

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MOST POWER WHEELCHAIRS IN
THE MEDICARE PROGRAM DID
NOT MEET MEDICAL NECESSITY
GUIDELINES**



Daniel R. Levinson
Inspector General

July 2011
OEI-04-09-00260



OBJECTIVES

1. To determine the extent to which standard power wheelchairs and complex rehabilitation power wheelchairs provided to Medicare beneficiaries during the first half of 2007 were medically necessary based on records from suppliers.
2. To determine whether records from physicians who prescribed power wheelchairs supported the medical necessity of power wheelchairs as documented by suppliers.

BACKGROUND

From 1999 to 2003, Medicare payments for power wheelchairs increased approximately 350 percent, from \$259 million to \$1.2 billion annually, raising concerns about inappropriate Medicare payments. In response, in 2005 and 2006 the Centers for Medicare & Medicaid Services (CMS) revised its policies related to power wheelchair coverage and coding. After these changes, Medicare's annual payments for power wheelchairs decreased to a relative low of \$658 million in 2007. However, expenditures rose to \$779 million in 2008 and \$723 million in 2009.

Beneficiaries are eligible to receive power wheelchairs under Medicare Part B coverage of durable medical equipment (DME). Beneficiaries who are prescribed power wheelchairs receive them from suppliers, which bill Medicare for reimbursement. Before providing a power wheelchair, a supplier receives from a prescribing physician a prescription for the power wheelchair and documentation from the beneficiary's medical record to support the medical necessity of a power wheelchair.

We selected a sample of 375 claims for standard and complex rehabilitation power wheelchairs supplied to beneficiaries in the first half of 2007 and conducted a medical record review. Based on suppliers' records, reviewers determined whether each claim was medically necessary and supported by sufficient documentation. They also reviewed records from prescribing physicians. For claims without errors based on suppliers' records, reviewers determined whether the prescribing physicians' records supported the suppliers' power wheelchair claims.

FINDINGS

Sixty-one percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 were medically unnecessary or had claims that lacked sufficient documentation to determine medical necessity.

Based on records submitted by suppliers that provided power wheelchairs, 9 percent of power wheelchairs were medically unnecessary and another 52 percent had claims that were insufficiently documented to determine whether the power wheelchairs were medically necessary. Of the \$189 million that Medicare allowed for power wheelchairs provided in the first half of 2007, \$95 million was for power wheelchairs that were medically unnecessary or had claims that were insufficiently documented. Beneficiaries who received medically unnecessary power wheelchairs needed a less expensive type of equipment or a different type of power wheelchair. For 2 percent of claims, a less expensive type of equipment (e.g., a scooter or a manual wheelchair) should have been provided. For the remaining 7 percent of claims, the beneficiaries should have received a different type of power wheelchair than was provided.

Medical necessity and documentation errors varied by power wheelchair type. Claims for standard and complex rehabilitation power wheelchairs had similar overall error rates (61 and 56 percent, respectively). However, standard power wheelchairs were less likely to be medically unnecessary than complex rehabilitation power wheelchairs (8 and 24 percent, respectively). Conversely, claims for standard power wheelchairs were more likely to have insufficient documentation than claims for complex rehabilitation power wheelchairs (53 and 32 percent, respectively). Because standard power wheelchairs accounted for most of Medicare's power wheelchair expenditures, errors among claims for such wheelchairs resulted in higher inappropriate payments than did errors among claims for complex rehabilitation power wheelchairs (\$90 million and \$5 million, respectively).

Prescribing physicians' records do not support the medical necessity of most power wheelchairs. Seventy-eight percent of claims without supplier-record errors were not supported by records provided by physicians who prescribed the power wheelchairs. That is, while suppliers' records indicated that power wheelchairs were medically necessary, physicians' records indicated that they were medically unnecessary, or physicians' records provided insufficient documentation or

no documentation of medical necessity. In most cases, physicians' records had insufficient documentation to support the medical necessity of power wheelchairs. Less often, physicians' records contradicted suppliers' records.

RECOMMENDATIONS

Our review found that power wheelchairs paid for by Medicare are not always medically necessary and that claims for power wheelchairs frequently have insufficient documentation to support medical necessity. We found that of the \$189 million that Medicare allowed for power wheelchairs provided in the first half of 2007, \$95 million was for power wheelchairs that were medically unnecessary or had claims that were insufficiently documented. Although CMS has taken steps since 2007 to decrease errors among suppliers of power wheelchairs and other DME, Medicare has paid significantly more in recent years for power wheelchairs than it did in 2007. These increases may indicate that CMS continues to pay for power wheelchairs that are not medically necessary and/or that have claims that do not meet documentation requirements.

Two previous OIG reports based on the same sample of power wheelchairs found problems with coding and with documentation requirements. This report shows additional problems with suppliers' compliance with Medicare requirements. Across all three reports, 80 percent of claims for power wheelchairs supplied to beneficiaries in the first half of 2007 did not meet Medicare requirements. Additionally, OIG has issued previous reports identifying substantial vulnerabilities in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

Based on our findings and prior work, we recommend that CMS:

Enhance reenrollment screening standards for current DMEPOS suppliers. Federal regulations place new DMEPOS suppliers at a risk level of "high," whereas currently enrolled DMEPOS suppliers are placed at a risk level of "moderate." We believe that currently enrolled DMEPOS suppliers should be subject to the same enrollment screening standards as newly enrolling DMEPOS suppliers and should also be placed at the risk level of "high."

Review records from sources in addition to the supplier, such as the prescribing physician, to determine whether power wheelchairs are medically necessary. CMS should direct its contractors to review records from prescribing physicians, in addition to those from suppliers.

Continue to educate power wheelchair suppliers and prescribing physicians to ensure compliance with clinical coverage criteria. In 2009, CMS began requiring that suppliers meet quality standards to be accredited. Additionally, in recent years CMS has developed a variety of educational materials for power wheelchair suppliers and prescribing physicians. However, our results indicate that CMS should continue to educate, and promote collaboration between, suppliers and physicians to ensure that beneficiaries receive medically necessary power wheelchairs that are appropriate for their mobility needs. We suggest that CMS focus its educational efforts for suppliers and prescribing physicians on the following topics:

- requirements for determining and documenting the medical necessity of a power wheelchair,
- requirements for determining the most appropriate power wheelchair for a beneficiary, and
- collaboration between supplier and physician to determine the most appropriate power wheelchair for a beneficiary.

Review suppliers of sampled claims we found to be in error.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with the second, third, and fourth recommendations. CMS did not concur with the first recommendation. In response to the first recommendation, CMS noted that it has in place other tools that allow for increased scrutiny of some current suppliers. Based on this report's findings, which reinforce the findings of multiple OIG reports in recent years identifying substantial vulnerabilities in the Medicare DMEPOS benefit, we maintain that all current DMEPOS suppliers should be subject upon reenrollment to the screening standards for the risk level of "high."

▶ T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 19

 Sixty-one percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 were medically unnecessary or had claims that lacked sufficient documentation to determine medical necessity 19

 Medical necessity and documentation errors varied by power wheelchair type 22

 Prescribing physicians' records do not support the medical necessity of most power wheelchairs 25

RECOMMENDATIONS 28

 Agency Comments and Office of Inspector General Response 31

APPENDIXES 32

 A: Clinical Coverage Criteria for Selected Power Wheelchairs 32

 B: Clinical Coverage Criteria for Selected Power Wheelchair Power Options and Accessories 36

 C: Population and Sample Sizes by Stratum, First Half of 2007 39

 D: Estimates and Confidence Intervals 40

 E: Agency Comments 44

ACKNOWLEDGMENTS 48

OBJECTIVES

1. To determine the extent to which standard power wheelchairs and complex rehabilitation power wheelchairs provided to Medicare beneficiaries during the first half of 2007 were medically necessary based on records from suppliers.
2. To determine whether records from physicians who prescribed power wheelchairs supported the medical necessity of power wheelchairs as documented by suppliers.

BACKGROUND

From 1999 to 2003, Medicare payments for power wheelchairs increased approximately 350 percent, from \$259 million to \$1.2 billion annually, while overall Medicare program expenditures rose 28 percent.^{1, 2} This increase caused concern within the Office of Inspector General (OIG), Government Accountability Office (GAO), and Centers for Medicare & Medicaid Services (CMS) about inappropriate Medicare payments.³ In response, CMS revised in 2005 and 2006 its Medicare policies related to power wheelchair coverage and coding.⁴ After these changes, Medicare's annual payments for power wheelchairs decreased to a relative low of \$658 million in 2007. However, expenditures rose to \$779 million in 2008 and \$723 million in 2009.

Beneficiaries are eligible to receive power wheelchairs under Medicare Part B coverage of durable medical equipment (DME).⁵ Most beneficiaries who require power wheelchairs are unable to walk and

¹ "Medicare payments" refers to the total Medicare-allowed amounts. Medicare pays 80 percent of the fee schedule amount, and the Medicare beneficiary is responsible for paying the remaining 20 percent.

² 71 Fed. Reg. 17021, 17022 (Apr. 5, 2006).

³ For example, Department of Health & Human Services (HHS) OIG, *Medicare Payments for Power Wheelchairs*, OEI-03-02-00600, April 2004; GAO, *CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs*, GAO-05-43, November 2004; and CMS and OIG, *New Efforts Aimed at Stopping Abuse of the Power Wheelchair Benefit in the Medicare Program*, September 9, 2003, accessed at <http://oig.hhs.gov/publications/docs/press/2003/090903release.pdf> on October 25, 2010.

⁴ CMS, Pub. No. 11272P, *2006 Fee Schedule Amounts for Power Mobility Devices Have Been Refined*, November 2006.

⁵ 42 CFR § 410.38.

have severe upper body weakness.⁶ Beneficiaries who are prescribed power wheelchairs by their physicians receive them from DME suppliers, which bill Medicare for reimbursement. Prior to January 1, 2011, the beneficiary was able to choose to rent or purchase the power wheelchair.⁷ Almost all beneficiaries chose to purchase their power wheelchairs.⁸

Power Wheelchair Types

Medicare covers more than 650 models of power wheelchairs.⁹ Each model is assigned to 1 of 42 power wheelchair HCPCS codes.¹⁰ The HCPCS code assignment is based on the model's performance, weight capacity, seat type, portability, and power seating system capability.¹¹

In the first half of 2007, two types of power wheelchairs—standard and complex rehabilitation—accounted for over 80 percent of all Medicare expenditures for power wheelchairs.^{12, 13} These two types are covered by Medicare under 27 HCPCS codes that include nearly 400 power wheelchair models.¹⁴

⁶ CMS's Medicare Learning Network, *Medicare Coverage of Power Mobility Devices: Power Wheelchairs and Power Operated Vehicles*, April 2006.

⁷ Effective for items furnished on or after January 1, 2011, section 3136(a)(2) of the Affordable Care Act (ACA) eliminated the lump-sum (up-front) purchase option for standard power wheelchairs. Medicare pays for a maximum of 13 continuous months of rental, and the supplier must transfer ownership to the beneficiary after the 13th month. For complex rehabilitation power wheelchairs, payment can continue to be made on a lump-sum purchase basis or monthly rental basis.

