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MEDICARE

CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs





Highlights of [GAO-05-43](#), a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicare spending for power wheelchairs—one of the program's most expensive items of durable medical equipment (DME)—rose more than fourfold from 1999 through 2003, while overall Medicare spending rose by about 11 percent for the same period, according to the Centers for Medicare & Medicaid Services (CMS). This spending growth has raised concerns that some of the payments may have been improper. In May 2003, the Department of Justice indicted several power wheelchair suppliers in Texas alleged to have fraudulently billed Medicare. GAO was asked to examine the early and more recent steps taken by CMS and its contractors to respond to improper payments for power wheelchairs.

What GAO Recommends

GAO recommends that CMS develop a process to analyze trends in Medicare spending and develop and implement strategies to address possible improper DME payments, implement revisions to provide clearer information for power wheelchair claims adjudication, strengthen the standards that suppliers must meet to obtain or retain their Medicare billing privileges, and direct its contractor to routinely conduct site visits to suppliers that are not predictable in their timing. CMS agreed with the recommendations and noted that it has undertaken several efforts to curb the abuse of the power wheelchair benefit in the last year.

www.gao.gov/cgi-bin/getrpt?GAO-05-43.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

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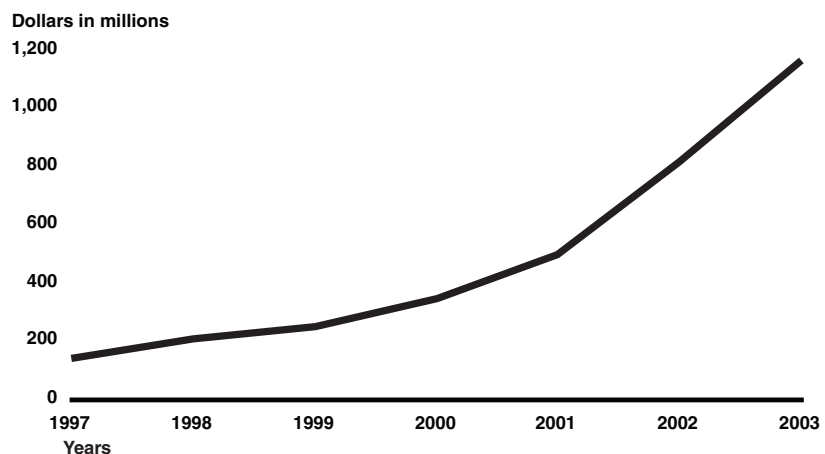
CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs

What GAO Found

Starting in 1997 and over the next 6 years, CMS's contractors repeatedly communicated with CMS officials about escalating spending for power wheelchairs, and the contractors took steps to respond to improper payments for this Medicare benefit. In 1997, one contractor warned the agency about rapid increases in power wheelchair spending. In 1998 and in 2000, medical directors at the four contractors that pay DME claims suggested steps that could be taken and sought CMS's help in curbing power wheelchair spending growth. However, while contractors continued to conduct in-depth medical reviews of claims for power wheelchairs and to investigate cases of suspected fraud, CMS did not begin to assume an active role in addressing the identified problems until September 2003. Problems included Medicare supplier standards that did not provide adequate guidance on appropriate marketing practices and the predictability of visits to screen suppliers, which made it relatively easy for illegitimate suppliers to prepare for, and pass, site inspections.

Since September 2003, CMS has taken steps to prevent fraudulent suppliers from entering the Medicare program, clarify coverage policy, ensure appropriate pricing for power wheelchairs, provide education on coverage rules, conduct detailed claims reviews where power wheelchair fraud was prevalent, and coordinate with law enforcement agencies. Although CMS has made progress, it has not implemented a revised form to collect better information for power wheelchair claims review, clarified guidance for suppliers on appropriate marketing, or required its contractor to routinely conduct less predictably timed site visits. Further, CMS's response to power wheelchair spending highlighted the lack of a process within the agency to rapidly address indications of potentially improper DME payments.

National Medicare Power Wheelchair Spending



Source: CMS.

Note: Medicare spending includes federal payments and beneficiary cost sharing.

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Abbreviations

CMN	certificate of medical necessity
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
HHS	Department of Health and Human Services
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NSC	National Supplier Clearinghouse
OIG	Office of Inspector General
SADMERC	statistical analysis durable medical equipment regional carrier

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United States Government Accountability Office
Washington, DC 20548

November 17, 2004

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

In 2003, Medicare and its beneficiaries spent more than \$1 billion for power wheelchairs, one of the program's most expensive individual items of durable medical equipment (DME).¹ According to the Centers for Medicare & Medicaid Services (CMS),² the agency responsible for managing the Medicare program, spending for power wheelchairs rose more than fourfold from 1999 through 2003. In contrast, CMS's records show that overall Medicare spending increased by about 11 percent during the same period. Concerns have been raised that the millions of dollars in increased spending for power wheelchairs was fueled by improper payments to suppliers that submitted fraudulent claims to Medicare. Improper power wheelchair payments can be due to mistakes on the part of suppliers, beneficiaries, or beneficiaries' physicians, fraud—intentional misrepresentation, and abuse. For example, improper payments can occur when suppliers submit claims on behalf of beneficiaries who do not meet the Medicare coverage criteria. Such improper payments have been a problem for other DME items paid by Medicare.³

Medicare pays about \$5,000 for each power wheelchair—not including accessories—making them an attractive target for those who would defraud the program and its beneficiaries. In May 2003, the Department of

¹Medicare defines DME as equipment that may be prescribed by a physician for a patient's use for an extended period. This equipment serves a medical purpose, can withstand repeated use, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home. 42 U.S.C. § 1395x(n) (2000).

²Until July 1, 2001, CMS was called the Health Care Financing Administration. We use the name CMS throughout this report.

³For example, see Janet Rehnquist, Inspector General, Department of Health and Human Services, *Medicare Reimbursement for Medical Equipment and Supplies*, testimony before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, 107th Cong., 2nd sess., Washington, D.C., June 12, 2002.

Justice began indicting some physicians and wheelchair suppliers in Texas that were alleged to have billed Medicare for power wheelchairs that beneficiaries never received.

Prompted by concerns about fraud and abuse in Medicare's power wheelchair benefit, your committee held a hearing on this issue in April 2004. We testified before your committee on how CMS and its contractors that administer Medicare DME fee-for-service claims addressed problems with power wheelchair payments.⁴ After the hearing, you requested that we report in more detail on early and more recent steps taken by CMS and its contractors to respond to improper payments for power wheelchairs.

In preparing this report, we reviewed DME claims payment data from 1997 through 2003; DME claims payment data analysis reports from CMS's statistical contractor; written policies and procedures from CMS and its contractors, including the four DME regional carriers that process power wheelchair claims; budget and expense data for contractor activities; Medicare coverage policies, which explain the criteria for covering power wheelchairs; and CMS's recent actions, including its September 2003 action plan and its April 2004 initiatives, for responding to payment problems with Medicare's power wheelchair benefit. We also interviewed CMS and contractor officials, suppliers, industry representatives, manufacturers, and representatives from beneficiary advocacy groups. For DME claims payment data covering 1997 to 2003, we reviewed CMS and contractor internal control procedures to help determine whether these data were accurate, timely, and complete. We determined that these data were sufficiently reliable for addressing the issues in this report. Contractor budget and expense data are self-reported by CMS or the contractors, and we did not validate these data. Appendix I includes a more detailed discussion of our scope and methodology. We conducted our work from February through November 2004 in accordance with generally accepted government auditing standards.

Results in Brief

Over a 6-year period beginning in 1997, CMS's contractors repeatedly communicated with CMS about escalating spending for power wheelchairs and conducted program safeguard activities to respond to improper payments for this benefit, but CMS did not lead a coordinated effort to

⁴GAO, *Medicare: CMS Did Not Control Rising Power Wheelchair Spending*, [GAO-04-716T](#) (Washington, D.C.: Apr. 28, 2004).

address the underlying problems. For example, in 1997, a CMS contractor tasked with analyzing Medicare data warned the agency about rapid increases in power wheelchair spending. Further, in 1998, and again in 2000, reacting to the continuing rise in power wheelchair spending, medical directors at the four DME regional carriers sent joint memorandums to CMS officials outlining steps that could be taken and sought CMS's support. For example, the medical directors expressed concerns about the certificate of medical necessity (CMN)—a document completed by physicians to provide information with which contractors make payment decisions. They noted that the CMN for power wheelchairs does not provide sufficient information for determining if claims for power wheelchairs should be paid, but CMS did not respond by revising the CMN at that time. During this period, contractors also took other actions, including conducting medical reviews of claims and investigating suspected instances of power wheelchair fraud. However, the amount of funding CMS allotted to them for medical review declined in relation to the rise in Medicare payments. Additional problems related to the power wheelchair benefit surfaced during this period. For example, inspectors had difficulty enforcing two of the broad standards used to screen suppliers before they obtain or renew their Medicare billing privileges. Because supplier standards do not adequately describe what constitutes an acceptable physical location and sufficient inventory, CMS's contractor had difficulty interpreting and enforcing these two standards. In addition, Medicare standards for suppliers do not address certain misleading or abusive marketing practices that were a factor in increased utilization of power wheelchairs in Texas. Finally, CMS officials did not address weaknesses in the site visits that are used to assess suppliers' compliance with Medicare standards. For example, the predictability of visits made it relatively easy for illegitimate suppliers to prepare for, and pass, site inspections.

