wheelchairs that are not designated complex rehabilitative power-driven wheelchairs. DME MACs will have the discretion to determine reasonable and necessary coverage of power seat elevation equipment for individuals who use Medicare-covered PWCs other than complex rehab power-driven wheelchairs.”

And this is the key sentence. “This allows for individualized decision-making based on unique characteristics of each individual who requests power seat elevation equipment on a claim-by-claim basis.”

This was a landmark decision, and one that the ITEM Coalition, as I’ve stated, celebrated. We went public in thanking CMS. We promoted this within the disability community, and we created an expectation that seat elevation was finally available for this population. That it in fact serves a medical purpose. It is not a luxury, it is not a convenience, and therefore it is durable medical equipment. And in fact, it is medically necessary for many beneficiaries with mobility impairments.

This aligned Medicare policy with the modern rehabilitation standard of care. And frankly, it informed, after years of work, this collaboration and good faith engagement with CMS, Stakeholders are now, as a result of this draft LCD, faced with a policy proposal that effectively narrows access to CMS explicitly, something that CMS explicitly expanded.

So, this creates confusion and mistrust, and we find that to be very problematic. We believe this violates the letter and the intent of the NCA on power wheelchair seat elevation by barring coverage to entire diagnostic categories of patients, rather than making claim-by-claim individualized decisions based on the unique characteristics of each individual.

Diagnosis alone should never dictate coverage. No published evidence on the benefits of seat elevation for a specific diagnosis, does not mean that seat elevation is not medically necessary. It’s difficult for me to imagine a scenario where a person can actually qualify for a Group 2 power wheelchair in their home to perform MRADLs and not benefit from seat elevation.

Coverage criteria for seat elevation should be the same, regardless of the base on which the technology sits or the diagnosis of the beneficiary.

This blanket exclusion in the LCD does not account for variation in patient need. It does not allow for clinical judgment. It does not reflect the way mobility impairments present across the Medicare population.

So I just want to, I know that I need to wrap up here in about four minutes. I want to say that this essentially creates a one-size-fits-all policy for a highly individualized clinical issue.

We honestly thought we were past this. We really thought that we had achieved something meaningful in this LCD, this NCD and NCA. We fully expected this coverage to be implemented by the DME MACs consistent with the LCA, which accounts for and explicitly mentions claim-by-claim review and individualized determinations of need, including explicitly for Group 2 power wheelchairs that do not employ CRT, but do use seat elevation.

So, for this reason, we oppose the coverage policy. We urge the DME MACs to reconsider it and withdraw the draft LCD.

What seat elevation actually does, it's clearly not a luxury or a convenience. It's important for people with spinal cord injury, amputation, multiple sclerosis, stroke, advanced arthritis, a whole range of conditions to perform MRADLs. To transfer from one setting, one level to another to reach to perform MRADLs. It prevents falls, which can be extremely costly. It reduces the risk of overuse syndrome of the rotator cuffs and upper extremities.

I'm very familiar with this. I'm a bilateral amputee since age 10. 52 years on artificial limbs. And I must tell you, my shoulders are completely cashed. And every time I get up from a chair, I don't use my quadriceps and calf muscles. I use my arms. I push myself out of a chair. And many, many people do that. And frankly, seat elevation is extremely helpful to enable me to stand much more easily, to be able to reach, to be able to do all kinds of things that this policy would allow. There are many, many people like me. And I just, I don't want to harp too much on my own personal experience. That's an N of one, but it's real. It's real experience with this issue.

I just want to close by saying the Amputee Coalition allowed us to read a statement from them. They were not able to meet the deadline to register. I suspect that's why you only had four people registering. I do wish the DME MACs would extend those dates a bit longer in comment periods, but that's an aside.

The Amputee Coalition opposes the draft LCD that deems seat elevation is not medically necessary for Group 2 non-CRT powered wheelchairs under the Medicare program. This feature is absolutely imperative for individuals with single or multiple limb loss, to improve function and performance of MRADLs in the home. Whether the individual uses limb prosthesis or not, seat elevation can be instrumental for these individuals to perform activities that require reach, assistance in transfers, and performance of MRADLs. This is the standard for coverage under the NCD issued in May 2023. We believe the draft LCD is inconsistent with and arguably violates the conclusion of CMS on seat elevation coverage whereby the DME MACs have discretion on a case-by-case basis, not a blanket prohibition, to grant coverage of certain individuals on the basis of medical necessity and they urge withdrawal with policy. The ITEM coalition would go farther, we were we were comfortable with the DME MACs having the discretion to determine this on an individualized.