⁸ In the first half of 2007, new power wheelchair purchases accounted for 95 percent of Medicare power wheelchair expenditures. OIG analysis of claims from the National Claims History file submitted under Healthcare Common Procedure Coding System (HCPCS) codes K0823–K0864 with dates of service from January 1 to June 30, 2007.

⁹ Medicare Pricing, Data Analysis, and Coding (PDAC) contractor, *Motorized Wheelchair Product Classification List*, April 21, 2010.

¹⁰ Power wheelchair HCPCS codes are K0813–K0864. Within that range, Medicare has not assigned power wheelchairs to the HCPCS codes K0817–K0819, K0832–K0834, and K0844–K0847.

¹¹ Medicare PDAC contractor, *Power Mobility Device Coding Guidelines*. Accessed at https://www.dnepdac.com/resources/articles/2006/08_14_06.pdf on September 20, 2010.

¹² Standard power wheelchairs are HCPCS code K0823, and complex rehabilitation power wheelchairs are HCPCS codes K0835–K0843 and K0848–K0864. *DMEPOS Supplier Quality Standards*, August 2007, p. 11. The remaining 20 percent of claims were for power wheelchairs with characteristics similar to those of standard power wheelchairs; these power wheelchairs are reimbursed under HCPCS codes K0813–K0831.

¹³ OIG analysis of claims from the National Claims History file submitted under HCPCS codes K0823 and K0835–K0864 with dates of service from January 1 to June 30, 2007, processed as of June 30, 2007.

¹⁴ PDAC contractor, *Motorized Wheelchair Product Classification List*, April 21, 2010.

Standard power wheelchairs. Standard power wheelchairs are designed for daily use to provide basic mobility for persons weighing less than 300 pounds. Accessories, such as armrests and oxygen tank carriers, may be added to standard power wheelchairs.¹⁵

In the first half of 2007, standard power wheelchairs accounted for nearly three-quarters of Medicare's claims and expenditures for power wheelchairs.¹⁶ Medicare covers 100 models of standard power wheelchairs under HCPCS code K0823.¹⁷

Medicare's 2007 fee schedule amount for standard power wheelchairs was \$4,024.¹⁸ In January 2009, the fee schedule amount for such wheelchairs was reduced by 9.5 percent, to \$3,641.¹⁹

Complex rehabilitation power wheelchairs. To receive a complex rehabilitation power wheelchair, a beneficiary must meet criteria beyond those required to receive a standard power wheelchair. The beneficiary's mobility limitation must either (1) require one or more power options or a ventilator; or (2) result from a neurological condition, muscle disease, or skeletal deformity.²⁰ The beneficiary must also have received a specialty evaluation, and the beneficiary's weight should be

¹⁵ In the first half of 2007, standard power wheelchairs were supplied with an average of two accessories. Medicare's average allowed amount for an accessory for a standard power wheelchair was \$234. OIG analysis of claims from the National Claims History file submitted under HCPCS code K0823 with dates of service from January 1 to June 30, 2007, processed as of June 30, 2007.

¹⁶ OIG analysis of claims from the National Claims History file submitted under HCPCS code K0823 with dates of service from January 1 to June 30, 2007, processed as of June 30, 2007.

¹⁷ Medicare PDAC contractor, *Motorized Wheelchair Product Classification List*, loc. cit.

¹⁸ *DME, Prosthetics, Orthotics, and Supplies (DMEPOS) 2007 Fee Schedule*. Accessed at <http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp#TopOfPage> on June 1, 2011.

¹⁹ In July 2008, the Medicare Improvements for Beneficiaries and Providers Act of 2008 (MIPPA) delayed and reformed the Medicare DMEPOS Competitive Bidding Program. To offset the cost savings lost by this delay, MIPPA reduced fee schedule amounts in January 2009 by 9.5 percent. In January 2011, Medicare began to use prices from the Round 1 Rebid of the Competitive Bidding Program in nine geographical areas. Under the program, Medicare and its beneficiaries will pay between \$2,276 and \$2,716 for standard power wheelchairs.

²⁰ *Local Coverage Determination (LCD) for Power Mobility Devices*, "Indications and Limitations of Coverage and/or Medical Necessity." Also, see Medicare's *LCD for Wheelchair Options/Accessories*.

less than or equal to the weight capacity of the power wheelchair type that is provided.²¹

In the first half of 2007, complex rehabilitation power wheelchairs accounted for less than 7 percent of Medicare power wheelchair claims and expenditures.^{22, 23} Medicare covers 299 models of complex rehabilitation power wheelchairs under 26 HCPCS codes.²⁴

As with standard power wheelchairs, a variety of accessories may be added to complex rehabilitation power wheelchairs. Unlike standard power wheelchairs, complex rehabilitation power wheelchairs can also be upgraded with power options (e.g., a power seating system) or many other electronic features (e.g., a device to enable the user to control the chair by sipping and puffing through a straw).²⁵ We refer collectively to the power options and other electronic features that can be added to complex rehabilitation power wheelchairs as “power options.”

Medicare’s 2007 fee schedule amounts for complex rehabilitation power wheelchairs ranged from \$4,132 to \$11,965.²⁶ In January 2009, fee schedule amounts for complex rehabilitation power wheelchairs were reduced by 9.5 percent, to a range of \$3,739 to \$10,828.²⁷

Medicare Clinical Coverage Criteria for Power Wheelchairs, Power Options, and Accessories

General provisions of the Social Security Act (the Act) govern Medicare reimbursement for all items and services, including power wheelchairs.

²¹ *LCD for Power Mobility Devices*, “Indications and Limitations of Coverage and/or Medical Necessity.”

²² Complex rehabilitation power wheelchairs include HCPCS codes K0835–K0864.

²³ OIG analysis of claims from National Claims History file submitted under HCPCS codes K0835–K0864 with dates of service from January 1 to June 30, 2007, processed as of June 30, 2007.

²⁴ Medicare PDAC contractor, *Motorized Wheelchair Product Classification List*, loc. cit.

²⁵ In the first half of 2007, complex rehabilitation power wheelchairs were supplied with an average of five power options and/or accessories. Medicare’s average allowed amount for a power option or an accessory supplied with a complex rehabilitation power wheelchair was \$995. OIG analysis of claims from National Claims History file associated with claims submitted under HCPCS codes K0835–K0864 with dates of service from January 1 to June 30, 2007, processed as of June 30, 2007.

²⁶ *DMEPOS 2007 Fee Schedule* ceiling amounts for HCPCS codes K0835 and K0864.

²⁷ In July 2008, MIPPA delayed and reformed the Medicare DMEPOS Competitive Bidding Program. To offset the cost savings lost by this delay, MIPPA reduced fee schedule amounts in January 2009 by 9.5 percent. MIPPA also exempted complex rehabilitation power wheelchairs from the Competitive Bidding Program.

- Section 1862(a)(1)(A) of the Act states that no payment may be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”²⁸
- Section 1833(e) of the Act requires that suppliers furnish “such information as may be necessary in order to determine the amounts due” to receive Medicare payment.²⁹

Coverage criteria for power wheelchairs are found in Medicare’s *National Coverage Determination (NCD) for Mobility-Assistive Equipment* and *LCD for Power Mobility Devices*.³⁰ The NCD establishes an approach to coverage that requires a sequential analysis of a patient’s mobility status, and the LCD integrates this approach to establish a comprehensive standard for the provision of power wheelchairs. Relevant sections of the NCD and LCD are included in Appendix A.

Until 2005, CMS used a “bed- or chair-confined” standard to establish the medical necessity of a power wheelchair.³¹ In 2005, CMS published revised criteria that more closely tied Medicare coverage for a power wheelchair to a beneficiary’s medical condition and ability to function in the home. According to the revised coverage criteria, power wheelchairs and other mobility-assistive equipment are medically necessary for beneficiaries who have mobility limitations that impair their participation in mobility-related activities of daily living, such as using the toilet, feeding, dressing, and bathing. A power wheelchair is

²⁸ 42 CFR § 411.15(k)(1).

²⁹ 42 CFR § 424.5(a)(6). This requirement applies to the entity that submits the claim for payment to Medicare; in the case of power wheelchairs, the supplier submits the claim.

³⁰ *Medicare National Coverage Determinations Manual*, § 280.3. Mobility-assistive equipment is a DME category that includes canes, crutches, walkers, manual wheelchairs, scooters, and power wheelchairs. The term “power mobility devices” includes power-operated vehicles (scooters) and power wheelchairs.

The *LCD for Power Mobility Devices* includes detail beyond that in the NCD regarding nonclinical coverage criteria (i.e., documentation) and clinical coverage criteria for power wheelchairs. Medicare’s four DME Medicare Administrative Contractors (MAC) have adopted the same *LCD for Power Mobility Devices*. The relevant LCD policy numbers are L21271, L23613, L23598, and L27239.

³¹ CMS’s Medicare Learning Network, loc. cit. Until 2005, a power wheelchair was covered when the beneficiary’s condition was such that, without the use of a wheelchair, the beneficiary would otherwise be bed- or chair-confined; a wheelchair was medically necessary and the beneficiary was unable to operate a wheelchair manually; and the beneficiary was capable of safely operating the controls for the power wheelchair.

medically necessary when a beneficiary's mobility deficit cannot be addressed using other types of mobility-assistive equipment, such as a cane, manual wheelchair, or scooter. Additional criteria for a power wheelchair include:

- a beneficiary or a beneficiary's caregiver must be willing and able, physically and mentally, to operate a power wheelchair; and
- a beneficiary's home must provide adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.

To qualify for specific types of power wheelchairs, a beneficiary must meet additional criteria.³² For example, his or her weight must be less than or equal to the capacity of the power wheelchair. Additionally, some power wheelchairs are medically necessary only when a beneficiary has a certain diagnosis.

Power options and accessories are covered only if the beneficiary has a power wheelchair that meets Medicare coverage criteria.³³ Medicare's *LCD for Wheelchair Options/Accessories* specifies additional coverage criteria. See Appendix B for criteria for some power options and accessories.

Prescribing and Providing Power Wheelchairs to Medicare Beneficiaries

A Medicare beneficiary may be prescribed a power wheelchair by a physician after the physician conducts a face-to-face examination. During this examination, the physician assesses the beneficiary's medical condition and mobility needs and determines whether a power wheelchair is medically necessary as part of an overall treatment plan.³⁴ CMS requires that a beneficiary who needs a complex rehabilitation power wheelchair receive an additional specialty evaluation, which must be performed by a medical professional with

³² These are detailed in the *LCD for Power Mobility Devices*.

³³ Medicare's *LCD for Wheelchair Options/Accessories*.