Since September 2003, CMS has led an effort to improve the processes for responding to improper payments for power wheelchairs. The agency's actions are in different stages of completion and focus on preventing fraudulent suppliers from entering the Medicare program; clarifying the coverage policy; ensuring appropriate pricing for power wheelchairs; educating physicians and beneficiaries on coverage rules; conducting detailed claims reviews in Texas, where power wheelchair fraud was prevalent; and coordinating with law enforcement agencies. Although CMS has made progress, it has not completed a revision to the CMN, clarified guidance on appropriate marketing to beneficiaries, or directed its contractor to conduct less predictably timed site visits to suppliers on a routine basis. Further, CMS's response to power wheelchair spending

highlighted the lack of a process within the agency to rapidly respond to indications of potentially improper DME payments.

To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, we recommend that the Administrator of CMS take four actions. We are recommending that CMS (1) establish a process to more quickly respond to indications of potentially improper DME spending, (2) finalize revisions to the CMN to make it a more effective tool for claims adjudication, (3) develop a more prescriptive supplier standard on appropriate marketing practices, and (4) amend the supplier inspection process to require that out-of-cycle inspections be routinely conducted. CMS agreed with our recommendations and stated that it has undertaken several efforts to curb the abuse of the power wheelchair benefit in the last year.

Background

Most Medicare beneficiaries purchase part B insurance, which helps pay for certain physician, outpatient hospital, laboratory, and other services; medical supplies and DME (such as oxygen, wheelchairs, hospital beds, and walkers); and certain outpatient drugs. Medicare covers a wide variety of DME items—including power wheelchairs. Medicare covers power wheelchairs when they are medically necessary, the beneficiary would be bed- or chair-confined without one, and the beneficiary can operate a power wheelchair, but not a manual wheelchair. Medicare part B pays for most medical equipment and supplies based on a series of state-specific fee schedules. Medicare pays 80 percent, and the beneficiary pays the balance, of either the actual charge submitted by the supplier or the fee schedule amount, whichever is less. If a beneficiary has supplemental insurance, the insurance may cover the 20 percent co-payment.

CMS contracts with four insurance companies, referred to as DME regional carriers, which review and pay claims submitted by outpatient providers and suppliers on behalf of beneficiaries residing in specific parts of the country.⁵ (See app. II for the states under each DME regional carrier's jurisdiction.) For example, Palmetto Government Benefits Administrators is responsible for processing claims for beneficiaries

⁵The four DME regional carriers are HealthNow New York, Inc. (region A), AdminaStar Federal (region B), Palmetto Government Benefits Administrators (region C), and CIGNA HealthCare Medicare Administration (region D). In this report, "states" refers to the 50 states, the District of Columbia, U.S. territories, and the Commonwealth of Puerto Rico.

permanently residing in region C, which encompasses 14 states, Puerto Rico, and the Virgin Islands. In 2002, Palmetto made about two-thirds of Medicare’s payments for power wheelchairs. In addition, the DME regional carriers and other CMS contractors conduct program safeguard activities to identify and respond to improper payments for DME claims (see table 1). CMS oversees contractors’ activities through various means, such as performing yearly on-site evaluations, reviewing planned activities, monitoring data and periodic reports, and conducting regular conference calls with the contractors.

Table 1: Contractors’ Key Safeguard Activities for DME Payments

Responsibility	Contractor	Safeguard activities
Analyze billing and report trends	Statistical analysis DME regional carrier (SADMERC)	The SADMERC conducts ongoing data analysis and reporting for the DME regional carriers and CMS. Its reports are used to identify trends in payment and potential fraud by item, geographic region, supplier, and physician.
	TriCenturion, LLC ^a and DME regional carriers for regions B, C, and D	TriCenturion and the DME regional carriers for regions B, C, and D analyze claims payment data to identify improper payments and to investigate and develop fraud cases.
Review claims against coverage criteria	TriCenturion and DME regional carriers for regions B, C, and D	These contractors are responsible for conducting medical reviews of submitted claims either before or after payment to determine if the claims should be, or should have been, paid. Claims are reviewed to see if the beneficiaries’ conditions meet the Medicare coverage criteria. If medical review identifies claims that should not have been paid, the DME regional carrier that paid the claim is responsible for collecting overpayments and educating the supplier about appropriate billing.
Investigate potential fraud	TriCenturion and DME regional carriers for regions B, C, and D	These contractors investigate cases of suspected fraud, which can involve conducting a more detailed analysis of claims and other investigative steps. Once a case has been developed, it is referred to the Department of Health and Human Services’ (HHS) Office of Inspector General (OIG) or to law enforcement for prosecution.
Enroll suppliers	National Supplier Clearinghouse (NSC)	CMS contracts with NSC to screen and enroll suppliers and assign Medicare supplier numbers. NSC is responsible for verifying information on supplier applications to ensure that suppliers meet 21 supplier standards and that only valid suppliers bill Medicare. NSC also maintains a central database of information on DME suppliers, reenrolls active suppliers every 3 years, and assists with fraud and abuse investigations.

Source: GAO.

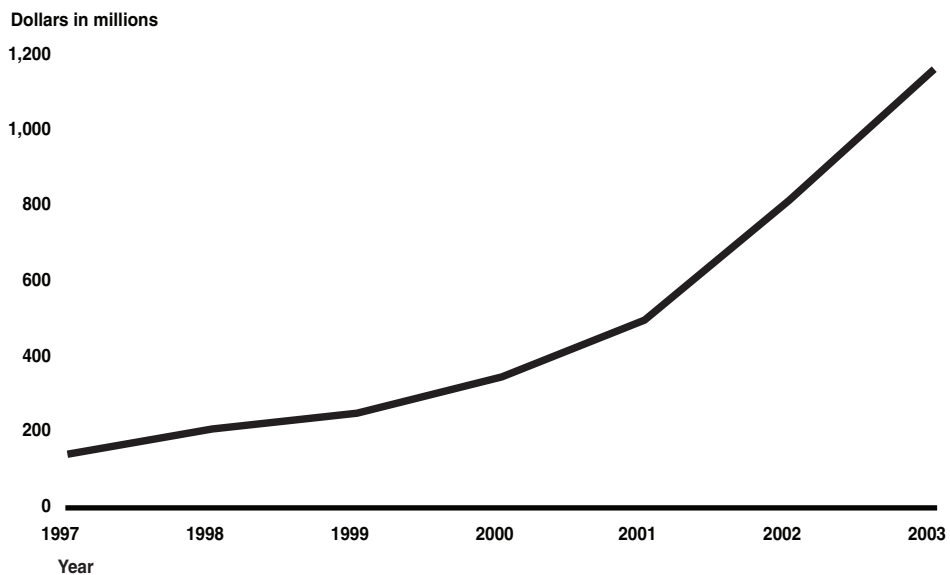
^aTriCenturion, LLC is a specialized program safeguard contractor responsible for reviewing claims and investigating and developing fraud cases for claims processed by region A.

These key safeguard activities help ensure that the more than 10 million claims the DME regional carriers process each year for power wheelchairs and other items are properly paid. For example, medical reviews can alert the DME regional carriers to potential cases of fraudulent billing, which

they may refer to their respective fraud investigation units. The DME regional carriers use both automated medical reviews and complex medical reviews to make decisions to pay or deny claims based on coverage criteria. Automated medical reviews are computerized checks of claims using available electronic information. Complex medical reviews are conducted by clinical staff, such as a nurse or doctor, who examine additional documentation provided by the supplier or the beneficiary's physician.

A key responsibility of CMS and its contractors is constraining improper program spending, while ensuring that beneficiaries who qualify for items and services have access to them. In the case of power wheelchairs, spending for claims processed by the DME regional carriers rose markedly from 1997 through 2003, as shown in figure 1. A number of factors other than improper payments may have contributed to it, including increased demand due to technological improvements or a growing number of beneficiaries who may meet the Medicare coverage criteria.

Figure 1: National Medicare Power Wheelchair Spending



Source: CMS.

Note: Medicare spending includes federal payments and beneficiary cost sharing.