Nicole Gunnarson: You have one minute remaining.

Peter Thomas: Thank you. but we see no evidence but we see no evidence whatsoever that that this technology, seat elevation, is not medically necessary for virtually anyone that qualifies for a Group 3 or Group 2 power wheelchair.

And so, we would like this policy withdrawn, but we'd also like the DME MACs to enter into some kind of process, we're happy to work collaboratively, to develop an affirmative coverage policy consistent with the NCA and the NCD to grant coverage for this patient population. I thank you very much for your time and appreciate the opportunity to speak.

Nicole Gunnarson: Thank you for your comments today, Peter.

Our second speaker today is Usman Afzal, and we're going to unmute your line now. Usman, are you there? Usman, are you there? Alright.

We will move on to our third speaker. Our third speaker today is Jon Kuykendall, and we're going to unmute your line now. Jon, are you there? Jon, are you there?

Alright, we will move on to our final speaker for today, before doing one more check for speakers two and three. But our final speaker today is Julie Piriano. We're going to unmute your line now. Julie, are you there?

Julie Piriano: I am.

Nicole Gunnarson: Perfect. And Julie, will you please let us know when to advance your slides?

Julie Piriano: I will indeed. Thank you.

Nicole Gunnarson: Awesome. You have 15 minutes and your time begins.

Julie Piriano: Well, good morning and thank you for the opportunity to provide comments on the proposed changes to the PMD and Wheelchair Options and Accessories LCDs that would essentially deny coverage for a power seat elevation system used with a Group 2 non-complex power wheelchair as not reasonable and necessary if implemented.

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My name is Julie Piriano, and I'm the Senior Director of Payer Relations and Regulatory Affairs at NCART.

I have no conflicts. We are a member organization, but I have no direct conflicts.

NCART strongly disagrees with this proposed recommendation and respectfully requests the DME MACs consider CMS's conclusions from its National Coverage Analysis of the evidence for seat elevation systems as an accessory to power wheelchairs.

Following a re-examination of the complete body of evidence, we respectfully request the DME MACs established coverage criteria for a power seat elevation system used by beneficiaries who qualify for a Medicare-covered, non-complex Group 2 power wheelchair that is aligned with the criteria for power seat elevation on complex rehab power wheelchairs.

We further request that the DME MACs allow for individualized decision-making based on the clinical evaluation and documentation of each beneficiary's unique medical needs and functional limitations that would be reviewed on a case-by-case basis.

And finally, we urge the DME MACs to protect beneficiary access and the Medicare Trust Fund by supporting voluntary prior authorization for power seat elevation.

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We believe the proposed LCDs are more restrictive than several of the NCDs. For example, when power seat elevation equipment was added to the DME NCD, it was not exclusive to those used with a CRT base, nor does it exclude a power seat elevation system used with a Group 2 non-complex power wheelchair. In the MAE NCD, the question is, are there additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADL and states the type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments, which would include access to the vertical environment for certain beneficiaries.

And finally, when we look at the seat elevation NCD, CMS gave discretion to the DME MACs to determine reasonable and necessary coverage of power seat elevation equipment for individuals who use Medicare-covered non-complex power wheelchairs, stating in their decision memo, and I quote, Allowing Medicare contractors to make these reasonable and necessary decisions provides the best mechanism to make power seat elevation equipment available to individuals who need it, as it will allow for individualized decision-making based on the unique medical needs and functional deficits of each individual who requests this equipment. A blanket prohibition of power seat elevation for this beneficiary population is not discretionary, it is discriminatory.

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In their review of the research, the DME MACs concluded that there is very low certainty evidence that power seat elevator systems for non-complex power wheelchair users lead to statistically significant improvements in their transfer completion success rate, transferring biomechanics and reduced upper extremity pain or shoulder impingement, the ability to perform MRADLs or the incidence of falls.

They also stated the evidence is insufficient to determine if power seat elevator systems improve health outcomes or are reasonable and necessary for Medicare beneficiaries who use non-complex power wheelchairs, which we feel is completely disingenuous.