³⁴ 42 CFR § 410.38(c)(2)(i). CMS has stated: "We believe the beneficiary's physician or treating practitioner is in the best position to evaluate and document the beneficiary's clinical condition and PMD [power mobility device] medical needs, and good medical practice requires that this evaluation be adequately documented." 71 Fed. Reg. 17024 (Apr. 5, 2006).

experience in evaluations for rehabilitation power wheelchairs, such as an occupational or physical therapist.³⁵

From a prescribing physician, a supplier receives a prescription for a power wheelchair and documentation from the beneficiary's medical record to support the medical necessity of the power wheelchair.³⁶ Supporting medical documentation includes the report from the face-to-face examination and any other parts of the beneficiary's medical record needed to support the medical necessity of the power wheelchair. For complex rehabilitation power wheelchairs, the specialty evaluation report is part of the supporting medical documentation. Based on the prescription and supporting medical documentation, the supplier recommends a type of power wheelchair for the beneficiary; the type must be approved by the prescribing physician.³⁷ The supplier is also responsible for assessing the beneficiary's home environment before or during the delivery of the power wheelchair to verify that the beneficiary can adequately maneuver the chair in his or her home.³⁸

CMS Activities To Improve Compliance With Medicare Power Wheelchair Requirements

CMS is responsible for paying Medicare claims and ensuring the integrity of those payments. CMS employs contractors that perform many functions to prevent, identify, and recover inappropriate Medicare payments for power wheelchairs. For example, DME MACs publish a variety of educational materials for suppliers and prescribing physicians. They also host educational symposia, "ask-the-contractor" calls, Web-hosted seminars, and online tutorials (podcasts). The DME MACs also publish "Dear Physician" letters for suppliers to educate physicians on coverage criteria for specific items, including power mobility devices.

Additionally, MIPPA required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009. The standards that CMS developed include business standards in areas such as suppliers' administration, consumer services, and product safety. Suppliers must also meet product-specific standards. For example,

³⁵ *LCD for Power Mobility Devices*. The specialty evaluation report must document the medical necessity for the power wheelchair and each recommended option and accessory.

³⁶ *LCD for Power Mobility Devices*, "Documentation Requirements."

³⁷ *Ibid.*

³⁸ *Ibid.*

power wheelchair suppliers are required to “provide the beneficiary with appropriate equipment for trial and simulation, when necessary” and “verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary’s record.”^{39, 40}

In February 2011, CMS published a final rule implementing provisions of ACA that establish procedures under which screening is conducted for providers of medical or other services and suppliers in the Medicare program.⁴¹ Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier. CMS created three levels of risk: limited, moderate, and high.⁴² New DMEPOS suppliers were placed at the “high” risk level, while currently enrolled DMEPOS suppliers were placed at the “moderate” risk level.⁴³

Medical Record Review by Medicare Contractors

Medicare contractors are required to analyze providers’ and suppliers’ compliance with Medicare coverage and coding requirements and to take corrective action when instances of noncompliance are identified.⁴⁴ As part of this, contractors conduct medical reviews of supporting documentation for selected claims to determine whether the claims met Medicare coverage criteria.⁴⁵ Every year, the Medicare Comprehensive Error Rate Testing (CERT) contractor reviews medical records to

³⁹ *DMEPOS Supplier Quality Standards*. Accessed at <http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOS AccreditationStandards.pdf> on December 5, 2008.

⁴⁰ The requirement pertaining to equipment trials applies only to suppliers of complex rehabilitation power wheelchairs.

⁴¹ 76 Fed. Reg. 5864, 5865 (Feb. 2, 2011).

⁴² Screening will include a licensure check, which may include checks across State lines, and the screening may also include (1) a fingerprint-based criminal background check; (2) unscheduled or unannounced site visits, including preenrollment site visits; (3) database checks, including checks across State lines; and other screening as the Secretary determines appropriate.

⁴³ To maintain Medicare billing privileges, a DMEPOS supplier must resubmit and recertify the accuracy of its enrollment information every 3 years. 42 CFR § 424.57(e).

⁴⁴ CMS’s *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.1.

⁴⁵ Contractors select claims for medical review by first selecting areas for review (e.g., providers, services) that are deemed high priority. Using claims data, the contractor determines the degree to which a potential error is widespread and meets established deviation indicators. If no legitimate explanation exists, the contractor selects a sample of cases representative of the universe in which the problem is occurring. CMS’s *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.2.

establish a national paid-claims error rate for the Medicare Fee-for-Service program. DME MACs and other benefit integrity contractors use error rates produced by the CERT contractor to target their efforts to prevent improper payments.⁴⁶

CMS directs its contractors to collect medical records from the provider or supplier submitting the claim. However, CMS does not require contractors to review records from the prescribing physician or any other providers that rendered care to the beneficiary. If the contractors choose to collect records from these other providers, they must first or simultaneously solicit the same information from the provider or supplier submitting the claim.⁴⁷

In 2006, OIG found that the CERT review of DME claims relied primarily on supplier records.⁴⁸ When additional medical records from physicians and other health care providers were reviewed, OIG found a large number of additional errors, including claims for medically unnecessary power wheelchairs, that were not identified by CMS's CERT contractor. OIG made a series of recommendations, among them that the CERT contractor review all medical records (including the records of prescribing physicians) necessary to determine compliance with applicable medical necessity requirements. CMS concurred, and in 2007, its CERT contractor began asking physicians, in addition to suppliers, for supporting information.⁴⁹

Prior Office of Inspector General Work

OIG has issued multiple reports in recent years identifying substantial vulnerabilities among Medicare power wheelchair claims and other DMEPOS claims. In April 2004, OIG reported on the medical necessity of power wheelchairs provided to Medicare beneficiaries during 2001.⁵⁰

⁴⁶ CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 1, § 1.3.1.

⁴⁷ CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.4.1.2.

⁴⁸ HHS OIG, *Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program*, A-01-07-00508, August 2008.

⁴⁹ OIG also recommended that CMS establish a written policy to address the appropriate use of clinical inference (i.e., a clinician's interpretation of the claim's appropriateness based on the medical record, considering the full scope of the beneficiary's circumstances). The primary modification resulting from CMS's concurrence with the recommendation was to require the CERT medical reviewers to strictly follow the documentation requirements outlined in the Medicare regulation, statute and policy, including LCDs, rather than allowing for clinical review judgment based on billing history and other available information.

⁵⁰ HHS OIG, *Medicare Payments for Power Wheelchairs*, OEI-03-02-00600, April 2004.

In that report, OIG found that only 13 percent of claims met Medicare's coverage criteria. After CMS revised in 2005 and 2006 its policies related to power wheelchair coverage and coding, OIG began a series of reports on Medicare payments for power wheelchairs provided during the first half of 2007.

Since 2009, OIG has issued two reports that assessed compliance with different Medicare requirements for power wheelchairs. Both reports are based on the same sample (of standard power wheelchairs and complex rehabilitation power wheelchairs supplied to Medicare beneficiaries in the first half of 2007) used in this report.⁵¹ In the first report, OIG found that 8 percent of claims for standard and complex rehabilitation power wheelchairs from the first half of 2007 were miscoded.⁵² OIG reviewed supplier-submitted manufacturer invoices for power wheelchairs and determined whether claims were miscoded (i.e., whether the HCPCS code that the supplier used to bill Medicare matched the model information on the invoice). In the second report, OIG found that 60 percent of claims for standard and complex rehabilitation power wheelchairs did not meet Medicare documentation requirements during the first half of 2007.⁵³ OIG determined the extent to which suppliers submitted documents that included all required information and whether suppliers received the documents from prescribing physicians within required timeframes.

Further, OIG issued multiple reports between 2005 and 2009 identifying substantial vulnerabilities in the Medicare DMEPOS

⁵¹ Additionally, OIG issued a report on the power wheelchair fee schedule amounts in the Medicare program. HHS OIG, *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009.

⁵² HHS OIG, *Miscoded Claims for Power Wheelchairs in the Medicare Program*, OEI-04-07-00403, July 2009. Power wheelchairs are assigned HCPCS codes based on the manufacturers' model information. Miscoded claims were defined as those for which the suppliers billed Medicare using HCPCS codes that did not match the model information on the invoices for power wheelchairs supplied to beneficiaries.

⁵³ HHS OIG, *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements*, OEI-04-07-00401, December 2009. The December 2009 report did not determine whether the required documents were sufficient to support the medical necessity of the power wheelchairs or whether the power wheelchairs were medically necessary because this review used a medical record review to address those questions.

benefit.⁵⁴ These problems include deficiencies in enrollment safeguards, excessive payments, inappropriate payments, and issues with provider appeals. For example, when OIG conducted unannounced site visits to 1,581 DME suppliers in South Florida in late 2006, nearly a third either did not maintain physical facilities or were not open and staffed. OIG has made a variety of recommendations to CMS to address these vulnerabilities, including strengthening the supplier enrollment process. CMS has implemented many of these recommended changes; however, OIG continues to find significant vulnerabilities.

Based on joint investigations by the Department of Justice (DOJ), CMS, and OIG, in recent years numerous DMEPOS suppliers have been charged with and convicted of defrauding the Medicare program, and many have had their Medicare billing privileges revoked based on OIG work. Examples include the 20 DME company owners and marketers, most of them in the Los Angeles area, who were charged in 2009 with allegedly billing Medicare for more than \$26 million in fraudulent claims for power wheelchairs, orthotics, and hospital beds.⁵⁵ Effective January 1, 2007, CMS revoked the billing privileges of 491 South Florida DME suppliers that did not maintain appropriate physical facilities or had facilities that were not accessible to beneficiaries during reasonable or posted business hours on at least two visits.⁵⁶

METHODOLOGY

Scope

This evaluation focused on standard and complex rehabilitation power wheelchairs provided to Medicare beneficiaries during the first half of 2007. Our population consisted of claims for new, nonrental power wheelchairs from CMS's National Claims History DME Standard

⁵⁴ For example, HHS OIG, *South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, OEI-03-07-00150, March 2007; HHS OIG, *Los Angeles County Suppliers' Compliance with Medicare Standards: Results From Unannounced Visits*, OEI-09-07-00550, February 2008; HHS OIG, *South Florida Medical Equipment Suppliers: Results of Appeals*, OEI-03-07-00540, October 2008; HHS OIG, *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009.

⁵⁵ DOJ, Office of Public Affairs, *Los Angeles Medicare Fraud Strike Force Charges 20 in Health Care Fraud Cases Involving Durable Medical Equipment*. Accessed at <http://www.justice.gov/opa/pr/2009/October/09-crm-1131.html> on February 23, 2011.

⁵⁶ HHS OIG, *South Florida Medical Equipment Suppliers: Results of Appeals*, OEI-03-07-00540, October 2008.

Analytical File with dates of service in the first half of 2007.⁵⁷ We based this evaluation on data from a medical record review of a random sample of power wheelchair claims.

Based on suppliers' records, we determined whether power wheelchairs met clinical coverage criteria. We also reviewed the medical necessity of power options and accessories supplied with complex rehabilitation power wheelchairs. We did not review accessories supplied with standard power wheelchairs because beneficiaries who received such wheelchairs needed fewer, less expensive accessories. We did not determine whether sampled power wheelchair claims were coded correctly or met nonclinical documentation requirements; in separate reports, OIG has noted the rates of miscoding and documentation error in power wheelchair claims.⁵⁸ We also reviewed prescribing physicians' records. However, we did not determine whether claims met clinical coverage criteria based on physicians' records.

Sample Selection

We removed from our population claims from suppliers or prescribing physicians under OIG investigation and claims from suppliers that were inactive or whose billing privileges had been revoked since the time they submitted the claims.^{59, 60} We grouped the resulting population into three strata:

⁵⁷ We analyzed claims that CMS processed as of June 30, 2007. That claims file is estimated to be 79 percent complete; that is, it included 79 percent of all claims for power wheelchairs provided during the first half of 2007.

⁵⁸ *Miscoded Claims for Power Wheelchairs in the Medicare Program*, loc. cit., and *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirement*, loc. cit.