Steps Taken by CMS and Its Contractors Did Not Deter Improper Payments for Power Wheelchairs

Beginning in 1997 and continuing over the next 6 years, CMS's contractors repeatedly communicated their concerns to the agency about rapid increases in Medicare spending for power wheelchairs. One area of concern focused on the CMN, which did not provide sufficient information to adjudicate claims, according to medical directors. During this period, the contractors, however, took a variety of steps, including conducting medical reviews of claims and investigating suspected instances of power wheelchair fraud. Other issues related to improper payments for power wheelchairs surfaced concerning the process for verifying the legitimacy of Medicare suppliers. However, CMS did not begin to lead efforts to address the underlying problems contributing to potentially improper payments for power wheelchairs until September 2003.

CMS Did Not Act on Contractors' Early Warnings about Escalating Power Wheelchair Payments

In 1997, CMS's SADMERC—its data analysis contractor—alerted CMS and the DME regional carriers about rapid increases in the spending for, and utilization of, power wheelchairs in the Medicare program. As part of its data monitoring efforts, the SADMERC noted that Medicare spending for power wheelchairs had grown from almost \$8 million in October 1995 to about \$24 million in March 1997. For the next several years, the SADMERC's quarterly reports continued to highlight rapid growth in power wheelchair spending and utilization, identifying the states and the suppliers for which claims volume was particularly high. Although the SADMERC's reports were sent to agency officials responsible for ensuring that program funds are safeguarded, CMS staff told us that they did not take action because the DME regional carriers have primary responsibility for responding to data indicating rapid increases in utilization. CMS officials acknowledged that the agency was not proactively identifying trends in data related to Medicare spending, developing strategies to address concerns about possible improper payments tied to spending increases, and implementing actions to address these concerns.

After reviewing the SADMERC data in 1997, the four DME regional carriers' medical directors found cause for concern and identified possible approaches to address what they described as "tremendous growth" in Medicare power wheelchair spending. In a joint April 1998 memorandum sent to CMS officials, the medical directors requested CMS's assistance in addressing power wheelchair spending growth and proposed implementing changes in the coverage policy for power wheelchairs. However, because of competing demands, the DME regional carrier medical directors never completed the policy revision, nor did CMS direct them to do so.

Power wheelchair fraud had already surfaced as a serious problem in Florida and in other southeastern states. In 1996, Palmetto began a major investigation of power wheelchair suppliers, during which it uncovered fraudulent activities such as billing for services not provided or not medically necessary, or delivering a less expensive power-operated vehicle—commonly called a “scooter,”⁶ while charging Medicare for a more expensive power wheelchair. Palmetto developed a fraud alert for other contractors and investigative agencies, which explained the schemes that suppliers were using to obtain inappropriate payments for power wheelchairs. CMS issued the fraud alert in June 1998.⁷ Fraud alerts are intended to increase external awareness of potential vulnerabilities and help the agency direct its efforts to address potential fraud. However, the June 1998 fraud alert did not prompt CMS to require the DME regional carriers to specifically scrutinize power wheelchair claims or to undertake any other efforts to identify fraudulent billing for this item.

In June 2000, the DME regional carriers’ medical directors sent a second jointly signed memorandum to CMS officials. The medical directors identified several problems tied to the provision of power wheelchairs and again asked for CMS’s assistance in addressing them. Despite this second warning from the medical directors, CMS officials did not begin to lead a coordinated effort to address escalating spending for power wheelchairs until September 2003.

One problem cited in the June 2000 memorandum concerned the CMN, a document that the physician is required to complete and sign to order a power wheelchair for a beneficiary. DME regional carriers do not routinely obtain beneficiaries’ medical records when deciding whether to pay wheelchair claims. Instead, DME regional carriers rely on information contained on the CMN. However, the medical directors of the four DME regional carriers noted that the CMN for power wheelchairs does not ask about the beneficiary’s functional abilities and limitations in sufficient detail for them to be able to determine if the Medicare coverage criteria are met. These criteria provide guidance on whether and under what

⁶Scooters are used by patients who are unable to walk and are unable to operate a manual wheelchair. A scooter has three or four wheels, is powered by an electric motor, steered by means of a tiller, and appropriate for indoor use. Scooters are more expensive than manual wheelchairs, but less expensive than power wheelchairs.

⁷Centers for Medicare & Medicaid Services, *Unrestricted National Medicare Fraud Alert*, UMFA 9802 (Baltimore, Md.: June 9, 1998, revised Oct. 6, 1998).

conditions Medicare will cover—and help pay for—a power wheelchair for a beneficiary.⁸

Our comparison of the CMN and the Medicare coverage criteria highlighted limitations in this document. (See table 2, which provides information on the clinical questions on the power wheelchair CMN, the Medicare coverage criteria, and limitations of the CMN.) For example, the CMN does not include a question about the beneficiary's capability to safely operate the controls of a power wheelchair, although having that capability is required by the Medicare coverage criteria. CMS did not change its CMN in response to the medical directors' 2000 memorandum that outlined their concerns with the CMN. In written comments on a draft of this report, CMS stated that it has a revised CMN under development, which it anticipates having in use in 2005.⁹

⁸Items or services that are not reasonable and necessary for diagnosis, treatment, or improvement of a bodily function, or are otherwise excluded by statute, are not covered by Medicare. 42 U.S.C. § 1395y(a) (2000).

⁹A CMS official told us that the revised CMN would incorporate information collected previously on three separate CMNs for manual wheelchairs, scooters, and power wheelchairs. He stated that the revised CMN would be structured to encourage the physician to consider the least costly, medically acceptable wheelchair or scooter for the beneficiary.

Table 2: Clinical Information Questions on the CMN, Power Wheelchair Coverage Criteria, and CMN Limitations

Information solicited by the CMN concerning medical necessity	The Medicare coverage criteria for power wheelchairs ^a	Limitations of the CMN
<p>What is the estimated length of need for a power wheelchair?</p> <p>What is the diagnosis code for patient's condition?</p>	<p>The patient's condition is such that a wheelchair is medically necessary.</p>	<p>The CMN asks for the patient's diagnosis, but it does not ask for information on the extent or severity of the patient's clinical condition, to indicate that a power wheelchair is medically necessary.</p>
<p>Does the patient require and use a wheelchair to move around in his or her residence?</p>	<p>The patient's condition is such that without the use of a wheelchair, the patient would otherwise be bed- or chair-confined.</p>	<p>The CMN is more open to interpretation as to when a patient would require a power wheelchair than the coverage criteria.</p>
<p>The CMN does not solicit information about a patient's capability to safely operate the controls of a power wheelchair.</p>	<p>The patient is capable of safely operating the controls for the power wheelchair.</p>	<p>The CMN does not ask if the patient is capable of safely operating the controls for the power wheelchair.</p>
<p>Is the patient unable to operate any type of manual wheelchair?</p> <p>Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?</p>	<p>The patient is unable to operate a manual wheelchair.</p>	<p>There are no limitations because the CMN elicits information that can be used to determine that the Medicare coverage criteria concerning the patient's ability to operate a power wheelchair are met.</p>

Source: GAO analysis.

Note: Information from Coverage Issues Manual, rev. 36, Section 60-9, www.cms.gov/manuals/06_cim/ci60.asp, accessed July 29, 2004; DME regional carrier coverage guidance; and Department of Health and Human Services, Centers for Medicare & Medicaid Services, Certificate of Medical Necessity, Motorized Wheelchairs, DMERC Form 02.03A.

^aA power wheelchair is covered when all the Medicare coverage criteria are met.

The HHS OIG recently testified that the CMN for power wheelchairs, which does not list coverage guidelines and is not completely consistent with coverage policy, is one of the reasons that DME regional carriers have paid claims for power wheelchairs for beneficiaries who did not qualify for them under Medicare coverage rules.¹⁰ In a related report, the OIG discussed the findings of an independent medical review contractor, which the OIG retained to review 230 medical records for beneficiaries for

¹⁰Department of Health and Human Services, Office of Inspector General, *Medicare: Reimbursement for Power Wheelchairs and Scooters*, Testimony of Dara Corrigan, Acting Principal Deputy Inspector General, before the U.S. Senate Committee on Finance, April 28, 2004.

whom Medicare claims for power wheelchairs were submitted in 2001.¹¹ The independent reviewer found that only 13 percent of the claims met the Medicare coverage criteria for a power wheelchair. The reviewer also found that 31 percent of the claims did not meet the Medicare coverage criteria for any type of power wheelchair or scooter, while an additional 45 percent did not meet the criteria for a power wheelchair, but may have met the criteria for another type of wheelchair or scooter.¹² The HHS OIG recommended that CMS educate physicians and beneficiaries about the Medicare coverage criteria for power wheelchairs and develop coverage policy to include specific information about the medical conditions for which Medicare will cover different types of power mobility equipment.