To NCART's knowledge, no known studies demonstrate that power seat elevation does not provide a medical benefit for certain beneficiaries, regardless of diagnosis or power wheelchair type.

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Peter has already outlined and provided information directly from the NCA with regard to CMS's conclusions in their review of the evidence. And we reiterate that it was abundantly clear what CMS's intent was when they reviewed the entire body of evidence.

I look at this like a myopic view of the research available. It's like looking through a hole in the fence at the baseball game and only seeing the pitcher, as opposed to standing up and looking over the fence and seeing the entire game or the entire body of evidence as it relates to this beneficiary population, or the applicability of the evidence to assure that individuals who need seat elevation might have access to this benefit.

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An analysis of 2024 and 2025 claims data for Group 2 non-complex power wheelchairs with a power seat elevation system prior authorized and funded by Medicare Advantage plans, state

Medicaid programs, Medicaid managed care organizations, and commercial payers that was provided to NCART by some of our members revealed a number of unique conditions influencing a beneficiary's health status and medical need for this equipment.

While diagnosis alone does not determine coverage, these payers found that power seat elevation was reasonable and necessary for certain individuals with a variety of diagnoses, when documentation from the clinical evaluation was reviewed in prior authorization and supported the need.

NCART's question to the DME MACs is, which is best to make reasonable and necessary decisions on behalf of Medicare beneficiaries? Looking for big data or reviewing the clinical evaluation and documentation findings of an N-of-1 trial, or the single-subject research design conducted with a beneficiary to determine the most effective treatment plan and equipment recommendation for them.

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I want to introduce you to my dad, a Medicare beneficiary, who at 84 years old had multiple medical conditions, but was sharp as a tack. As these conditions progressed, he could still stand up from his lift chair, but required someone to walk with him at times, well, no, at all times, due to multiple falls resulting in countless fractures.

He received an optimally configured manual wheelchair to mitigate the falls, with attempts to ambulate, but still made countless trips to the ER and had several overnight stays as a result of falls when attempting to transfer from the low seat to floor height of his manual wheelchair.

However, when he had a trial with a Group 2 non-complex power wheelchair with power seat elevation, he was independent in transfers to and from the wheelchair via a stand pivot, squat pivot, or sit pivot method.

And when we look at RESNA's original position paper with regard to transfers, it states one must be able to safely transfer to the wheelchair as part of their daily routine to accomplish MRADLs, therefore transferring is considered a medical necessity for beneficiaries who rely on mobility assistive equipment.

Seat elevating devices can facilitate safe and more independent transfers by elevating or lowering the seated height of the wheelchair, depending on the type of transfer and the height of the surface the beneficiary is transferring to or from.

This statement was not made based on the type of wheelchair someone used or the diagnosis that might qualify them for a Group 2 or a Group 3 power wheelchair. It was based on the needs of Medicare beneficiaries or people that need to transfer.

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When we look at feeding as an ADL, it's much more than just eating. For my dad, however, sitting in his manual wheelchair, set to where he could propel with his feet because he was not able to successfully propel with his upper extremities. He was so low compared to the height of the table that he could not effectively cut his own food or eat without spilling all over himself, which from a dignity standpoint, was very hard. But in the power wheelchair with the seat elevated, he was completely independent in eating, in cutting his food, in feeding himself. He didn't rely on somebody else.

In his apartment, he was able to make himself a cup of coffee, prepare lunch, and grab a snack because he was able to get to where that activity needed to take place in the power wheelchair, in the locations of the home where those customarily take place. And he had access to the vertical environment to complete the tasks.

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Dressing is more than putting arms and legs in clothes. And when my mom was no longer able or capable of doing laundry, he had to take over the task. Not only did he struggle to get to the laundry room in his manual wheelchair, as you can see, he could heave the laundry into the washing machine, but he had absolutely no way to operate it or get the clothes back out.

However, in the power wheelchair, not only was he able to get to and from the laundry room, but he was also able to complete the task entirely, with regard to washing, drying, folding, and putting clothes away, even though it was a job he hated to do.

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He was also able to shave, brush his teeth, comb the hair that he had, and manage his medications independently, in the customary locations of their apartment because the power

wheelchair allowed him to get from point A to point B and use the seat elevation system provided and therefore have access to the vertical environment once he got to where he needed to be. As opposed to paying $15,000 a month for personal care assistants to do the things he absolutely was capable of doing when he had access to the appropriate equipment solution.