⁵⁹ Pursuant to 42 CFR § 424.520(a), to maintain Medicare billing privileges after initial enrollment, suppliers must comply with Medicare regulations and relevant Federal and State requirements. Pursuant to 42 CFR § 424.535, Medicare may revoke a supplier's billing privileges because of a felony, noncompliance with enrollment requirements, etc. Pursuant to 42 CFR § 424.540, Medicare also may deactivate a supplier's billing privileges when the supplier does not submit a claim for a full year or when the supplier fails to report a change in the information provided on the enrollment application, such as a change in practice location or ownership.

⁶⁰ After we removed these claims—3,430 claims for standard power wheelchairs and 301 claims for complex rehabilitation power wheelchairs—our population consisted of 43,133 claims for standard power wheelchairs, or 93 percent of such claims; and 3,001 claims for complex rehabilitation power wheelchairs, or 91 percent of such claims.

1. standard power wheelchair claims submitted by low-volume suppliers (i.e., those that submitted fewer than 10 standard power wheelchair claims in the first half of 2007),⁶¹
2. standard power wheelchair claims submitted by high-volume suppliers (i.e., those that submitted 10 or more standard power wheelchair claims in the first half of 2007), and
3. complex rehabilitation power wheelchair claims.

We sampled 375 claims by selecting simple random samples of 125 claims from each stratum.⁶² Appendix C provides the number of claims, amount of Medicare expenditures, and number of suppliers for the population and sample, by stratum.

We also identified power options and accessories supplied with complex rehabilitation power wheelchairs in our sample. Claims for power options and accessories (1) had HCPCS codes listed in Medicare's *LCD for Wheelchair Options/Accessories* and (2) shared the same unique control number assigned by the DME MAC as a sampled claim for a complex rehabilitation power wheelchair.

Data Collection

We requested beneficiary records from the supplier and prescribing physician to support each sampled claim.

Supplier records. We obtained the supplier addresses from the National Supplier Clearinghouse data file. To increase our response rate, we sent an initial request and, as needed, sent at least two followup letters and contacted the supplier by phone. We received or classified as errors 364 of the 375 power wheelchair claims, a 97-percent response rate. We received supplier records for 363 claims. We classified the single remaining claim as an error because the supplier received but did not respond to our third request letter, which was sent via certified mail. In our analysis, we considered this claim to be undocumented. We did not include the

⁶¹ We divided the standard power wheelchair population by supplier volume based on the distribution of suppliers and claims. For example, 25 percent of suppliers received Medicare reimbursement for 10 or more standard power wheelchair claims during the first half of 2007, and these claims accounted for 83 percent of all standard power wheelchair claims. High-volume suppliers had an average of 50 standard power wheelchair claims, while low-volume suppliers had an average of 3 such claims.

⁶² All evaluations in the current series of OIG power wheelchair reports, described earlier in the report, use this sample methodology.

remaining 11 claims in our analysis because we could not obtain current addresses for the suppliers of 10 claims and the supplier's record for 1 claim was in another language.⁶³

Prescribing physician records. We obtained the names and addresses of physicians who prescribed the power wheelchairs in our sample from suppliers. When suppliers did not provide this information, we obtained it from either the Unique Physician Identification Number Directory or the National Provider Identifier Directory. We requested from the prescribing physician all documentation from the beneficiary's medical record, including office visit notes, referrals, and hospital admission histories and discharge summaries, during the 12 months prior to the date the beneficiary received the power wheelchair.

We used a medical review contractor to collect medical records from prescribing physicians. The contractor sent a request and, as needed, at least two followup letters and contacted the physician by phone to increase the response rate. We received or classified as errors 360 of the 375 power wheelchair claims, a 96-percent response rate. We received prescribing physician records for 322 claims. We classified the remaining 38 claims as errors, either because the physician received but did not respond to our third request letter (sent via certified mail) or because the documentation that the physician produced did not contain any information relevant to our sampled claim. In our analysis, we considered these claims to be undocumented. We did not include the remaining 15 claims in our analysis because we could not obtain current addresses for the physicians.

Medical Record Review

We used a contractor to conduct a medical record review of the claims in our sample and the power options and accessories supplied with the complex rehabilitation power wheelchair claims in our sample. For each claim, the supplier's record and the prescribing physician's record were reviewed by a licensed clinician with experience in establishing medical necessity for power wheelchairs. The reviewers completed a standardized review instrument twice for each claim in the sample: once based on a review of the supplier's record and once based on a review of the physician's record.

⁶³ We referred to CMS the suppliers that did not respond to our request or for which we were unable to locate current addresses. In addition, OIG is considering these suppliers for investigation.

The reviewers determined whether claims met Medicare coverage criteria from the *NCD for Mobility-Assistive Equipment* and *LCD for Power Mobility Devices*. They determined whether the power wheelchairs were medically necessary and, if not, which other type of mobility-assistive equipment (e.g., cane, manual wheelchair, or scooter) or other power wheelchair corresponding to a different HCPCS code would have been medically necessary, if any. The reviewers indicated whether the supplier's record was insufficient to determine whether the power wheelchair was medically necessary. They also determined whether power options and accessories provided with the complex rehabilitation power wheelchairs were medically necessary and had claims that were sufficiently documented.

Analysis

We aggregated data received from the medical review contractor and determined the percentage of sampled claims that did not meet Medicare coverage criteria based on the supplier's record.⁶⁴ We identified the percentages of claims for power wheelchairs that were medically unnecessary, claims that were insufficiently documented to determine the medical necessity of the power wheelchair, and claims that were undocumented. We calculated these error rates for the entire sample and for the following subgroups: standard power wheelchair claims, complex rehabilitation power wheelchair claims, standard power wheelchair claims submitted by low-volume suppliers, and standard power wheelchair claims submitted by high-volume suppliers. See Appendix D (Table D-1) for the point estimates and confidence intervals for the projections of these error rates. We also determined whether these error rates differed significantly between claims for standard power wheelchairs and those for complex rehabilitation power wheelchairs. See Appendix D (Table D-2) for the point estimates and confidence intervals associated with these statistical comparisons.

We calculated the inappropriate payments for erroneous claims using Medicare-allowed amounts from the National Claims History data. See Appendix D (Table D-3) for the point estimates and confidence intervals for inappropriate payment projections. We calculated partial inappropriate payments for cases in which beneficiaries did not meet the coverage criteria for the provided power wheelchair but would have

⁶⁴ As the provider submitting the claim, the supplier must have records to support that the claim met coverage criteria. Therefore, error rates are based on suppliers' records.

qualified for a manual wheelchair, cane, or walker or for a different power wheelchair. We derived the adjusted allowances from the 2007 DME fee schedule ceiling amounts.

When the beneficiary would have qualified for a manual wheelchair, a cane, or a walker, we used the HCPCS codes E1161 for manual wheelchairs and E0147 for canes or walkers because these codes had the highest fee schedule amounts for those types of mobility-assistive equipment and thus yielded the most conservative figures for overpayments. When the beneficiary needed a different power wheelchair, we used the fee schedule amount for the appropriate power wheelchair (using the HCPCS code indicated by the medical record reviewer), calculating the loss to the Medicare program as the difference between the cost of the two power wheelchairs. (If the beneficiary needed a more expensive power wheelchair, we subtracted that difference from the amount of total inappropriate payments.) If the beneficiary needed a different type of power wheelchair but the reviewer could not determine which HCPCS code would have been appropriate, we did not consider any portion of the allowed amount to be inappropriate.

We also identified the percentage of power options and accessories that were medically unnecessary or insufficiently documented to determine medical necessity.⁶⁵ Finally, we identified the percentage of claims for complex rehabilitation power wheelchairs for which at least one power option or accessory was medically unnecessary or insufficiently documented to determine medical necessity.⁶⁶ See Appendix D (Table D-4) for the point estimates and confidence intervals for the projections of these error rates.

We determined whether the records from prescribing physicians supported claims that suppliers submitted. For claims for which the suppliers' records indicated no errors, we determined whether the prescribing physicians' records yielded the same determinations—that is, we identified claims that the prescribing physicians' records indicated were for medically unnecessary power wheelchairs, had insufficient documentation, or were undocumented. We removed from

⁶⁵ This analysis is based on 556 claims for power options and accessories provided with sample complex rehabilitation power wheelchair claims.

⁶⁶ This analysis is based on the 108 claims for complex rehabilitation power wheelchairs supplied with at least one power option or accessory.

our analysis claims for which the only difference between the suppliers' records and the physicians' records was that the former contained a home assessment report and the latter did not.⁶⁷ See Appendix D (Table D-5) for the point estimates and confidence intervals for the projections of these calculations.

Finally, we calculated the combined error rate across the three OIG reports that had each calculated error rates based on the same sample of power wheelchairs.⁶⁸ We calculated the combined error rate based on two sets of claims from the shared sample of 375 claims: (1) the 339 claims that were reviewed in all three reports and (2) the 365 claims that were reviewed in at least one of the three reports. See Appendix D (Table D-6) for the point estimates and confidence intervals for the projections of these error rates.

We projected the error rates, total inappropriate payments, and rates of inconsistency between supplier and physician records to the populations defined by the strata from which we selected sample claims. We used SAS and SUDAAN survey data analysis software to project these results. Appendix D includes the point estimates and confidence intervals for all reported projections.

Limitations

Our results cannot be extrapolated beyond the timeframe of our evaluation. We recognize that since the first half of 2007, CMS has continued to educate suppliers and prescribing physicians about its power wheelchair clinical coverage criteria and has implemented additional program integrity safeguards. Additionally, all suppliers were required to meet quality standards as of September 30, 2009. Although CMS has taken steps since 2007 to decrease errors among suppliers of power wheelchairs and other kinds of DME, Medicare has

⁶⁷ This analysis is based on 121 claims. There were 140 claims without errors in the supplier record. From these, we removed 19 claims for which the only difference between the suppliers' records and the physicians' records was that the former contained home assessment reports and the latter did not. Discrepancies arising because of this difference between records are acceptable; the supplier must have the home assessment report on file, but the prescribing physician is not explicitly required to have this report. This analysis includes only claims for which we either received the supplier record and the physician record or did not receive a response from the supplier and considered the claim to be undocumented.

⁶⁸ The three reports are this report and two others: *Miscoded Claims for Power Wheelchairs in the Medicare Program*, loc. cit.; and *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirement*, loc. cit.

I N T R O D U C T I O N

paid significantly more for power wheelchairs in recent years than it did in 2007.⁶⁹

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

⁶⁹ Medicare and its beneficiaries paid \$658 million for power wheelchairs in 2007, \$779 million in 2008, and \$723 million in 2009.

Sixty-one percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 were medically unnecessary or had claims that lacked sufficient documentation to determine medical necessity

Based on records submitted by suppliers that provided power wheelchairs, 9 percent of claims were for power wheelchairs that were medically unnecessary and another 52 percent had insufficient documentation to determine whether the power wheelchairs

were medically necessary.⁷⁰ Because of these errors, these claims should not have been paid. However, Medicare and its beneficiaries paid \$95 million for power wheelchairs provided in the first half of 2007 that were medically unnecessary, had claims with insufficient documentation, or had claims that were undocumented, out of \$189 million allowed by Medicare. Table 1 presents the percentage of claims that had each type of error and the associated Medicare payments.

| Table 1: Error Rates for Medicare Power Wheelchairs, First Half of 2007 | | |
|---|-------------------------|-------------------------------|
| Type of Error | Claim Error Rate | Inappropriate Payments |
| Power Wheelchair Was Medically Unnecessary * | 9% | \$2 million |
| <i>Beneficiary needed a less expensive type of equipment (i.e., not a power wheelchair)</i> | 2% | |
| <i>Beneficiary needed a different type of power wheelchair</i> | 7% | |
| Claim Had Insufficient Documentation | 52% | \$93 million |
| Claim Was Undocumented * | <1% | <\$1 million |
| Total Errors | 61% | \$95 million |

* We are unable to reliably project the weighted point estimates for inappropriate payments associated with these error rates because of the small number of sample claims in these categories. We did not include the 95-percent confidence intervals for these estimates in Appendix D.