Funding for Claims Review Declined as Power Wheelchair Spending Rose

Because annual funding for the DME regional carriers to conduct medical reviews declined, while power wheelchair spending rose, the DME regional carriers' capacity to conduct medical review was affected. CMS decreased the total funding for the medical review of claims submitted to the four DME regional carriers by about 22 percent, comparing fiscal year 1999 and fiscal year 2003.¹³ Consistent with the decrease in funding, the number of claims for all items undergoing complex medical review in regions B, C, and D fell by about 39 percent from fiscal year 2001 through fiscal year 2003.¹⁴ These funding decreases can weaken program safeguard efforts. For example, three of the four DME regional carriers told us that conducting medical review on a larger number of claims would allow them to better address improper Medicare billing. Furthermore, Palmetto officials said that the funding they received for medical review did not equip them to handle the level and type of fraudulent power wheelchair billing that was discovered in Texas in 2002. In addition, they told us that

¹¹Department of Health and Human Services, Office of Inspector General, *Medicare Payments for Power Wheelchairs*, OEI-03-02-00600 (Washington, D.C.: April 2004).

¹²For 11 percent of the claims, due to insufficient documentation, the reviewer could not determine whether the beneficiaries' conditions met coverage criteria.

¹³Our data include funding for medical review activities performed by the four DME regional carriers and, starting in fiscal year 2001, the program safeguard contractor for region A. From fiscal year 1999 through fiscal year 2001, total funding for the medical review of claims submitted to these carriers increased from \$10,806,376 to \$12,388,461. However, total funding for the medical review of claims decreased from \$9,472,076 in fiscal year 2002 to \$8,432,894 in fiscal year 2003.

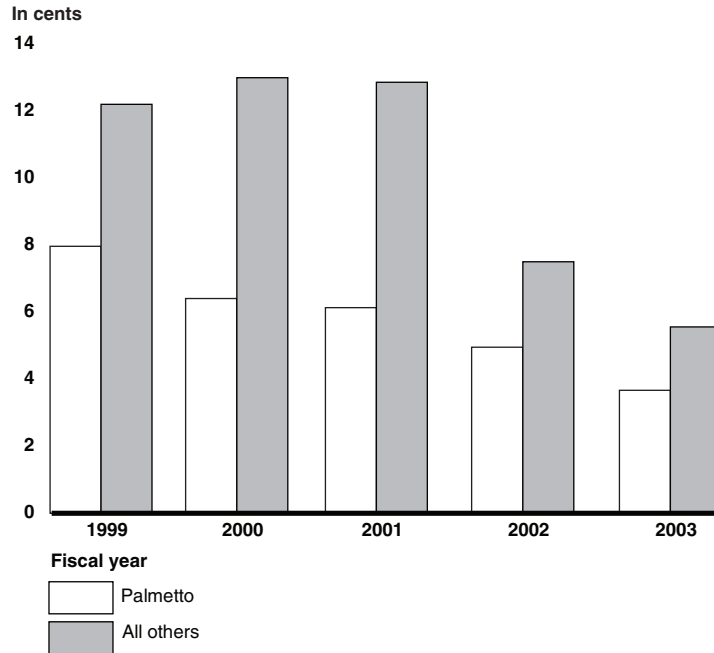
¹⁴Regions B, C, and D conducted complex medical reviews on about 297,600 claims for all items in fiscal year 2001 and on about 180,600 claims in fiscal year 2003. This information was not available for region A.

they were also addressing fraudulent billing related to other items for which they had made payments.

The decline in funding for medical review is even more dramatic when weighed against claims submitted to the DME regional carriers. Overall, the amount of medical review funding from CMS per \$100 in total submitted claims dropped over 50 percent from fiscal year 1999 through 2003 for total claims submitted to the four DME regional carriers. Palmetto's funding dropped from about 8 cents per \$100 in submitted claims in 1999 to less than 4 cents per \$100 in submitted claims in 2003.¹⁵ Compared to the other three DME regional carriers, Palmetto was allocated less medical review funding per \$100 in total submitted claims each year from fiscal year 1999 through 2003, as figure 2 shows.

¹⁵In fiscal year 2003, Palmetto received \$3.1 million for medical review activities—about 15 percent less than it received in 1999.

Figure 2: Medical Review Funding for Each \$100 in Submitted Claims for Palmetto and the Other Three DME Regional Carriers



Source: GAO analysis.

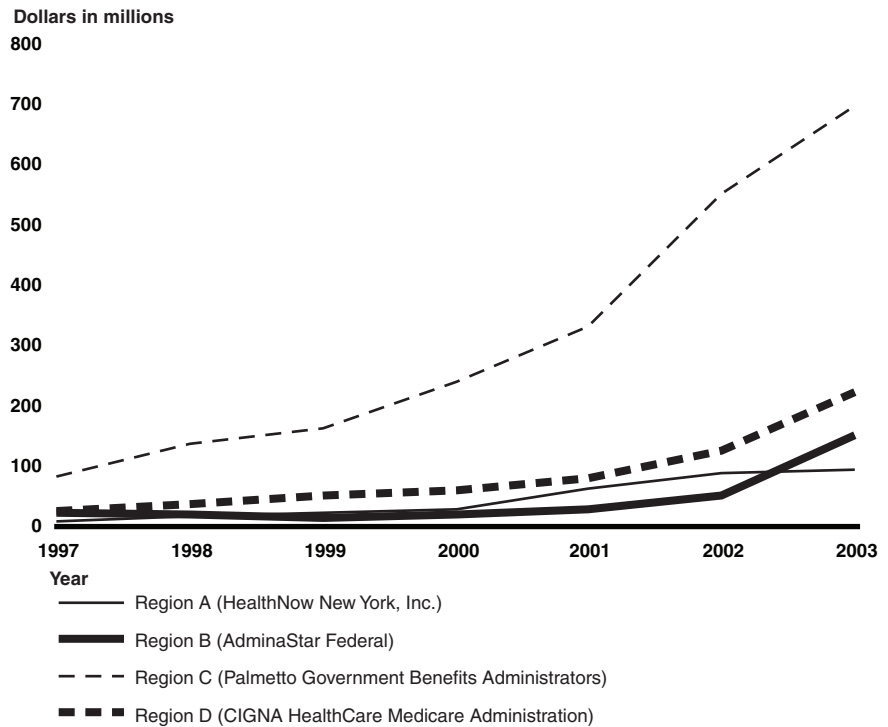
Note: Based on CMS data on medical review funding and submitted claims.

Despite the relatively low funding allotted by CMS to Palmetto for medical review, Palmetto more than tripled the number of power wheelchair claims on which it conducted complex medical review from fiscal years 2000 to 2002. Nevertheless, Palmetto still reviewed less than 3 percent of its power wheelchair claims in 2002,¹⁶ while it paid about \$550 million to suppliers for this item.

The reduction in medical review funding for Palmetto is of particular interest because Palmetto had already found significant power wheelchair fraud in its region in the late 1990s. Further, from 1997 through 2003, spending growth for power wheelchairs in Palmetto's region surpassed that of the three other regions combined, as shown in figure 3.

¹⁶Palmetto reviewed about 4,400 of the approximately 158,000 claims submitted for power wheelchairs in 2002.

Figure 3: Regional Medicare Power Wheelchair Spending



Source: CMS.

Note: Medicare spending includes federal payments and beneficiary cost sharing.

Palmetto Conducted Fraud Investigations in Texas to Address Improper Payments

In early 2002, Palmetto officials became concerned that some power wheelchair suppliers in Harris County, Texas, and other parts of the state had submitted—and Palmetto had paid—fraudulent power wheelchair claims. Specifically, a Palmetto fraud analyst had identified highly aberrant billing behavior for one supplier, which he began to monitor. Palmetto analysts also discovered that some suppliers were billing for a power wheelchair or for power wheelchair accessories multiple times on behalf of a single beneficiary.

Also in 2002, legitimate power wheelchair suppliers in Harris County, Texas, became increasingly suspicious about the activities of some suppliers in their area. For example, representatives of two suppliers with whom we spoke learned that Medicare had paid other suppliers for power wheelchairs that beneficiaries had never received. Suppliers told us that they, other suppliers, and beneficiaries reported their suspicions to the Palmetto fraud unit, the Medicare fraud hotline, the Federal Bureau of

Investigation, and the HHS OIG. The suppliers' suspicions were supported by data indicating that in 2002, 14 percent of Medicare's power wheelchair spending was for beneficiaries in Harris County, although only 1 percent of Medicare beneficiaries lived in that area in 2001. During January 2003, Palmetto referred 22 Harris County area suppliers suspected of fraud in their billing for power wheelchairs to the Dallas office of the HHS OIG for potential prosecution.¹⁷ Palmetto officials estimated that at least 200 individuals in region C were involved in fraudulent power wheelchair schemes and that Medicare had improperly paid at least \$20 million in its region for fraudulent claims from fiscal year 2000 through fiscal year 2003.

