Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE POWER WHEELCHAIR CLAIMS FREQUENTLY DID NOT MEET DOCUMENTATION REQUIREMENTS

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Inspector General

December 2009
OEI-04-07-00401

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which standard and complex rehabilitation power wheelchair claims met Medicare documentation requirements during the first half of calendar year 2007.

BACKGROUND

Medicare beneficiaries are eligible to receive power wheelchairs under Medicare Part B coverage of durable medical equipment. Beneficiaries receive power wheelchairs from suppliers, which bill the Medicare program for reimbursement. The supplier receives the power wheelchair prescription, along with documentation from the beneficiary's medical record to support the power wheelchair's necessity, from the prescribing physician. Based on the prescription, the supplier recommends a specific power wheelchair for the beneficiary. The physician must then review and approve the supplier's recommendation.

Standard power wheelchairs accounted for nearly three-quarters of Medicare's power wheelchair claims and expenditures in the first half of 2007. These power wheelchairs provide basic, daily mobility. Complex rehabilitation power wheelchairs accounted for less than 7 percent of power wheelchair expenditures during the first half of 2007. To receive a complex rehabilitation power wheelchair, the beneficiary's mobility limitation must result from a neurological condition, muscle disease, or skeletal deformity. Complex rehabilitation power wheelchairs can be upgraded with power options and other electronic features to accommodate beneficiaries' mobility needs.

To receive Medicare payment for a power wheelchair, suppliers must meet all documentation requirements included in the power wheelchair Local Coverage Determinations (LCD). The power wheelchair LCDs published by each of Medicare's four Durable Medical Equipment Medicare Administrative Contractors are identical. The LCD requires that suppliers maintain a variety of documents that support the beneficiary's need for, and the appropriateness of, the provided power wheelchair. Specifically, the supplier must have the power wheelchair prescription, supporting documentation from the beneficiary's medical record, the specialty evaluation report, the detailed product description, the home assessment report, and proof of delivery. For many of these documents, the LCD includes requirements related to the documents'

contents and the timeframes within which the supplier should create or receive the documents.

We selected a random sample of 375 claims for standard and complex rehabilitation power wheelchairs supplied to Medicare beneficiaries in the first half of 2007. We then collected documents required by Medicare from the power wheelchair suppliers, determined the extent to which claims met documentation requirements, and projected our results nationally.

FINDINGS

Three out of five claims for standard and complex rehabilitation power wheelchairs did not meet Medicare documentation requirements during the first half of 2007. We found that 60 percent of Medicare claims for standard and complex rehabilitation power wheelchairs that beneficiaries received in the first half of 2007 did not meet one or more documentation requirements. Power wheelchair claims that did not meet all documentation requirements accounted for $112 million in improper Medicare payments, out of $189 million total allowed by Medicare during the 6-month period. Beneficiaries were responsible for paying $22 million of this amount. Power wheelchair claims were more likely to meet some documentation requirements than others. Error rates ranged from 1 percent of claims for which the suppliers did not submit proof of delivery to 40 percent of claims for which the supporting documentation and detailed product descriptions were not submitted or were incomplete. Two out of five power wheelchair claims had multiple errors. In addition, suppliers submitted incomplete documents almost three times as often as they failed to submit required documents. The specialty evaluation report was one of the documents most often not submitted by complex rehabilitation power wheelchair suppliers.

Medicare documentation error rates varied by power wheelchair type and supplier volume during the first half of 2007. Complex rehabilitation power wheelchair claims had a higher documentation error rate (93 percent) than standard power wheelchair claims (58 percent). However, because suppliers provided over 13 times more standard than complex rehabilitation power wheelchairs, documentation errors for standard power wheelchair claims resulted in more improper payments than claims for complex rehabilitation power wheelchairs ($97 million and $15 million, respectively). Standard power

wheelchair claims submitted by low-volume suppliers had a higher documentation error rate (72 percent) than those from high-volume suppliers (55 percent). However, claims that high-volume suppliers submitted accounted for more improper payments than did claims submitted by low-volume suppliers ($77 million and $20 million, respectively).

RECOMMENDATIONS

Power wheelchair suppliers must maintain specific documentation to support beneficiaries' need for the provided power wheelchairs. Medicare policy requires that suppliers and prescribing physicians coordinate to ensure that beneficiaries receive the most appropriate equipment to accommodate their mobility needs.

We found that 60 percent of claims for standard and complex rehabilitation power wheelchairs that beneficiaries received in the first half of 2007 did not meet all Medicare documentation requirements. These claims accounted for $112 million in improper Medicare payments, out of the $189 million total allowed by Medicare. Beneficiaries were responsible for paying $22 million of this amount.