Source: OIG medical record review of Medicare power wheelchair claims.

Two previous OIG reports based on the same sample of claims for power wheelchairs found problems with coding and documentation

⁷⁰ Additionally, less than 1 percent of claims for power wheelchairs were “undocumented”—that is, the supplier did not submit any medical records to document the claims. Claims that lack documentation to show that the care was reasonable and necessary do not meet Medicare coverage criteria.

requirements.⁷¹ Across all three reports, 80 percent of claims for power wheelchairs supplied to Medicare beneficiaries in the first half of 2007 did not meet Medicare requirements.⁷² In the current report, we found that 61 percent of claims were for wheelchairs that were medically unnecessary or had insufficient documentation to determine medical necessity. In the two previous reports, OIG found that 8 percent of claims were miscoded and 60 percent did not meet documentation requirements; many claims had more than one of these error types.

Nine percent of power wheelchairs were medically unnecessary

Claims for 9 percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 were for power wheelchairs that were medically unnecessary. Beneficiaries who received power wheelchairs that were medically unnecessary needed a less expensive type of medical equipment or a different type of power wheelchair. For 2 percent of power wheelchair claims, a less expensive type of equipment (e.g., a manual wheelchair, cane, or walker) would have been more appropriate. For another 7 percent of claims, the beneficiaries should have received a different type of power wheelchair than was provided. The beneficiaries should have received a less expensive power wheelchair for 1 percent of all claims. For another 3 percent of claims, the beneficiaries needed a more expensive power wheelchair.⁷³

Regardless of whether a more expensive or less expensive power wheelchair was needed, Medicare paid for the wrong equipment to meet these beneficiaries' needs. These claims did not meet Medicare clinical coverage criteria as stated in the NCD and LCD. Examples of these types of inappropriate power wheelchairs from our sample are:

- Claim A: The beneficiary received a complex rehabilitation power wheelchair for which Medicare allowed \$5,081. This type of power wheelchair is necessary for beneficiaries with a neurological,

⁷¹ *Miscoded Claims for Power Wheelchairs in the Medicare Program*, loc. cit., and *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirement*, loc. cit.

⁷² Based on sample claims that were reviewed in all three reports. We also calculated the combined error rate using claims that were reviewed in at least one of the three reports. These claims yielded a combined error rate of 79 percent.

⁷³ For the remaining 3 percent of claims for which the beneficiary should have received a different power wheelchair, the reviewer could not determine the specific power wheelchair that the beneficiary needed. Therefore, we did not consider any portion of the Medicare-allowed amount to be inappropriate.

muscular, or skeletal deformity. However, the beneficiary had a diagnosis of chronic obstructive pulmonary disease and cardiac disease. Therefore, the beneficiary should have received a standard power wheelchair for which Medicare would have allowed up to \$4,024. In this situation, Medicare overpaid by \$1,057.

- Claim B: The beneficiary received a complex rehabilitation power wheelchair with a weight capacity of 301–450 pounds, for which Medicare allowed \$6,130. However, the beneficiary weighed 85 pounds. Therefore, he should have received a complex rehabilitation power wheelchair with a weight capacity of less than 300 pounds for which Medicare would have allowed up to \$5,672. In this situation, Medicare overpaid by \$458.
- Claim C: The beneficiary received a complex rehabilitation power wheelchair with an automotive-style seat for which Medicare allowed \$4,208. However, she had a neurological diagnosis that results in poor sitting balance and a high risk of skin breakdown. Therefore, she needed a power wheelchair with a rehabilitation seat providing better postural support and skin protection. For such a wheelchair, Medicare would have allowed up to \$5,672. In this situation, Medicare underpaid by \$1,464.

Fifty-two percent of claims for power wheelchairs had insufficient documentation to determine medical necessity

Claims for 52 percent of power wheelchairs provided during the first half of 2007 were insufficiently documented. That is, suppliers' records were insufficient to enable reviewers to determine whether these power wheelchairs were medically necessary. Inappropriate payments for these claims totaled \$93 million.

Suppliers are required to maintain documentation that supports the appropriateness of claims they submit for Medicare reimbursement. These claims did not contain sufficient documentation to show that they met Medicare clinical coverage criteria as stated in the NCD and LCD. Examples of sampled claims that did not have sufficient documentation are:

- Claim D: The record did not provide sufficient information about the beneficiary's ability to participate in mobility-related activities of daily living, ability to use the power wheelchair in her home, or ability to use the power wheelchair safely. Additionally, the documentation did

not rule out other, less expensive types of mobility-assistive equipment.

- Claim E: The record did not explain why the beneficiary needed a power wheelchair. The report of the face-to-face examination by the prescribing physician documented a diagnosis of osteoporotic hip fracture, which is usually reversible following the surgery that the beneficiary received. However, the report did not explain how the beneficiary’s condition had changed to require a power wheelchair. That is, it did not contain sufficient documentation to show that the claims met Medicare clinical coverage criteria.

Medical necessity and documentation errors varied by power wheelchair type

Claims for standard and complex rehabilitation power wheelchairs had similar overall error rates. However, standard power wheelchairs were less likely to be

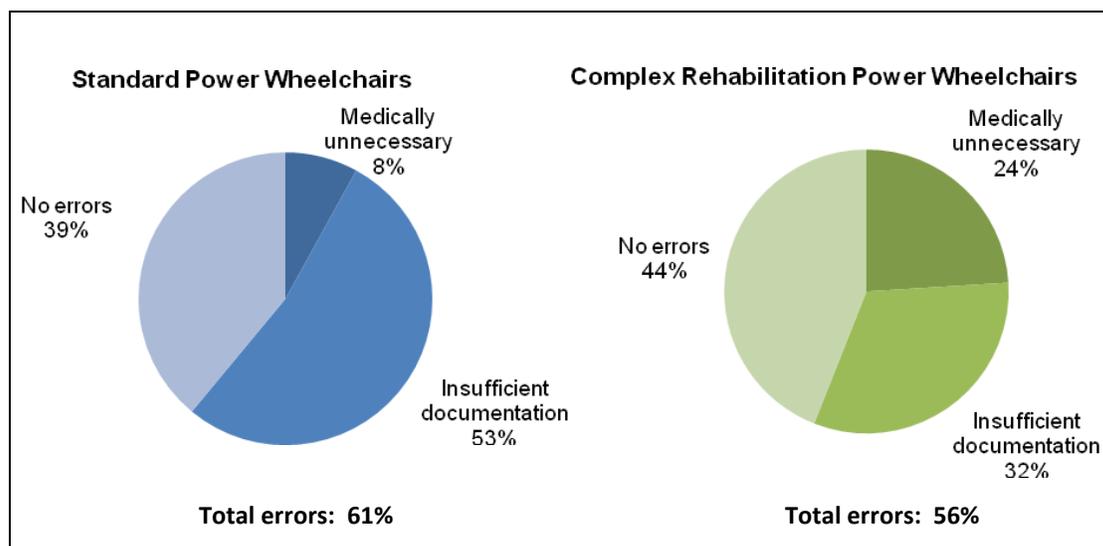
medically unnecessary than complex rehabilitation power wheelchairs. Conversely, claims for standard power wheelchairs were more likely to have insufficient documentation than were claims for complex rehabilitation power wheelchairs.⁷⁴ Because standard power wheelchairs accounted for most of Medicare’s power wheelchair expenditures, errors among claims for standard power wheelchairs resulted in higher inappropriate payments than did errors among claims for complex rehabilitation power wheelchairs.⁷⁵

⁷⁴ The differences in error rates between the two power wheelchair types are statistically significant at the 95-percent confidence level.

⁷⁵ Standard power wheelchairs accounted for 73 percent of Medicare’s power wheelchair expenditures in the first half of 2007 and 92 percent of the population we reviewed, which did not include power wheelchairs reimbursed under HCPCS codes K0813–K0817, K0820–K0822, and K0824–K0831.

Figure 1 illustrates the differences between the percentage of error rates for claims for standard and complex rehabilitation power wheelchairs.

Figure 1:
Percentage of Error Rates for Claims for Standard and Complex Rehabilitation Power Wheelchairs, First Half of 2007



Notes: In addition to claims for power wheelchairs that were medically unnecessary and claims that had insufficient documentation, less than 1 percent of claims for standard power wheelchairs were undocumented. No claims for complex rehabilitation power wheelchairs were undocumented. Error rates for claims for complex rehabilitation power wheelchairs do not sum to 57 percent because of rounding.

Source: OIG medical record review of Medicare claims for power wheelchairs, 2010.

Standard power wheelchairs. In the first half of 2007, 61 percent of Medicare standard power wheelchairs were medically unnecessary or had claims that were insufficiently documented. Eight percent were medically unnecessary, and another 53 percent had claims with insufficient documentation to determine medical necessity. In total, these errors for claims for standard power wheelchairs resulted in \$90 million in inappropriate payments.

Beneficiaries who received medically unnecessary standard power wheelchairs needed either a different and less expensive type of equipment or a more expensive power wheelchair, such as a complex rehabilitation power wheelchair. For 2 percent of claims for standard power wheelchairs, a less expensive manual wheelchair, cane, or walker should have been provided. For another 3 percent of claims, beneficiaries should have received power wheelchairs that were more expensive than the ones provided.⁷⁶

⁷⁶ For another 3 percent of claims, beneficiaries should have received a different power wheelchair, but the reviewer could not determine which specific power wheelchair beneficiaries needed.

The difference in error rates between standard power wheelchairs supplied by low- and high-volume suppliers was not statistically significant. Sixty-six percent of standard power wheelchairs provided by low-volume suppliers were medically unnecessary or had claims that were insufficiently documented, and 60 percent of those provided by high-volume suppliers were medically unnecessary or had claims that were insufficiently documented.

Complex rehabilitation power wheelchairs. In the first half of 2007, 56 percent of Medicare complex rehabilitation power wheelchairs were medically unnecessary or had claims that were insufficiently documented. Twenty-four percent of complex rehabilitation power wheelchairs were medically unnecessary, and another 32 percent had claims with insufficient documentation to determine medical necessity. In total, these errors for claims for complex rehabilitation power wheelchairs resulted in \$5 million in inappropriate payments.