Fraud Investigations and Supplier Inspections Highlighted Weaknesses in Verifying the Legitimacy of Suppliers

NSC, which is the CMS contractor responsible for DME supplier enrollment, noted in 2002 that Texas had an unusually high number of suppliers compared to the number of beneficiaries residing in the state. At CMS's request, NSC stationed one of its inspectors in the Harris County area to conduct supplier site visits. During these site visits, which began in September 2002, NSC's inspector found instances where suppliers lacked appropriate places of business or had moved their businesses without giving NSC the required forwarding addresses. Based on these findings, NSC's inspector subsequently led site visits of every active supplier that had not been inspected since January 2003 in the Harris County, Texas, area. These out-of-cycle site visits of about 1,300 suppliers were conducted from August 2003 through January 2004, and identified instances where suppliers did not meet required Medicare standards,¹⁸ including lacking appropriate inventory and insurance. Due to problems identified during regular and out-of-cycle site visits, NSC revoked 367 supplier billing numbers for power wheelchair suppliers in the Harris County, Texas, area, from September 2002 through March 2004.

Many suppliers, whose billing numbers were later revoked, gained entry into the Medicare program because of three weaknesses in the enrollment process. First, NSC did not always verify submitted documents. NSC officials told us that they had routinely accepted copies of key documents, such as liability insurance forms, at face value without verifying them.

¹⁷Palmetto conducted additional investigations and made referrals throughout 2003, and, as of August 18, 2004, investigations were continuing.

¹⁸Suppliers must meet 21 standards. 42 C.F.R. § 424.57(c)(1) – (21) (2003) (in effect since December 11, 2000). Suppliers must be in compliance with these standards in order to obtain and maintain their Medicare billing privileges.

Failure to verify the accuracy of these documents had enabled supplier applicants to submit falsified papers and still become enrolled as Medicare suppliers. NSC officials indicated that they began verifying suppliers' liability insurance forms in September 2003.

Second, the 21 standards that NSC uses to evaluate suppliers lack the specificity needed to screen out illegitimate suppliers and do not provide guidance on appropriate marketing practices. For example, the supplier standards are not specific about the characteristics of a physical location or the amount or type of inventory that would be expected, given the items the supplier intends to provide to Medicare beneficiaries. According to NSC staff, the broad language used in these standards is difficult to interpret and enforce. CMS and NSC are in the process of developing additional guidance concerning supplier standards, including prescribing how existing standards on physical location and inventory should be interpreted.

In addition, the 21 standards do not address certain misleading or abusive marketing practices, including offers to routinely waive beneficiaries' co-payments and certain types of personal solicitations. Individuals with whom we spoke contended that misleading and abusive marketing practices have escalated nationwide utilization of power wheelchairs and were a factor in increased utilization of power wheelchairs in Texas. For example, CMS officials told us of instances of suppliers promising free power wheelchairs to beneficiaries in Texas. We also found supplier advertisements on the Internet, in print, and on television, that used the words "free" or "no cost to you" in connection with beneficiaries receiving power wheelchairs. Appendix III shows an example of an Internet advertisement that appears to illegally offer to waive Medicare co-payments.¹⁹ CMS officials also reported suppliers canvassed beneficiaries door-to-door in Texas to solicit their business. By statute, Medicare suppliers are not permitted to offer free wheelchairs by waiving beneficiary co-payments routinely or as part of an advertisement or solicitation.²⁰ Furthermore, the Medicare statute generally prohibits suppliers from canvassing beneficiaries by telephone to solicit their

¹⁹The supplier has since withdrawn this advertisement from its Web site.

²⁰42 U.S.C. § 1320a-7a(a)(5) and (i)(6)(A) (2000). As a result, suppliers soliciting Medicare business by advertising that they can provide a beneficiary with a free wheelchair may be subject to penalties if they actually provide the beneficiary with a wheelchair at no cost.

business.²¹ While the 21 supplier standards reflect the statutory restriction on telephone solicitations, they do not prohibit door-to-door solicitation. Furthermore, the standards do not reflect the prohibition on waiving copayments routinely or as part of an advertisement or solicitation. CMS has statutory authority to specify additional supplier requirements, but has not used this authority to modify the 21 standards to ensure that suppliers' marketing practices are not misleading or abusive.²²

A third weakness in the enrollment process concerns the predictability of NSC's initial and subsequent site visits to suppliers. CMS requires NSC to conduct a site visit to assess compliance with the 21 supplier standards before authorizing a new supplier to bill Medicare. NSC is also required to conduct a site visit to assess the supplier's continued compliance with the standards every 3 years, when suppliers must reenroll in order to retain their Medicare billing privileges.²³ Because the timing of such visits is predictable, a supplier that is intent on committing fraud can anticipate a site visit and present an illusion of legitimacy for the purpose of passing the initial inspection, fully understanding that an inspector is not likely to return for 3 years, even if beneficiaries complain of potential fraud. For example, the person convicted of Medicare fraud who testified before your committee on April 28, 2004, stated that although a fraud analyst contacted her after a beneficiary complained about nondelivery of a power wheelchair billed to Medicare, no inspector visited the facility. According to this individual, she was able to bill Medicare \$50,000 for power wheelchairs in the next month without any further scrutiny, though her operation rarely delivered the power wheelchairs billed.²⁴

The experience in Harris County, Texas, suggests that conducting out-of-cycle site visits was valuable to uncover fraud and suppliers that were not complying with required standards. Nevertheless, CMS does not require NSC to routinely conduct out-of-cycle site visits, maintain data on the

²¹42 U.S.C. § 1395m(a)(17) (2000).

²²42 U.S.C. § 1395m(j)(1)(B)(ii)(IV) (2000).

²³CMS does not require NSC to conduct a site visit to every supplier. Suppliers that are Medicare-enrolled entities (hospitals, skilled nursing facilities, home health agencies, physicians, and ambulatory surgical centers) and existing supplier chains with 25 or more locations are excluded from site visits.

²⁴This individual reported that prior to submitting additional power wheelchair claims, she did mail a refund check to Medicare for the power wheelchair that the beneficiary complained about not receiving.

number of out-of-cycle visits that NSC may choose to conduct, or report on the results of such visits. According to an NSC official, NSC may choose to conduct an out-of-cycle visit to a supplier when a complaint is lodged or when data analysis of the supplier's claims indicate that there is a potential problem. In its written comments on a draft of this report, CMS reported that, in the summer of 2003, NSC had conducted over 600 out-of-cycle site inspections and had found more than 300 suppliers out of compliance with supplier standards.

Recent Actions May Help Control Improper Power Wheelchair Payments

CMS has recently taken steps, including issuing an action plan in September 2003 and announcing additional initiatives in April 2004, that should strengthen the processes the agency and its contractors use to identify and respond to improper payments for power wheelchairs and other DME items. While some of these activities addressed fraud, abuse, and utilization issues in Harris County, Texas, others focused on clarifying the Medicare coverage criteria for adjudicating power wheelchair claims. Still others were in response to requirements in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).²⁵ As shown in table 3, CMS's and its contractors' actions to respond to rising spending for power wheelchairs are in different stages of completion and focus on supplier enrollment; coverage policy; pricing; provider and beneficiary education; actions to address concerns in Harris County, Texas; and law enforcement.

²⁵Pub. L. No. 108-173, § 302, 117 Stat. 2066, 2223.