We also found that complex rehabilitation power wheelchair claims had a higher documentation error rate than standard power wheelchair claims. Standard power wheelchair claims submitted by low-volume suppliers had a higher documentation error rate than those from high-volume suppliers.

Based on these findings, we recommend that the Centers for Medicare & Medicaid Services (CMS):

Improve compliance with Medicare's power wheelchair documentation requirements. CMS should consider the following methods for improving compliance:

- conduct additional reviews of power wheelchair claims,
- recover overpayments from suppliers that do not meet documentation requirements and consider further action as appropriate, and
- increase education for suppliers and prescribing physicians about documentation requirements.

Take appropriate action on sampled claims found to be in error.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. CMS noted that it has multiple efforts underway or planned that align with each suggested method to improve compliance with Medicare's power wheelchair documentation requirements. CMS will also forward the sampled claims we found to be in error to the appropriate contractors to identify and recover overpayments. We will forward information on these claims to CMS under separate cover.

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INTRODUCTION

OBJECTIVE

To determine the extent to which standard and complex rehabilitation power wheelchair claims met Medicare documentation requirements during the first half of calendar year 2007.

BACKGROUND

Between 1999 and 2003, Medicare payments for power wheelchairs increased approximately 350 percent, from $259 million to $1.2 billion, while overall Medicare program expenditures rose 28 percent.[1] In 2005 and 2006, the Centers for Medicare & Medicaid Services (CMS) revised its policies related to power wheelchair coverage and coding in response to numerous instances of fraud and abuse and the growth in Medicare power wheelchair expenditures.[2] In 2007, approximately 173,300 Medicare beneficiaries received power wheelchairs, at a total cost of $686 million.[3]

Medicare beneficiaries are eligible to receive power wheelchairs under Medicare Part B coverage of durable medical equipment (DME). Power wheelchairs are medically necessary for beneficiaries who cannot perform mobility-related activities of daily living using other mobility-assistive equipment, such as a cane, manual wheelchair, or power-operated scooter.[4, 5] Most beneficiaries who require power wheelchairs are unable to walk and have severe upper body weakness because of a neurologic or muscular condition.[6]

Medicare beneficiaries receive power wheelchairs from DME suppliers, which bill the Medicare program for reimbursement. The supplier receives the power wheelchair prescription, along with documentation from the beneficiary's medical record to support the power wheelchair's

[1] 71 Fed. Reg. 17021, 17022 (Apr. 5, 2006).

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

[3] Office of Inspector General (OIG) analysis of CMS's claims data, July 2008.

[4] *Medicare National Coverage Determinations Manual*, Section 280.3. Last modified in August 2005.

[5] Based on Medicare's National Coverage Decision for Power Mobility Devices, mobility-related activities of daily living include toileting, feeding, dressing, grooming, and bathing in customary locations within the home.

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

necessity, from the prescribing physician.[7] Based on the prescription, the supplier recommends a specific power wheelchair. The physician must then review and approve the supplier's recommendation.[8]

The beneficiary may choose to rent or purchase the power wheelchair.[9] However, most Medicare beneficiaries choose to purchase power wheelchairs.[10]

To receive reimbursement, suppliers submit claims to Medicare for power wheelchairs using Healthcare Common Procedure Coding System codes (procedure codes). Medicare determines the highest dollar amount that suppliers may be reimbursed for each procedure code (fee schedule amount). Medicare pays 80 percent of the fee schedule amount and the beneficiary is responsible for the remaining 20 percent.

Power Wheelchair Types

Medicare covers more than 650 power wheelchair models. Medicare assigns each model to 1 of Medicare's 42 power wheelchair procedure codes (K0813–K0864).[11] The procedure code assignment is based on the model's performance, patient weight capacity, seat type, portability, and power seating system capability.[12]

Two types of power wheelchairs, standard and complex rehabilitation, accounted for over 80 percent of all Medicare power wheelchair expenditures in the first half of 2007.[13] These are covered by Medicare

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[7] Ibid.

[8] DME Medicare Administrative Contractors in jurisdictions A, B, C, and D, *Local Coverage Determination (LCD) for Power Mobility Devices* (hereinafter referred to as *LCD for Power Mobility Devices*). Available online at http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=23598&lcd_version=18&show=all. Accessed on October 16, 2007.

[9] Ibid. Medicare covers power wheelchairs under a capped rental arrangement. Medicare pays for a maximum of 13 continuous months of rental. Should a beneficiary choose to rent his or her power wheelchair, the supplier must transfer ownership to the beneficiary after the 13th month.

[10] In the first half of 2007, new power wheelchair purchases accounted for 95 percent of all Medicare power wheelchair expenditures. (OIG analysis of 2007 CMS claims data, January 2009.)

[11] Medicare has not assigned power wheelchairs to procedure codes K0817–K0819, K0832–K0834, and K0844–K0847.