Beneficiaries who received medically unnecessary complex rehabilitation power wheelchairs needed a different and less expensive type of equipment, a less expensive power wheelchair, or a more expensive power wheelchair. For 1 percent of complex rehabilitation power wheelchair claims, a less expensive manual wheelchair should have been provided. For 13 percent of claims, beneficiaries should have received a less expensive power wheelchair than was provided, and for another 6 percent of claims, beneficiaries needed a more expensive power wheelchair.⁷⁷

Complex rehabilitation power wheelchair options and accessories. Nineteen percent of power options and accessories supplied with complex rehabilitation power wheelchairs were medically unnecessary or insufficiently documented. Four percent of the power options and accessories were medically unnecessary, and for another 16 percent of claims, beneficiaries' medical records had insufficient documentation to determine whether the power options or accessories were medically necessary.⁷⁸ Fourteen percent of complex rehabilitation power wheelchairs were supplied with at least one medically unnecessary

⁷⁷ For another 5 percent of claims, beneficiaries should have received a different power wheelchair, but the reviewer could not determine which specific power wheelchair beneficiaries needed. The types of claims for medically unnecessary complex rehabilitation power wheelchairs do not sum to 24 percent because of rounding.

⁷⁸ The medical necessity and insufficient documentation error rates do not sum to 19 percent because of rounding.

power option or accessory.⁷⁹ Medically unnecessary power options and accessories resulted in \$2 million in inappropriate payments in the first half of 2007, separate from the inappropriate payments for power wheelchairs.

Prescribing physicians’ records do not support the medical necessity of most power wheelchairs

Thirty-nine percent of power wheelchair claims had no errors based on suppliers’ records. However, 78 percent of such claims were not supported by

medical records kept by physicians who prescribed the power wheelchairs. Physicians’ records contradicted suppliers’ records for 7 percent of claims with no errors based on suppliers’ records. These power wheelchairs were medically unnecessary based on physicians’ records. For another 71 percent of claims with no errors based on suppliers’ records, physicians’ records were insufficiently documented to determine medical necessity or the claims were undocumented. Table 2 presents the types of errors in physicians’ records for claims with no errors based on suppliers’ records.

⁷⁹ This analysis is based only on the 108 complex rehabilitation power wheelchairs supplied with at least 1 power option or accessory out of the 124 in the sample.

Table 2: Claims With Errors Based on Prescribing Physicians' Records and No Errors Based on Suppliers' Records, First Half of 2007

| Type of Error in Physician's Record | Claims Error Rate |
|---|-------------------|
| Power Wheelchair Was Medically Unnecessary | 7% |
| Claim Had Insufficient Documentation To Determine Medical Necessity | 62% |
| Claim Was Undocumented | 9% |
| Total Claims | 78% |

Source: OIG medical record review of Medicare power wheelchair claims, 2010.

Physicians' records sometimes contradicted suppliers' records

Seven percent of power wheelchair claims that were medically necessary based on suppliers' records were medically unnecessary based on prescribing physicians' records. In these cases, prescribing physicians' records indicated that beneficiaries needed different power wheelchairs or did not need power wheelchairs at all. Examples of each of these types of claims from our sample are:

- **Claim F:** The beneficiary's weight is recorded as 230 pounds in the supplier's record and as more than 350 pounds in the physician's record. The physician's record also documents lower extremity edema and wounds. The supplier's record does not note these impairments. The beneficiary received a standard power wheelchair, but based on the physician's record, the patient needed a complex rehabilitation power wheelchair. A complex rehabilitation power wheelchair would have had a greater weight capacity and would have allowed for the addition of power options, such as elevating legrests and a power tilt seating system, to manage the lower extremity edema and allow wound healing and pressure relief.
- **Claim G:** In the supplier's record, a letter from the physician states that the beneficiary was recovering from a total replacement of the left knee. The letter also states that the beneficiary has severe osteoarthritis, a history of brain surgery, and poor balance. Finally, the letter states that the beneficiary is obese, unable to walk safely with a cane or walker, and unable to propel a manual wheelchair because of severe joint pain. There is no documentation of a power wheelchair in the physician's record. An entry from the physician's

record from 1 week after the date of the letter in the supplier's record states that the beneficiary had recovered from the knee replacement enough to bear her full weight and discontinue using a cane. The beneficiary received a standard power wheelchair, but based on the physician's record, she needed a cane or walker.

Physicians' records often insufficiently documented the beneficiaries' need for power wheelchairs

Sixty-two percent of power wheelchair claims that were medically necessary based on the suppliers' records were insufficiently documented in the physicians' records. That is, the medical records from the prescribing physicians were insufficient to support the medical necessity of these power wheelchairs. For another 9 percent of claims that were medically necessary based on the suppliers' records, physicians did not provide supporting medical records (i.e., the claims were undocumented).

A physician is required to assess a beneficiary's mobility needs before prescribing a power wheelchair. The report from the physician's face-to-face examination, along with other documentation in the physician's record, must support the medical necessity for the power wheelchair. Examples of claims that were insufficiently documented in the physicians' records are:

- Claim H: There is no documentation in the physician's record from the entire year in which the beneficiary received a power wheelchair. However, physician documentation in the supplier's record documents a mobility limitation and a risk of falls. It also documents significantly decreased strength in bilateral upper and lower extremities.
- Claim I: Portions of the physician's record were inconsistent regarding the beneficiary's history of seizures. Therefore, it is unclear from the physician's record whether the beneficiary had the mental and physical capabilities to safely operate the power wheelchair that was provided, a Medicare coverage requirement. In the supplier's record, a note from a physical therapist documented that the beneficiary had not had a seizure in a long time.

► R E C O M M E N D A T I O N S

A power wheelchair can greatly improve the quality of life for an individual with limited mobility. However, our review found that power wheelchairs paid for by Medicare are not always medically necessary, and claims for power wheelchairs frequently have insufficient documentation to support medical necessity. In the first half of 2007, Medicare paid \$95 million for power wheelchair claims with these errors. Although CMS has taken steps since 2007 to decrease errors among suppliers of power wheelchairs and other kinds of DME, Medicare has paid significantly more in recent years for power wheelchairs than it did in 2007. Medicare and its beneficiaries paid \$658 million in 2007, compared to \$779 million in 2008 and \$723 million in 2009. These increases may indicate that CMS continues to pay for power wheelchairs that are not medically necessary and/or have claims that do not meet documentation requirements.

Additionally, we found that power wheelchairs that were medically necessary according to suppliers' records were often not medically necessary according to the records of physicians who prescribed the power wheelchairs, a further indication of potential fraud, waste, and abuse. In most cases, physicians' records had insufficient documentation to support the medical necessity of power wheelchairs and, less often, physicians' records contradicted suppliers' records.

Two previous OIG reports based on the same sample of power wheelchairs found problems with suppliers' compliance with Medicare requirements, and this report also shows such problems. Across all three reports, 80 percent of claims for power wheelchairs supplied to beneficiaries in the first half of 2007 did not meet Medicare requirements. In addition to finding in this report that 61 percent of claims were for power wheelchairs that were medically unnecessary or had insufficient documentation to determine medical necessity, OIG found in previous reports that 8 percent of claims were miscoded and 60 percent did not meet documentation requirements. Many claims had more than one of these error types.

Further, in recent years OIG has issued multiple reports identifying substantial vulnerabilities in the Medicare DMEPOS benefit, including deficiencies in enrollment safeguards, excessive payments, inappropriate payments, and issues with provider appeals. OIG has made a variety of recommendations to CMS to address these vulnerabilities. Finally, numerous DMEPOS suppliers have been convicted of Medicare fraud.

Based on the findings of this report and prior work, we recommend that CMS:

Enhance reenrollment screening standards for current DMEPOS suppliers

Federal regulations categorize provider types into three levels of risk of fraud, waste, and abuse: limited, moderate, and high. New DMEPOS suppliers are placed at a risk level of “high,” whereas currently enrolled DMEPOS suppliers are placed at a risk level of “moderate.” Based on the overall error rate of 80 percent among power wheelchair claims, we believe that currently enrolled DMEPOS suppliers should be subject to the same enrollment screening standards as newly enrolling DMEPOS suppliers and should also be placed at the risk level of “high.”

Review records from sources in addition to the supplier, such as the prescribing physician, to determine whether power wheelchairs are medically necessary

In some cases in which the physicians’ records did not support the suppliers’ claims, the physicians’ records may not include the same level of detail in the suppliers’ records. Alternatively, the differences may exist because the suppliers’ records contained inaccurate information that was included to justify the medical necessity of a power wheelchair. Medicare contractors are not required to review the prescribing physician’s records, although in 2007 the CERT contractor began asking physicians for supporting information in response to OIG’s recommendation. We continue to recommend that CMS direct its contractors to review records from prescribing physicians as well as those of suppliers.

Continue to educate power wheelchair suppliers and prescribing physicians to ensure compliance with clinical coverage criteria

In 2009, CMS began requiring that DME suppliers meet quality standards to be accredited. Additionally, since the first half of 2007, CMS contractors have developed a variety of educational materials for power wheelchair suppliers and prescribing physicians. Our review highlights the importance of these efforts and the need for CMS to continue to educate, and promote collaboration between, suppliers and physicians. We suggest that CMS focus its educational efforts for suppliers and prescribing physicians on the following topics:

- *Requirements for determining and documenting the medical necessity of a power wheelchair.* We found that 9 percent of power wheelchairs were medically unnecessary and an additional 52 percent had claims with insufficient documentation for reviewers to determine medical

necessity. Suppliers' records must show that the power wheelchairs they provided were medically necessary and met beneficiaries' mobility needs. We suggest that CMS focus on suppliers of standard power wheelchairs because we found that claims for such wheelchairs were more likely to have insufficient documentation than those for complex rehabilitation power wheelchairs.

- *Collaboration between supplier and physician necessary to determine the most appropriate power wheelchair for a beneficiary.* Collaboration ensures that beneficiaries receive medically necessary power wheelchairs that are appropriate for their mobility needs. Additionally, we found that the 78 percent of claims for power wheelchairs that were medically necessary according to suppliers' records were not supported by the records of the physicians who prescribed them. Collaboration between the physician and the supplier should also result in a consistent clinical assessment of the beneficiary and consistent supporting records.
- *Requirements for determining the most appropriate power wheelchair for a beneficiary.* We found that 7 percent of beneficiaries who received power wheelchairs needed a different type than was provided. Medicare covers hundreds of power wheelchair models that are reimbursed under 42 different HCPCS codes. These power wheelchairs vary widely in their ability to fulfill a beneficiary's mobility needs. The wrong power wheelchair not only may fail to address a beneficiary's mobility deficits but, in some cases, may harm the beneficiary. We suggest that CMS focus on suppliers of complex rehabilitation power wheelchairs because we found that such wheelchairs were more likely to be medically unnecessary than standard power wheelchairs and that the beneficiaries often needed a different type of power wheelchair.

Review suppliers of sampled claims we found to be in error

In a separate transmittal, we forwarded to CMS information—including the suppliers' identifying information—about the 61 percent of claims that were for medically unnecessary power wheelchairs, were insufficiently documented to determine medical necessity, or were undocumented. We also provided CMS with information on the claims for which physicians' records contradicted suppliers' records, so that CMS may follow up appropriately. Finally, we will inform CMS of physicians for whom we could not obtain current addresses. (We have

informed CMS of suppliers for whom we could not obtain current addresses.)

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with the second, third, and fourth recommendations. CMS did not concur with the first recommendation. In response to the first recommendation, CMS stated that it has in place other tools that allow for increased scrutiny of some current DMEPOS suppliers. CMS also noted that several triggering events can elevate individual suppliers from the “moderate” to the “high” risk level. Based on this report’s findings, which reinforce the findings of multiple OIG reports in recent years identifying substantial vulnerabilities in the Medicare DMEPOS benefit, we maintain that all current DMEPOS suppliers should be subject to the screening standards of the “high” risk level upon reenrollment.