Table 3: CMS's Actions to Address Improper Payments for Power Wheelchairs and Other DME Items

Action	Explanation	Status ^a
Supplier enrollment		
Prevent fraudulent suppliers from enrolling in Medicare for the purpose of receiving inappropriate payments.	CMS stated it would begin to aggressively scrutinize all new applications; NSC stopped issuing new supplier numbers in Harris County, Texas, in March 2003 and nationally in September 2003. NSC began issuing supplier numbers again in November 2003.	Since October 2003, NSC had received over 5,800 new applications from potential Medicare suppliers and had approved over 4,000 of these applications. During the same period, over 8,000 supplier numbers were inactivated and 4,000 were reactivated.
Identify and prevent inappropriate enrollment of suppliers by providing a more detailed screening process, allowing CMS the time needed to properly review applications, and providing sanctions against suppliers abusing the enrollment process.	CMS stated its intent to publish regulations to enhance its ability to screen new supplier applications. MMA requires CMS to establish quality and consumer service standards for suppliers. MMA § 302(a)(1), 117 Stat. 2223 (to be codified at 42 U.S.C. § 1395m(a)(20)).	CMS plans to establish quality and consumer service standards for suppliers by January 2005.
Clarify existing supplier enrollment standards.	CMS is currently working with NSC on clarifying the existing 21 supplier standards.	CMS planned to implement the clarified 21 supplier standards by October 2004.
Implement an accreditation process to determine if suppliers meet quality standards, which MMA requires CMS to establish.	This action is required by MMA. MMA § 302(a)(1), 117 Stat. 2223 (to be codified at 42 U.S.C. § 1395m(a)(20)).	The agency has not developed a schedule for this action.
Coverage policy for power wheelchairs		
Ensure national policy accurately defines the conditions under which Medicare will cover mobility products.	CMS stated it would promulgate regulations revising coverage policy for power wheelchairs and scooters. The coverage policy will implement the MMA provision requiring medical providers to conduct face-to-face examinations of patients before prescribing wheelchairs. MMA § 302(a)(2), 117 Stat. 2224 (to be codified at 42 U.S.C. § 1395m(a)(1)(E)(iv)).	CMS developed a proposed rule that would require medical providers to conduct face-to-face examinations of patients prior to prescribing wheelchairs and scooters. In July 2004, the proposed rule was under review; on August 5, 2004, it was published.
Accurately portray the clinical conditions for which mobility products are reasonable and necessary, and facilitate correct billing and payment for mobility devices.	CMS stated that DME regional carriers would immediately adopt local medical review policies to educate suppliers and beneficiaries on the Medicare coverage criteria for wheelchairs.	In December 2003, the DME regional carriers published an educational bulletin to clarify coverage criteria. It explained how claims would be reviewed and should be coded and how the beneficiary's medical need for the item should be documented. This information has since been removed from their Web sites, in response to concerns raised by suppliers, beneficiary representatives, and industry groups. As part of its April 2004 initiatives, CMS convened an interagency work group to develop guidance on power wheelchair coverage policy.

Action	Explanation	Status ^a
Coverage policy for power wheelchairs (cont'd)		
When national billing and utilization trends are identified, ensure that only claims that are reasonable and necessary are paid and resolve national billing problems consistently.	CMS stated that the DME regional carriers would adopt a consistent approach to medical review.	Each DME regional carrier has assured CMS that it is consistently using local and national policy guidance when reviewing claims.
Establish an interagency work group, including clinicians from CMS, the National Institutes of Health, the Department of Veterans Affairs, and the National Institute on Disability and Rehabilitation Research.	This group of clinicians will develop guidance on implementing power wheelchair coverage policy.	CMS will provide for a public comment period, and then issue guidance by the end of 2004.
Power wheelchair pricing		
Ensure that Medicare is paying appropriately for power wheelchairs.	CMS stated it would develop guidelines to implement its payment rate adjustment process for most part B services (called inherent reasonableness) and apply this process first to power wheelchairs.	CMS officials indicated that the agency would issue guidelines for implementing an inherent reasonableness process soon. Once the guidelines are issued, CMS can use them to determine whether payment amounts for power wheelchairs should be adjusted.
Develop a new set of power wheelchair billing codes. The DME regional carriers use billing codes to identify power wheelchairs and other items billed by a supplier on a beneficiary's behalf.	These codes will provide more specificity in differentiating the various power wheelchairs on the market.	CMS will consult with other experts and solicit public comments before finalizing its coding changes. When new codes are established, CMS will develop payment ceilings for each new code.
Implement competitive bidding, and include power wheelchairs in this process.	MMA requires CMS to begin a Medicare competitive bidding program for medical equipment and supplies in 2007. Under this program, suppliers will compete by offering bids or amounts they will accept to supply DME products to beneficiaries, and CMS will use the bid information to set payments and choose suppliers (MMA § 302(b), 117 Stat. 2224).	CMS may consider including power wheelchairs in its competitive bidding effort as early as 2007.
Provider and beneficiary education		
Provide physicians and beneficiaries with the necessary information about Medicare coverage policies for power wheelchairs.	CMS stated that it would work with physicians to clarify their prescribing responsibilities. It would also educate physicians, beneficiaries, and suppliers on the Medicare coverage criteria for power wheelchairs.	The DME regional carriers provided an online tutorial to physicians and suppliers to better educate them about the power wheelchair benefit. The DME regional carriers have also provided one-on-one and group education to suppliers.

Action	Explanation	Status ^a
Focus on Harris County, Texas		
Address what CMS called “rampant” fraud and abuse in the Harris County, Texas, area.	CMS stated, effective with plan’s issuance, all payments for power wheelchairs in the Harris County, Texas, area would be individually approved by CMS staff in the Dallas regional office.	CMS has continued to have medical professionals in its Dallas regional office review all claims for power wheelchairs from Harris County, Texas, that have been approved for payment, but anticipated phasing out this review.
Ensure that all suppliers of manual wheelchairs, scooters, and power wheelchairs in Harris County, Texas, know and understand Medicare coverage rules.	CMS stated that it would require all wheelchair suppliers in the Harris County, Texas, area to attend mandatory training on wheelchair coverage and medical review policies.	Palmetto and the CMS Dallas regional office sponsored mandatory training for all Houston-based suppliers of manual wheelchairs, scooters, and power wheelchairs, which was completed in October 2003. Employees representing 328 suppliers attended the training. CMS plans to take administrative action against, and has not paid claims from, any of the 53 suppliers that did not attend.
Law enforcement		
Quickly identify and punish fraudulent suppliers and work collaboratively with law enforcement to process fraud cases.	CMS, DME regional carriers, and law enforcement agencies will collaborate to process criminal prosecutions. CMS also indicated that it would use payment suspension against suppliers referred to law enforcement, as needed, to prevent loss of Medicare funds.	Since September 2003, 179 fraud cases involving 296 suppliers had been referred to law enforcement officials. In addition, the DME regional carriers had 121 active investigations under way.

Source: GAO analysis.

Note: Based on CMS’s September 2003 action plan, April 2004 initiatives, and other status information provided by CMS.

^aInformation on status as of July 2004, unless otherwise noted.

Conclusions

Fraud, abuse, and misapplication of Medicare rules in the program’s power wheelchair benefit highlight four areas of concern relating to how CMS and its contractors safeguard Medicare program dollars. First, while contractors repeatedly communicated concerns about potential problems to the agency, CMS was slow to react to rising spending. Some of this spending was on behalf of beneficiaries who met all of the Medicare coverage criteria, but millions of dollars were spent on power wheelchair claims submitted by suppliers intent on defrauding the Medicare program. CMS’s failure to take an early leadership role underlines the need for a more proactive response by the agency in the future when there appears to be disproportionate and suspicious spending for DME items provided to Medicare beneficiaries.

A second area of concern centers on the CMN. CMS is in the process of revising the CMN for power wheelchairs, but has not implemented a version that provides sufficient information to allow DME regional carriers to correctly adjudicate power wheelchair claims. Until it does so, its DME regional carriers will continue to be hampered in their efforts to properly pay power wheelchair claims.

Third, fraud that occurred among suppliers in Harris County, Texas, highlights significant weaknesses in the supplier enrollment process—especially standards covering suppliers’ physical locations, required inventory, and marketing. Other than constraining suppliers’ communications with beneficiaries by telephone, the 21 supplier standards do not provide guidance on appropriate marketing practices. For example, they do not include language reflecting the statutory provision that prohibits suppliers from waiving beneficiaries’ co-payments when offered as part of an advertisement or solicitation. While CMS is working on more specific guidance relating to a supplier’s physical location and inventory, it has not modified the 21 supplier standards to ensure that marketing practices are not misleading or abusive. Such marketing practices include offering to waive beneficiaries’ co-payments, using the words “free” or “no cost to you” in relation to provision of Medicare items to beneficiaries, and using door-to-door solicitations.

Fourth, site visits, which can help ensure compliance with supplier standards, are less effective in screening potential suppliers because they are highly predictable. Despite evidence that out-of-cycle site visits proved useful in identifying fraudulent suppliers in Harris County, Texas, CMS does not require its contractor to conduct such site visits on a routine basis across the country.

Recommendations for Executive Action

To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, we recommend that the Administrator of CMS take four actions:

- Develop a process within CMS to focus on trends in Medicare spending and disproportionate or suspicious Medicare payments; develop strategies to address the trends that may indicate possible improper payments for DME; and take timely action, when warranted.
- Implement a revised CMN that incorporates key elements of power wheelchair coverage criteria to help DME regional carriers properly adjudicate claims.

-
- Strengthen the standards for Medicare DME suppliers to include prohibiting certain misleading or abusive marketing practices.
 - In addition to conducting the currently required initial and reenrollment site visits, direct NSC to routinely conduct out-of-cycle site visits to suppliers that are suspected of billing improperly and to maintain data on these visits and their results.