[12] Statistical Analysis DME Regional Carrier, *Power Mobility Device Coding Guidelines*, August 3, 2006.

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

under 27 procedure codes, which include 395 power wheelchair models.[14]

Standard power wheelchairs. In the first half of 2007, procedure code K0823 was the most frequently reimbursed power wheelchair type; it accounted for nearly three-quarters of Medicare's power wheelchair claims and expenditures.[15] As of July 2009, Medicare covered 98 power wheelchair models under procedure code K0823.[16] We refer to K0823 power wheelchairs as "standard power wheelchairs" in this report.

Standard power wheelchairs are designed to provide basic, daily mobility for persons weighing less than 300 pounds and feature an automotive-style seat. These power wheelchairs cannot be upgraded with power options (e.g., a powered seating system) or other electronic features (e.g., a device to enable the user to control the chair by sipping and puffing through a straw).[17] Medicare's 2007 fee schedule amount for standard power wheelchairs was $4,024.[18, 19]

Complex rehabilitation power wheelchairs. Medicare payments for complex rehabilitation power wheelchairs accounted for less than 7 percent of power wheelchair claims and expenditures in the first half of 2007.[20] As of July 2009, Medicare covered 297 complex rehabilitation power wheelchair models under 26 procedure codes.[21, 22]

Complex rehabilitation power wheelchairs can be upgraded with power options and other electronic features to accommodate beneficiaries' specific mobility needs.[23] For a beneficiary to receive many types of

[14] Medicare Pricing, Data Analysis, and Coding (PDAC) contractor, *Motorized Wheelchair Product Classification List*, July 16, 2009.

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

[16] Medicare PDAC contractor, op. cit.

[17] *LCD for Power Mobility Devices*, "Code Specific Requirements" and "Definitions."

[18] DME, Prosthetics, Orthotics, and Supplies (DMEPOS) 2007 Fee Schedule.

[19] In January 2009, the fee schedule amount for standard power wheelchairs was reduced by 9.5 percent, to $3,641.

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

[21] DMEPOS Supplier Quality Standards, August 2007, p. 11. Complex rehabilitation procedure codes are K0835–K0843 and K0848–K0864.

[22] Medicare PDAC contractor, op. cit.

[23] *LCD for Power Mobility Devices*, "Code Specific Requirements."

complex rehabilitation power wheelchairs, the beneficiary's mobility limitation must result from a neurological condition, muscle disease, or skeletal deformity.[24] Medicare's 2007 fee schedule amounts for complex rehabilitation power wheelchairs ranged from $4,132 to $11,965.[25, 26]

Medicare Documentation Requirements for Power Wheelchairs

Section 1833(e) of the Social Security Act states in part that "no payment shall be made to any provider . . . unless there has been furnished such information as may be necessary in order to determine the amounts due such provider." The Social Security Act, Code of Federal Regulations, Medicare's National Coverage Decision for Power Mobility Devices, and Medicare's Local Coverage Determinations (LCD) for Power Mobility Devices specify the circumstances under which power wheelchairs are reasonable and necessary.[27, 28] To meet coverage requirements, these guidances require that suppliers maintain a variety of documents that support the beneficiary's need for, and the appropriateness of, the provided power wheelchair.

For any item to be covered by Medicare, it must "meet all . . . applicable Medicare statutory and regulatory requirements."[29] Medicare requires the following documentation to support power wheelchair claims:

- power wheelchair prescription,
- supporting documentation from the beneficiary's medical record (hereinafter "supporting documentation"),
- specialty evaluation report (for complex rehabilitation power wheelchairs only),
- detailed product description,

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[24] *LCD for Power Mobility Devices*, "Indications and Limitations of Coverage and/or Medical Necessity."

[25] DMEPOS 2007 Fee Schedule.

[26] In January 2009, the fee schedule amounts were reduced by 9.5 percent, to between $3,739 and $10,828.

[27] See 42 U.S.C. § 1395m(a)(1)(E)(iv), § 1834(a)(1)(E)(iv) of the Social Security Act, 42 CFR 410.38(c)(2), Medicare's National Coverage Decision for Power Mobility Devices, and *LCD for Power Mobility Devices*. LCDs provide guidance to the public and the medical community within their jurisdictions. CMS requires that the power wheelchair LCDs be the same for each jurisdiction to ensure uniformity for DMEPOS suppliers that operate nationally.

[28] The term "power mobility device" refers to both power wheelchairs and power-operated vehicles, which are commonly referred to as scooters. *LCD for Power Mobility Devices*.

[29] *LCD for Power Mobility Devices*.

- home assessment report, and
- proof of delivery.[30]

Each of these documents is described in more detail below. For many of these documents, the LCD includes requirements related to the documents' contents and the timeframes within which the supplier should create or receive the documents.