In response to the second recommendation, CMS stated that it will continue to emphasize the need for proper documentation from the prescribing physician. We support this initiative and believe that CMS contractors should consider collecting records directly from the physician in addition to the records that they collect from the supplier. In response to the third recommendation, CMS stated that it is committed to continuing education of providers and suppliers about Medicare clinical coverage criteria for power wheelchairs. Not only have CMS’s contractors provided education, but also CMS conducted an educational outreach call and published educational materials in 2010. In response to the fourth recommendation, CMS stated that it will share OIG-provided information with Recovery Auditors and MACs for appropriate followup. For the full text of CMS’s comments, see Appendix E.

Clinical Coverage Criteria for Selected Power Wheelchairs

This appendix is adapted from the *National Coverage Determination (NCD) for Mobility-Assistive Equipment* and the *Local Coverage Determination (LCD) for Power Mobility Devices*. Information from the NCD has been incorporated in the LCDs, and we have included only the sections that are relevant to our evaluation. Full copies of these policies from all durable medical equipment regions can be found by searching the CMS Web site at

<http://www.cms.gov/mcd/search.asp?clickon=search>.

Basic Coverage Criteria

All of the following basic criteria (A–C) must be met for a power mobility device (Healthcare Common Procedure Coding System (HCPCS) codes K0800–K0898) to be covered.⁸⁰ Additional coverage criteria for specific devices are listed below.

A) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs), such as using the toilet, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

- prevents the patient from accomplishing a MRADL entirely; or
- places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or
- prevents the patient from completing a MRADL within a reasonable timeframe.

B) The patient’s mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C) The patient does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination; presence of pain or deformity; and absence of one or both upper extremities are relevant to the assessment of upper extremity function.

⁸⁰ CMS does not cover HCPCS codes K0865–K0898.

- An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

Power Wheelchairs (HCPCS codes K0813–K0898)

A power wheelchair is covered if:

- a. All of the basic coverage criteria (A–C) are met;
 - b. The patient does not meet coverage criteria for a power-operated vehicle;
 - c. Either criterion J or K^[81] (see below) is met;
 - d. Criteria L, M, N, and O (see below) are met; and
 - e. Any coverage criteria pertaining to the specific wheelchair type (see below) are met.
- J) The patient has the mental and physical capabilities to safely operate the power wheelchair that is provided; or
- K) If the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and
- L) The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided.
- M) The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- N) Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs, and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
- O) The patient has not expressed an unwillingness to use a power wheelchair in the home.

⁸¹ Criteria D–I apply to a different type of power mobility device.

Standard Power Wheelchairs

Medicare covers standard power wheelchairs (HCPCS code K0823) if all of the power wheelchair coverage criteria are met and the beneficiary weighs less than 301 pounds.

Complex Rehabilitation Power Wheelchairs

Group 2 single power option (HCPCS codes K0835–K0840).^[82] Medicare covers such wheelchairs if all of the power wheelchair coverage criteria are met and if criterion 1 or 2 is met and criterion 3 is met.

1. The beneficiary requires a drive control interface other than a hand- or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system (see Appendix B), and the system is being used on the wheelchair.
3. The beneficiary has had a specialty evaluation performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experience in rehabilitation wheelchair evaluations, and this specialty evaluation documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the supplier.

Group 2 multiple power option (HCPCS codes K0841–K0843). Medicare covers such wheelchairs if all of the power wheelchair coverage criteria are met and if criterion 1 or 2 is met and criterion 3 is met.

1. The beneficiary meets coverage criteria for a power tilt and recline seating system (see Appendix B), and the system is being used on the wheelchair.
2. The beneficiary uses a ventilator mounted on the wheelchair.
3. The beneficiary has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and this specialty evaluation documents the medical necessity for the wheelchair and its special features. The

⁸² Group 1 power wheelchairs (HCPCS codes K0813–K0816) are not included in this review.

PT, OT, or physician may have no financial relationship with the supplier.

Group 3 with no power options (HCPCS codes K0848–K0855). Medicare covers such wheelchairs if all of the power wheelchair coverage criteria are met; the beneficiary’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and the beneficiary has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and this specialty evaluation documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may have no financial relationship with the supplier.

Group 3 with single power option (HCPCS codes K0856–K0860) or with multiple power options (HCPCS codes K0861–K0864). Medicare covers such wheelchairs if all of the power wheelchair coverage criteria are met; the beneficiary’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and the Group 2 single power option or multiple power options are met.

Clinical Coverage Criteria for Selected Power Wheelchair Power Options and Accessories

This appendix is adapted from the *Local Coverage Determination (LCD) for Wheelchair Options/Accessories*. Full copies of this policy from all durable medical equipment regions can be found by searching the CMS Web site at <http://www.cms.gov/mcd/search.asp?clickon=search>.

Arm of Chair

Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the beneficiary requires an arm height that is different from that available using nonadjustable arms and the beneficiary spends at least 2 hours per day in the wheelchair.

An arm trough (E2209) is covered if the beneficiary has quadriplegia, hemiplegia, or uncontrolled arm movements.

Footrest/Legrest

Elevating legrests (E0990, K0046, K0047, K0053, K0195) are covered if:

1. the beneficiary has a musculoskeletal condition or a cast or brace that prevents 90-degree flexion at the knee; or
2. the beneficiary has significant edema of the lower extremities that requires having an elevating legrest; or
3. the beneficiary meets the criteria for and has a reclining back on the wheelchair.

Nonstandard Seat Frame Dimensions

A nonstandard seat width and/or depth for a manual wheelchair (E2201–E2204) is covered only if the beneficiary's dimensions justify the need.

Batteries/Chargers

Up to two batteries (E2361, E2363, E2365, E2371, K0731, K0733) at any one time are allowed if required for a power wheelchair.

A nonsealed battery (E2360, E2362, E2364, E2372) will be denied as not medically necessary.

A dual-mode battery charger (E2367) is not medically necessary; when it is provided as a replacement, payment is based on the allowance for the least costly medically appropriate alternative, E2366.

Power Tilt and/or Recline Seating Systems (E1002–E1010):

A power seating system—tilt only, recline only, or combination tilt and recline—with or without power elevating legrests will be covered if criteria 1 and 2 are met and if criterion 3, 4, or 5 is met:

1. the beneficiary meets all the coverage criteria for a power wheelchair described in the *LCD for Power Mobility Devices*; and
2. a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT or physician who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary’s seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier; and
3. the beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
4. the beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or
5. the power seating system is needed to manage increased tone or spasticity.

Power Wheelchair Drive Control Systems

An attendant control is covered in place of a beneficiary-operated drive control system if the beneficiary meets coverage criteria for a wheelchair, is unable to operate a manual or power wheelchair, and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.

Other Power Wheelchair Accessories

An electronic interface (E2351) to allow a speech-generating device to be operated by the power wheelchair control interface is covered if the beneficiary has a covered speech-generating device.

Miscellaneous Accessories

An antirollback device (E0974) is covered if the beneficiary propels himself/herself and needs the device because of ramps.

A safety belt/pelvic strap (E0978) is covered if the beneficiary has weak upper body muscles, upper body instability, or muscle spasticity that requires use of this item for proper positioning.

One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the

component out of the way so that the beneficiary could perform a slide transfer to a chair or bed.

A manual fully reclining back option (E1226) is covered if the beneficiary has one or more of the following conditions:

1. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
2. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

➤ A P P E N D I X ~ C

Table C-1: Population and Sample Sizes by Stratum, First Half of 2007

| Stratum | Definition | Population | | | Sample | | |
|--------------|--|---------------|----------------------|--------------------------|------------|--------------------|------------------------|
| | | Claims | Expenditures | Suppliers | Claims | Expenditures | Suppliers |
| 1 | Standard power wheelchair claims* by low-volume suppliers | 7,223 | \$28,949,132 | 2,352 | 125 | \$499,152 | 124 |
| 2 | Standard power wheelchair claims* by high-volume suppliers | 35,910 | \$144,354,060 | 716 | 125 | \$502,989 | 94 |
| 1 and 2 | All standard power wheelchair claims* | 43,133 | \$173,303,192 | 3,068 | 250 | \$1,002,141 | 218 |
| 3 | Complex rehabilitation power wheelchair claims** | 3,001 | \$16,010,906 | 1,064 | 125 | \$665,200 | 113 |
| Total | | 46,134 | \$189,314,098 | 3,362[†] | 375 | \$1,667,341 | 325[†] |

* Healthcare Common Procedure Coding System (HCPCS) code K0823.

** HCPCS codes K0835–K0864.

[†] Suppliers' figures do not sum to totals because of overlap (some suppliers in our sample provided standard and complex rehabilitation power wheelchairs).

Source: Office of Inspector General analysis of Medicare power wheelchair claims with dates of service from January 1 to June 30, 2007.

► A P P E N D I X ~ D

Table D-1: Estimates and Confidence Intervals for Power Wheelchair Error Rates, First Half of 2007

| Estimate Description | Sample Size | Point Estimate | 95-Percent Confidence Interval |
|--|-------------|----------------|--------------------------------|
| All Power Wheelchairs | | | |
| Wheelchair was medically unnecessary | 364 | 8.9% | 5.7%–13.5% |
| Beneficiary needed a manual wheelchair, cane, or walker | 364 | 1.6% | 0.5%–5.0% |
| Beneficiary needed a different power wheelchair | 364 | 7.3% | 4.5%–11.5% |
| Beneficiary needed a less expensive power wheelchair | 364 | 0.9% | 0.6%–1.4% |
| Beneficiary needed a more expensive power wheelchair | 364 | 3.0% | 1.4%–6.3% |
| Reviewer could not determine specific power wheelchair that beneficiary needed | 364 | 3.4% | 1.6%–7.2% |
| Claim was insufficiently documented | 364 | 51.7% | 44.5%–58.7% |
| Claim was undocumented | 364 | 0.1% | 0.02%–0.9% |
| No errors | 364 | 39.3% | 32.6%–46.5% |
| Total errors | 364 | 60.7% | 53.5%–67.4% |
| Standard Power Wheelchairs: All Suppliers | | | |
| Wheelchair was medically unnecessary | 240 | 7.8% | 4.6%–12.9% |
| Beneficiary needed a manual wheelchair, cane, or walker | 240 | 1.7% | 0.5%–5.3% |
| Beneficiary needed a more expensive power wheelchair | 240 | 2.8% | 1.16%–6.5% |
| Reviewer could not determine specific power wheelchair that beneficiary needed | 240 | 3.3% | 1.5%–7.5% |
| Claim was insufficiently documented | 240 | 53.1% | 45.4%–60.6% |
| Claim was undocumented | 240 | 0.1% | 0.02%–1.0% |
| No errors | 240 | 39.0% | 31.9%–46.7% |
| Total errors | 240 | 61.0% | 53.3%–68.2% |
| Standard Power Wheelchairs: Low-Volume Suppliers | | | |
| Total errors | 120 | 65.8% | 56.9%–73.8% |
| Standard Power Wheelchairs: High-Volume Suppliers | | | |
| Total errors | 120 | 60.0% | 51.0%–68.4% |
| Complex Rehabilitation Power Wheelchairs | | | |
| Wheelchair was medically unnecessary | 124 | 24.2% | 17.5%–32.4% |
| Beneficiary needed a manual wheelchair | 124 | 0.8% | 0.1%–5.4% |
| Beneficiary needed a less expensive power wheelchair | 124 | 12.9% | 8.1%–19.9% |
| Beneficiary needed a more expensive power wheelchair | 124 | 5.7% | 2.7%–11.3% |
| Reviewer could not determine specific power wheelchair that beneficiary needed | 124 | 4.8% | 2.1%–10.3% |
| Claim was insufficiently documented | 124 | 32.3% | 24.7%–40.8% |
| Claim was undocumented | 124 | 0% | 0%–2.9% |
| No errors | 124 | 43.6% | 35.2%–52.3% |
| Total errors | 124 | 56.5%* | 47.7%–64.8% |

* Point estimate is rounded from 56.45% to 56.5%.