Agency Comments

In its written comments on a draft of this report, CMS agreed with our recommendations and stated that it had undertaken several efforts to curb the abuse of the power wheelchair benefit in the Medicare program within the last year. CMS mentioned its September 2003 power wheelchair initiative, which focused on aggressive claims review, enforcement, and supplier training, and its April 2004 initiative, which targeted coverage, payment, and the quality of suppliers of power wheelchairs.

In response to the draft report's discussion on the decline in annual funding for the DME regional carriers to conduct medical reviews, CMS indicated that it agreed that funding had decreased when fiscal year 1999 is compared to fiscal year 2003. However, CMS noted that funding had increased steadily before it began to decrease. In response to CMS's comment, we revised the report to provide additional information on funding changes from fiscal year 1999 to fiscal year 2003. CMS also stated that it continues to request additional funding for Medicare Integrity Program efforts and that legislative caps on that funding had affected medical review spending. CMS was referring to funding for the Medicare Integrity Program, which was provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).²⁶ Medicare Integrity Program activities include medical review of claims, investigation of potential fraud cases, and provider education and training to combat Medicare fraud, waste, and abuse. Beginning in fiscal year 1997, HIPAA appropriated an increasing level of funding through fiscal year 2003 and permanent funding at the 2003 level thereafter.

²⁶Pub. L. No. 104-191, sec. 201(b), § 1817(k)(4), 110 Stat. 1936, 1995.

CMS agreed with our recommendation that it develop a process to focus on trends in Medicare spending and disproportionate or suspicious Medicare payments; develop strategies to address the trends that may indicate possible improper payments for DME; and take timely action, when warranted. CMS indicated that it is building on its current program integrity efforts to implement a new data-driven approach to detect improper payments and potential areas of fraud and abuse in the Medicare program. In response to our recommendation that CMS implement a revised CMN for power wheelchairs, CMS stated that it anticipates having a revised CMN in use in 2005, which it said should provide useful information for more accurate and timely claims reviews. CMS agreed with our recommendation on strengthening the standards for DME suppliers by prohibiting certain misleading or abusive marketing practices. The agency noted that it is examining whether its current authorities allow it to address direct-to-consumer marketing beyond telephone solicitations or if it needs to seek a legislative remedy to amend the supplier standards to do so. However, CMS indicated that it intended to further delineate appropriate marketing practices by DME suppliers to beneficiaries. Finally, CMS agreed with our recommendation to direct NSC to routinely conduct out-of-cycle site visits to selected suppliers. CMS noted that NSC had conducted out-of-cycle site inspections in 2003 and 2004, and the agency said that it has directed NSC to continue these reviews in fiscal year 2005.

We have reprinted CMS's letter in appendix IV. CMS also provided us with a technical comment, which we incorporated.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. We are sending copies of this report to the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (312) 220-7600 or Sheila K. Avruch at (202) 512-7277. Other key contributors to this report are Sandra D. Gove, Joy L. Kraybill, Lisa S. Rogers, and Craig Winslow.

Sincerely yours,

A handwritten signature in cursive script that reads "Leslie G. Aronovitz".

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Scope and Methodology

We assessed the early and more recent steps taken by the Centers for Medicare & Medicaid Services (CMS) and its contractors to respond to improper payments for power wheelchairs. First, we obtained reports on national and regional annual Medicare claims payment data for power wheelchairs from 1997 through 2003 from the statistical analysis durable medical equipment regional carrier (SADMERC). These annual reports included the paid claims data for power wheelchairs with dates of service during a calendar year. They included all paid claims data received by the SADMERC during that calendar year through March 31 of the next calendar year. We reviewed CMS and contractor internal control procedures to help ensure that these data were accurate, timely, and complete. We determined that these data were sufficiently reliable for addressing the issues in this report.

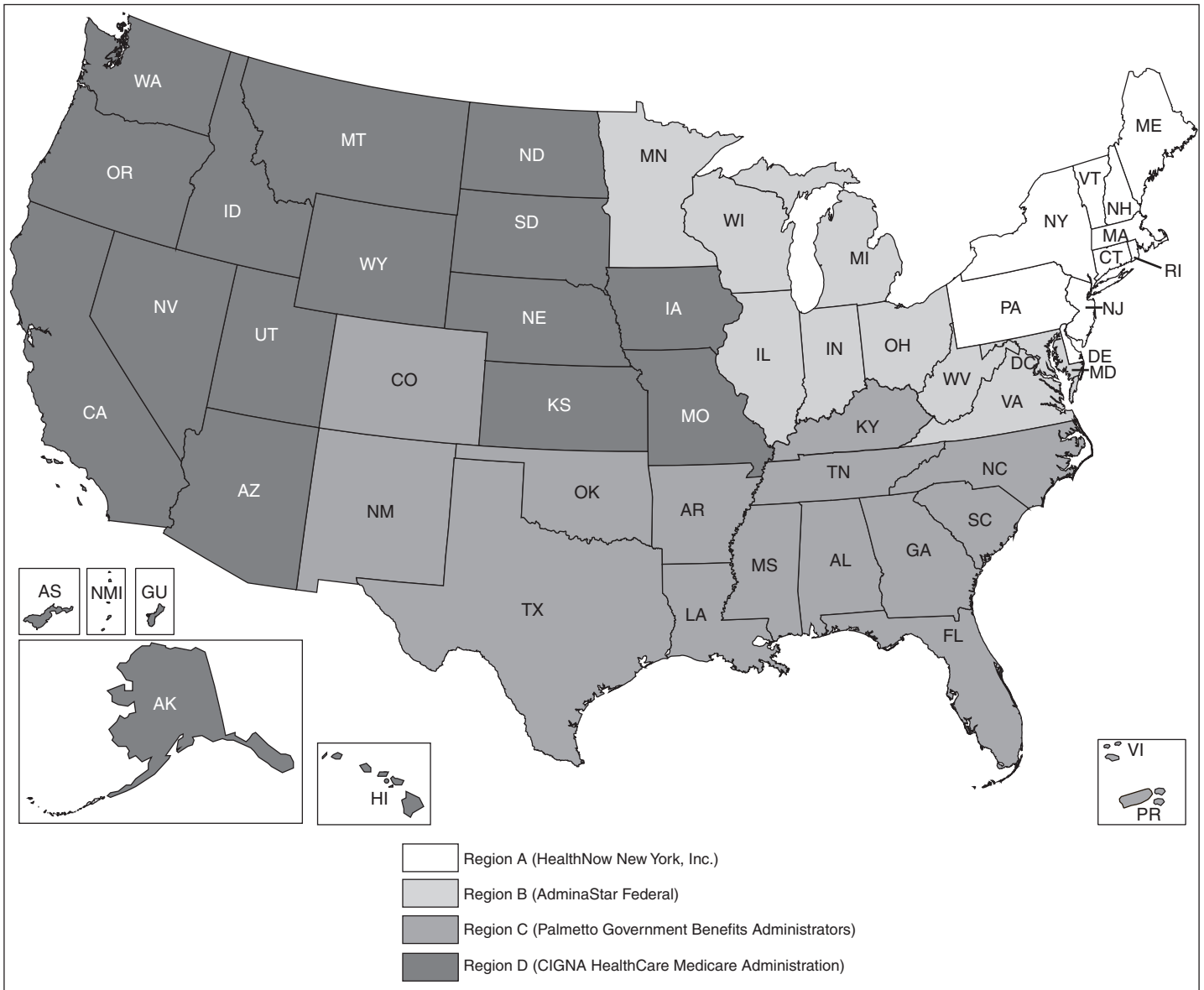
We reviewed actions taken by the SADMERC in identifying claims payment trends and possible improper payments and informing the other durable medical equipment (DME) regional carriers and CMS. To do so, we reviewed SADMERC reports from 1997 to 2003 sent to DME regional carrier and CMS staff that contained information on power wheelchair billing and interviewed SADMERC, DME regional carrier, TriCenturion, and CMS staff about SADMERC activities.

We reviewed actions taken by DME regional carriers in responding to possible improper payments and informing CMS about potential issues. We reviewed DME regional carrier and CMS documents, including memorandums, a fraud alert, reports related to power wheelchair fraud activities, the certificate of medical necessity for power wheelchairs, the Medicare coverage criteria, and CMS budget documents for fiscal year 1999 through fiscal year 2003. From the budget documents provided by CMS and submitted claims information provided by the SADMERC, we analyzed funding for claims review activities. Contractor budget and expense data are self-reported by CMS and the contractors, and we did not validate these data. We also interviewed DME regional carriers and TriCenturion staff, including their medical directors, and CMS headquarters and regional staff with responsibility for overseeing, or budgeting for, DME regional carrier and TriCenturion activities.

To review steps taken by the National Supplier Clearinghouse (NSC), we reviewed CMS and NSC documents, such as the 21 supplier standards and correspondence from NSC highlighting problems with the supplier standards. We also interviewed CMS and NSC staff about power wheelchair supplier issues; on-site review activities, particularly in Harris County, Texas; and potential weaknesses in supplier verification activities.