CMS's findings in the NCA clearly demonstrate that for certain Medicare individuals or beneficiaries, the need to transfer and/or reach from a medically necessary power wheelchair is not determined by diagnosis or the HCPCS code of the power wheelchair base. Instead, it is driven by the individual's clinical presentation and medical need for mobility assistive equipment to perform or participate in their MRADLs in the customary locations of the home.

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While NCART strongly believes that the clinical evidence demonstrates power seat elevation is reasonable and necessary for certain beneficiaries who qualify for a non-complex power wheelchair base, we cannot support any proposal to eliminate two Group 2 power wheelchair base codes, K0830 and 831, unless the DME MACs continue coverage for power seat elevation systems used with a Group 2 non-complex power wheelchair K0822 through K0829, and align coverage criteria used to make reasonable and necessary decisions and determinations as follows.

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NCART contends aligning coverage criteria will not only ensure individualized assessment of each beneficiary's medical needs but will also enable the DME MACs to exercise discretion in determining whether the equipment is reasonable and necessary based on a review of the beneficiary's medical information, clinical presentation, and functional limitations.

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To assess utilization of a power seat elevation system, NCART reviewed CMS's data obtained through the Freedom of Information Act for the months where complete information for 2024 and 2025 were available for the four HCPCS codes requested, K0822, K0823, K0830, and K0831.

Our analysis reveals that less than 10% of the Group 2 non-complex power wheelchairs covered through traditional Medicare or Part B included a power seat elevation system in 2024 and 2025 combined. We do not believe utilization of these HCPCS codes is unwarranted. Rather, NCART's position is

Nicole Gunnarson: You have one minute remaining.

Julie Piriano: An expected shift in the provision of Group 2 complex power wheelchairs, 822 and 823, to a Group 2 non-complex power wheelchair with a seat elevation system based on the clinical evaluation and recommendation of a technology solution that meets the beneficiary's identified needs.

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Therefore, NCART recommends the DME MACs continue to cover power seat elevation systems on Medicare-covered Group 2 non-complex power wheelchairs, align coverage criteria for determining whether a power seat elevation system is reasonable and necessary for this beneficiary population, and support adding seat elevation systems the list of DMEPOS PMD accessories eligible for voluntary prior authorization, when the prior authorization request includes a corresponding power mobility device. This would enable the DME MACs to exercise discretion in determining whether the equipment is reasonable and necessary based on a review of the beneficiary's clinical information and their unique medical needs and functional limitations on a case-by-case basis.

Nicole Gunnarson: Thank you for your comment. Your time has expired. Thank you, Julie.

We are going to go back to our second speaker to see if they are on the line.

Our second speaker today is Usman Afzal. We're going to unmute your line now. Usman, are you there? Usman, can you hear me? Are you there? You may be muted on your end. Could you try unmuting on your end and speaking again? Usman, are you there? Alright, Usman is having some mic difficulties.

We will check to see if our other speaker that wasn't able to join earlier is present. Our third speaker is Jon Kuykendall. We're going to unmute your line now. Jon, are you there? Jon, are you there?

Alright, one more check for Usman. Usman, were you able to unmute your mic or resolve your mic difficulties?

Alright, well, we are going to go ahead and close the open meeting. We encourage Usman to please, and the other speakers and whoever else, to submit their written comments.

But all right, thank you. That concludes the stakeholder comments portion for this open meeting. At this point, I'm turning it back over to Dr. Lalla with the closing remarks.

Dr. Sunil Lalla: Thank you, Nicole. We want to thank the speakers today for your thoughtful comments. Once again, please do remember to send your comments in writing to the appropriate e-mail address as displayed on the slides.

As another reminder, the comment period does end on Saturday, April the 4th. Once we've considered and collated all the comments received during the open comment period, we'll consider any changes necessary as a result of those comments received and then follow the PIM Chapter 13 process to determine a possible final LCD along with a response to comments article.

The final LCDs would take effect at a minimum of 45 days following the posting of the final LCDs. For any updates, please refer to the DME MAC websites.

And lastly, I would like to thank everyone for their participation today. Julie and Peter, thank you so much. Your comments are always welcomed and quite insightful. We will now formally adjourn this meeting. Thank you so much.