Source: Office of Inspector General (OIG) medical record review of Medicare power wheelchair claims, 2010.

Table D-2: Estimates and Confidence Intervals for Comparisons of Error Rates by Power Wheelchair Type, First Half of 2007

| Estimate Description | Sample Size | Point Estimate | 95-Percent Confidence Interval | P-Value |
|--|-------------|----------------|--------------------------------|---------|
| Comparisons of Standard Versus Complex Rehabilitation Power Wheelchairs | | | | |
| Difference in percentage of power wheelchairs that were medically unnecessary | 364 | 16.4%* | 8.0%–24.9% | 0.0002 |
| Difference in percentage of power wheelchairs with claims that were insufficiently documented or were undocumented | 364 | 20.9%** | 9.8%–32.1% | 0.0003 |

* Twenty-four percent of complex rehabilitation power wheelchairs were medically unnecessary and 8 percent of standard power wheelchairs were medically unnecessary.

** Fifty-three percent of claims for standard power wheelchairs were insufficiently documented and 32 percent of claims for complex rehabilitation power wheelchairs were insufficiently documented.

Source: OIG medical record review of Medicare power wheelchair claims, 2010.

Table D-3: Estimates and Confidence Intervals for Inappropriate Payments for Power Wheelchairs With Errors, First Half of 2007

| Estimate Description | Sample Size | Point Estimate* | 95-Percent Confidence Interval* |
|---|-------------|---------------------|-----------------------------------|
| All Power Wheelchairs | | | |
| Insufficient documentation | 364 | \$93,227,220 | \$80,467,932–\$105,986,508 |
| Total errors | 364 | \$95,182,002 | \$82,376,901–\$107,987,103 |
| Standard Power Wheelchairs: All Suppliers | | | |
| Total errors | 240 | \$89,983,213 | \$77,245,694–\$102,720,732 |
| Complex Rehabilitation Power Wheelchairs | | | |
| Total errors | 124 | \$5,198,789 | \$3,884,930–\$6,512,648 |

* Dollar figures are rounded to the nearest whole dollar.

Source: OIG medical record review of Medicare power wheelchair claims, 2010.

Table D-4: Estimates and Confidence Intervals for Error Rates and Inappropriate Payments for Power Options and Accessories, First Half of 2007

| Estimate Description | Sample Size | Point Estimate | 95-Percent Confidence Interval |
|--|-------------|----------------|--------------------------------|
| Power option or accessory was medically unnecessary or insufficiently documented | 556 | 19.4% | 14.5%–25.6% |
| Power option or accessory was medically unnecessary | 556 | 3.8% | 2.2%–6.3% |
| Power option or accessory was insufficiently documented | 556 | 15.7% | 11.2%–21.5% |
| One or more options or accessories provided with power wheelchair were medically unnecessary | 108 | 13.9% | 8.6%–21.6% |
| Power option or accessory error | 556 | \$1,908,688 | \$856,598–\$2,960,778 |

Note: Dollar figures are rounded to the nearest whole dollar.
 Source: OIG medical record review of Medicare power wheelchair claims, 2010.

Table D-5: Estimates and Confidence Intervals for Types of Errors in Physicians’ Records for Claims With No Errors Based on Suppliers’ Records, First Half of 2007

| Estimate Description | Sample Size | Point Estimate | 95-Percent Confidence Interval |
|---|-------------|----------------|--------------------------------|
| Claims for power wheelchairs that were medically necessary based on supplier record but medically unnecessary based on physician record | 121 | 6.9% | 2.4%–18.2% |
| Claims for power wheelchairs that were medically necessary based on supplier record but insufficiently documented based on physician record | 121 | 62.1% | 49.1%–73.6% |
| Claims for power wheelchairs that were medically necessary based on supplier record but undocumented based on physician record | 121 | 8.7% | 3.7%–19.1% |
| Claims for power wheelchairs that were medically necessary based on supplier record but medically unnecessary, insufficiently documented, or undocumented based on physician record | 121 | 77.7% | 65.7%–86.4% |

Source: OIG medical record review of Medicare power wheelchair claims, 2010.

| Table D-6: Estimates and Confidence Intervals for Combined Error Rate Across Three Reports, First Half of 2007 | | | |
|---|--------------------|-----------------------|---------------------------------------|
| Estimate Description | Sample Size | Point Estimate | 95-Percent Confidence Interval |
| Combined error rate—claims reviewed in all three reports | 339 | 79.8% | 72.9%–85.4% |
| Combined error rate—claims reviewed in at least one report | 365 | 78.9% | 72.2%–84.3% |

Sources: OIG medical record review of Medicare power wheelchair claims, 2010; HHS OIG, *Miscoded Claims for Power Wheelchairs in the Medicare Program*, OEI-04-07-00403, July 2009; and HHS OIG, *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements*, OEI-04-07-00401, December 2009.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 27 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. /SI/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines" (OEI-04-09-00260)

Thank you for the opportunity to review and comment on the above OIG draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has invested in determining the extent to which Medicare improperly paid claims for power wheelchairs. CMS is keenly focused on the issues related to power wheelchairs in the Medicare program. We appreciate OIG's work in this area. Since 2009, OIG has issued two reports based on the same sample of claims used in this study that assessed compliance with different Medicare requirements for power wheelchairs. Across the three reports, the OIG found that 80 percent of power wheelchairs provided in the first half of 2007 did not meet Medicare requirements. This particular study found that 61 percent of power wheelchair claims were not medically necessary or lacked sufficient documentation to determine medical necessity. CMS understands that inadequate and/or insufficient documentation is a significant problem associated with power wheelchair claims.

As mentioned in the report, CMS is actively engaged in improving provider and supplier compliance with Medicare's power wheelchair requirements. In January 2011, CMS updated the payment policy for power wheelchairs, eliminating the up-front purchase option and keeping the rent-to-own option. Previously, Medicare allowed for either an up-front purchase or a rental period that would lead to ownership after 13 months. The 13 month period allows additional opportunities for CMS to potentially conduct review on power wheelchair claims.

The CMS continues to support efforts to reduce improper power wheelchair payments, including increased prepayment reviews of power wheelchairs. Moreover, CMS plans to pursue additional provider and supplier education to ensure suppliers and prescribing physicians understand Medicare's coverage and documentation requirements for power wheelchairs.

Page 2 – Daniel R. Levinson

We appreciate the effort that went into this report and look forward to continuing to work with OIG on safeguarding the Medicare program. We have reviewed the report and have responded to your recommendations below.

OIG Recommendation

Enhance reenrollment screening standards for current DMEPOS suppliers.

CMS Response

The CMS non-concurs. CMS has in place other tools that allow for increased scrutiny of existing DMEPOS suppliers – particularly new authorities provided to us under the Affordable Care Act. In addition, CMS can impose a payment suspension against an existing provider or supplier in cases where it has been determined, after consulting with OIG and, as appropriate, the Department of Justice, that there is a credible allegation of fraud against the provider or supplier. Furthermore, in the event an existing DMEPOS supplier meets one of the triggering events described in 42 C.F.R. § 424.518(c)(3), that supplier automatically is elevated to the “high” category of risk such that persons with a direct or indirect ownership interest of 5 percent or greater in the supplier would be subject to fingerprinting and criminal background check requirements.

Accordingly, while CMS understands the concern that OIG has expressed regarding existing DMEPOS suppliers, CMS believes utilizing the current authorities will allow us the flexibility to combat fraud, waste, and abuse among existing DMEPOS suppliers as effectively as if such suppliers were initially categorized as “high” risk via the methodology described in 42 C.F.R. § 424.518.

OIG Recommendation

Review records from sources in addition to the supplier, such as the prescribing physician, to determine whether power wheelchairs are medically necessary.

CMS Response

The CMS concurs. CMS already requires its contractors to review records from the prescribing physician when conducting a medical review of power wheelchair claims. For example, the Program Integrity Manual Section 5.8 states, “For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).”

The CMS will continue to emphasize the need for proper documentation from the prescribing physician.

Page 3 – Daniel R. Levinson

OIG Recommendation

Continue to provide education to power wheelchair suppliers and prescribing physicians to ensure compliance with clinical coverage criteria.

CMS Response

The CMS concurs. CMS is committed to continually educating providers and suppliers about clinical coverage criteria, including the documentation requirements for power wheelchairs. In June 2010, CMS conducted an educational outreach call for providers and suppliers on Medicare power wheelchair documentation requirements. Later, in October 2010, CMS published a Power Mobility Fact Sheet to educate providers and suppliers on Medicare requirements for determining and documenting a power wheelchair's medical necessity. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have and will continue to conduct education and outreach to the provider and supplier community on power wheelchair requirements.

The CMS will continue to provide such education to power wheelchair suppliers and prescribing physicians on an ongoing basis.

OIG Recommendation

Review suppliers of sampled claims we found to be in error.

CMS Response

The CMS concurs. Upon receipt of the claims information files from the OIG, CMS will share the pertinent information with the Recovery Auditors and Medicare Administrative Contractors (MACs). The Recovery Auditors review Medicare claims on a post-payment basis and are tasked with identifying inappropriate payments to providers and suppliers. While CMS does not mandate areas for Recovery Audit review, we will share this information with the Recovery Auditors. We will also continue to emphasize to the MACs the importance of this issue when prioritizing their medical review strategies or other interventions.

The CMS requests that OIG furnish all necessary data (Provider numbers, claims information including the paid date, HIC numbers, Contractor Medicare ID number, Contractor Name, Provider Specialty, if applicable, Place of Service Code, if applicable, Provider State, and Number of Beneficiaries, etc.) to assist with any subsequent claims review. In addition, CMS also requests all Medicare contract-specific data be written to separate CD-ROMs to better facilitate the transfer of information to the appropriate contractors.

Once CMS receives the data file referred to in the report, CMS will review the Provider Enrollment, Chain and Ownership System (PECOS) and the local provider enrollment systems to determine if current information on the location of the provider is available.

Page 4 – Daniel R. Levinson

The CMS appreciates OIG's efforts and insight on this report. CMS looks forward to continually working with OIG on issues related to waste and abuse in the Medicare program.

A C K N O W L E D G M E N T S

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Sarah Ambrose and Jaime Durley, Deputy Regional Inspectors General.

Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Holly Williams; central office staff who contributed include Berivan Demir Neubert, Kevin Farber, and Scott Manley.

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.