We assessed the steps taken by CMS to respond to improper payments for power wheelchairs by reviewing CMS's action plan to combat improper payments for power wheelchairs; relevant sections of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Social Security Act; and other documents mentioned above. We interviewed CMS officials with responsibility for safeguarding DME payments and overseeing SADMERC, DME regional carrier, TriCenturion, and NSC activities. We also interviewed SADMERC, DME regional carrier, TriCenturion, and NSC staff; supplier representatives; beneficiary advocates; and industry representatives. The beneficiary advocates whom we interviewed included members of the Independence Through Enhancement of Medicare and Medicaid Coalition. In addition, we interviewed clinicians from the University of Pittsburgh. We also interviewed representatives of manufacturers, suppliers, and a trade association, including representatives from Hoveround, Invacare, Pride Mobility Products Corporation, the Power Mobility Coalition, and two suppliers in Harris County, Texas. We also participated in three "listening sessions" on February 24, March 31, and June 14, 2004, that were organized by CMS staff so that they could hear the viewpoints of suppliers, beneficiary advocates, and industry representatives on the actions taken by CMS and its contractors to address power wheelchair issues. We performed our work from February through November 2004 in accordance with generally accepted government auditing standards.

Appendix II: DME Regional Carriers' Jurisdiction



Source: CMS.

Appendix III: Internet Advertisement for Power Wheelchairs

electric wheel chair -- electric wheel chairs -- electric wheelchair -- electric wheelchairs -- Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Media Print AutoFill Options

Address Go Links

Google Search Web 120 blocked AutoFill Options

INCREASING YOUR MOBILITY... AND QUALITY OF LIFE

[Home](#) | [Products](#) | [Insurance Qualification](#) | [Cost](#) | [Submit Info](#)

Call today to see if you qualify—toll-free (866) 332-XXXX

Cost for an Electric Wheelchair

Payment by Insurance through Medicare


When an individual is interested in getting an electric wheelchair, costs become a primary issue. What many people don't realize is that Medicare and some private insurance companies cover 80% of the cost of an electric wheelchair, and generally most secondary insurance companies will cover the remaining 20%. We can even waive the remaining 20% of the cost for those who only have Medicare coverage.

For any insurance company to cover an electric wheelchair, there is a process that has to be completed; insurance has to be verified, paperwork must be completed, and a doctor must sign a prescription.

To make the process easy for you, we will verify your insurance, and prepare the paperwork for your insurance and your doctor. Throughout the process, an appointed Customer Support Professional will work with you. Our goal is to make the process easy for you.

We can even waive the remaining 20% of the cost for those who only have Medicare coverage.

If you do not qualify through your insurance, we will work with you in setting up a payment plan.



Source: Internet Web site.

Note: This advertisement was downloaded from a supplier's Web site on April 24, 2004. The supplier has since withdrawn this advertisement from its Web site.

Appendix IV: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 22 2004

TO: Leslie G. Aronovitz
Director, Health Care - Program
Administration and Integrity Issues
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report, *MEDICARE: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs* (GAO-04-1032)

The Centers for Medicare & Medicaid Services (CMS) would like to thank the GAO for reviewing this area of the Medicare program and making recommendations to assist CMS in further safeguarding the Medicare Trust Funds. This has been an issue of importance to CMS and we have undertaken several efforts to curb the abuse of the power wheelchair benefit in the Medicare Program within the last year alone.

On September 9, 2003, CMS launched a power wheelchair initiative aimed at aggressive review, enforcement, and training of suppliers. On April 28, CMS announced a three-pronged approach focused on coverage, payment, and quality of suppliers of power wheelchairs. And most recently, on August 27, CMS announced a renewed approach to tackling Medicare fraud and abuse in more data-driven, analytical ways. The recommendations made in this report confirm the need for the Agency's newest effort and we look forward to working collaboratively with the GAO in the future to further address Medicare fraud and abuse issues.

Medicare covers power wheelchairs under limited circumstances; specifically, when a beneficiary is 1) bed or chair confined; 2) unable to operate a wheelchair manually; 3) able to safely operate a motorized wheelchair; and 4) usually totally non-ambulatory. Medicare spending on power wheelchairs grew dramatically since 1997, increasing from \$145 million to over \$1.2 billion in 2003. Between 1999 and 2003 spending on power wheelchairs increased more than 300 percent compared to an increase in total Medicare spending of slightly over 11 percent.

Page 2 - Leslie G. Aronovitz

The CMS initially addressed this rapid growth in spending through developing and operationalizing a 10-point plan called "Operation Wheeler Dealer." Operation Wheeler Dealer implemented a coordinated approach to enrolling suppliers, enforcing coverage rules, identifying and prosecuting fraud, and educating suppliers, physicians and beneficiaries. This coordinated approach was designed to assure appropriate payments with little or no impact on access to care.

The CMS appreciates the level of effort that the GAO expended conducting this review. We look forward to working collaboratively with the GAO to protect the Medicare Trust Funds in the future. Attached are CMS' specific comments to GAO's report and recommendations.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the GAO
Draft Report: *MEDICARE: CMS's Program Safeguards Did Not Deter
Growth in Spending for Power Wheelchairs (GAO-04-1032)***

The GAO report states "CMS decreased the total funding for the medical review of claims submitted to the four durable medical equipment (DME) regional carriers by about 22 percent, comparing fiscal year 1999 and fiscal year 2003." Although this may technically be the case, it is important to note that durable medical equipment regional carrier (DMERC) medical review funding steadily increased from fiscal year 1999-2002. Beginning in 2002 there was a decrease in funding as a result of CMS' decision to move work to the Region A DMERC program safeguard contractor and as a result of the Medicare Integrity Program funding being held static since 2003, as prescribed in legislation. The CMS continues to request additional funding for future Medicare Integrity Program efforts.

GAO Recommendation

CMS should develop a process within CMS to focus on trends in Medicare spending and disproportionate or suspicious Medicare payments. develop strategies to address the trends that may indicate possible improper payments for DME, and take timely action, when warranted.

CMS Response

The CMS agrees with this recommendation and is building on its current program integrity efforts by implementing new steps to analyze program data and detect improper payments and potential areas of fraud and abuse in the Medicare program quickly and accurately. Our most recent efforts include the recent opening of a Los Angeles satellite office that will focus on identifying fraud and abuse in Southern California, a hot spot for those who would defraud the Medicare program.

GAO Recommendation

CMS should implement a revised CMN that incorporates key elements of power wheelchair coverage criteria to help DME regional carriers properly adjudicate claims.

CMS Response

As the report correctly noted, the revised Certificate of Medical Necessity (CMN) is currently in the clearance process; it is anticipated that it will be available for use in 2005. While we recognize that no form can fully replace the seasoned, clinical review of medical records, the revised CMN will provide useful information to allow a more accurate and timely review of claims.

Page 2 - Attachment

GAO Recommendation

CMS should strengthen the standards for Medicare DME suppliers to include prohibiting certain misleading or abusive marketing practices.

CMS Response

The CMS agrees and is exploring whether or not our current authorities allow us to effectively address direct-to-consumer marketing beyond telephone solicitations. Currently, in the Social Security Act, Congress implemented Section 1834(a)(17) – Prohibition Against Unsolicited Telephone Contacts by Suppliers. If it is determined that CMS cannot reasonably utilize this authority beyond telephone solicitations, we would consider requesting a legislative remedy that would aid CMS in pursuing an amendment to the supplier standards. It is our intentions to further delineate appropriate marketing practices by DME Suppliers to Medicare beneficiaries.

GAO Recommendation

In addition to conducting the currently required initial and re-enrollment site visits, CMS should direct the NSC to routinely conduct out-of-cycle site visits to suppliers that are suspected of billing improperly and to maintain data on these visits and their results.

CMS Response

The CMS agrees with the recommendation, and has already taken steps to implement this recommendation as detailed below.

The National Supplier Clearinghouse (NSC) initiated out-of-cycle on-site reviews in the summer of 2003 and found this to be an effective practice. During this time, over 600 suppliers received out-of-cycle site inspections that resulted in finding 306 suppliers out of compliance with the supplier standards. As a result of this increased action, the number of revocations processed by the NSC almost doubled over a period of only four months. The NSC has continued this practice with field reviews in fiscal year 2004, conducting over 400 out-of-cycle site inspections targeted specifically at high volume, non-chain suppliers. These suppliers have been identified through our data analysis as those who have submitted claims in the top five policy groups, or suppliers that have common ties to suspected fraudulent billing companies, as well as other suspect suppliers. The CMS has directed the NSC to continue conduct these out-of-cycle reviews in fiscal year 2005.

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