Prescription. Medicare requires suppliers to obtain the power wheelchair prescription from the physician who examined the beneficiary.[31, 32] The supplier must receive the prescription within 45 days of the beneficiary's examination date and before delivering the power wheelchair to the beneficiary.[33] Power wheelchair prescriptions must include seven elements:

1. beneficiary name,
2. examination date,
3. diagnoses and conditions that support the claim,
4. item description,
5. expected length of time the beneficiary will need the chair,
6. prescribing physician signature, and
7. prescription date.

[30] The *LCD for Power Mobility Devices* requires all listed documents, other than proof of delivery, which is required by 42 CFR § 424.57(c)(12).

[31] *LCD for Power Mobility Devices*, "Documentation Requirements." In addition to being part of the power wheelchair LCD, this requirement is codified in the Social Security Act at section 1843(a)(1)(E)(iv) and is also found in the regulations issued by CMS at 42 CFR § 410.38(c)(2)(ii).

[32] Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L.No. 108-173, amended the Social Security Act to include section 1834(a)(1)(E)(iv), requiring that a physician or other treating practitioner assess the beneficiary's need for a power wheelchair during a face-to-face examination before writing a prescription. See 42 U.S.C. § 1395m(a)(1)(E)(iv); section 1843(a)(1)(E)(iv) of the Social Security Act. If a specialist, such as a physical or occupational therapist, performs the evaluation, a physician still must review the examination report and sign and date it to meet Medicare requirements. See *LCD for Power Mobility Devices*.

[33] See *LCD for Power Mobility Devices*. The 45-day period does not include the time required by the supplier to provide the power wheelchair to the beneficiary, as time may be required to assemble or adjust it to meet the specific needs of the beneficiary.

The supplier must document the date it receives the prescription using a date stamp or an equivalent method.[34]

Supporting documentation. The supplier must also receive documentation from the prescribing physician that supports the medical necessity for the power wheelchair.[35] The supplier must receive the supporting documentation within 45 days after the physician's examination of the beneficiary and before the power wheelchair's delivery.[36]

The medical record from the beneficiary's examination is often sufficient supporting documentation to demonstrate the medical necessity for the power wheelchair.[37] However, the physician's medical record notes from the examination must clearly indicate that the primary reason for the visit was to assess the beneficiary's need for a power wheelchair. A physician-completed form or letter of attestation may not serve as the supporting documentation. The supplier must document the date it receives the supporting documentation using a date stamp or an equivalent method.[38]

Specialty evaluation report. A beneficiary who receives a complex rehabilitation power wheelchair must receive a specialty evaluation, in addition to the physician's initial examination. The specialty evaluation report must document the medical necessity for the power wheelchair and each recommended option and accessory. A medical professional with experience in rehabilitation power wheelchair evaluations, such as an occupational or physical therapist, must perform the specialty evaluation.[39]

Detailed product description. Based on the physician's prescription, the supplier determines the specific power wheelchair that is appropriate for the beneficiary. The supplier must prepare a detailed product description that lists the specific power wheelchair and all options and accessories. This document should include a procedure code, a

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[34] *LCD for Power Mobility Devices*.

[35] See 42 CFR 410.38(c)(2)(iii); *LCD for Power Mobility Devices*, "Documentation Requirements."

[36] Ibid. The 45-day period does not include the time required by the supplier to provide the power wheelchair to the beneficiary, as additional time may be required to make or adjust it to meet the specific needs of the beneficiary.

[37] Preamble to Final Rule: 42 CFR Part 410.38(c), p. 10.

[38] *LCD for Power Mobility Devices*.

[39] *LCD for Power Mobility Devices*, "Documentation Requirements."

description, a fee schedule amount, and the charge for each item the supplier plans to bill.[40]

The supplier is required to submit the detailed product description for the prescribing physician's approval. The supplier must receive the signed and dated detailed product description from the physician before delivering the power wheelchair to the beneficiary. The supplier must document the date it receives the detailed product description using a date stamp or an equivalent method.

Home assessment report. The supplier must perform an onsite home assessment before or during the power wheelchair's delivery to verify that the beneficiary can adequately maneuver the chair in his or her home. The assessment should consider the home's layout, surfaces, etc. The supplier must maintain a written report of the assessment.[41]

Proof of delivery. The supplier must maintain documentation, such as a delivery slip or an invoice, to show that the power wheelchair was delivered to the beneficiary.[42]

Appendix A contains a summary of Medicare's power wheelchair documentation requirements.

Prior Office of Inspector General Work

OIG has conducted several evaluations of power wheelchairs in the Medicare program.[43] In 2001, OIG evaluated suppliers' compliance with power wheelchair documentation requirements. That report found that over half of reviewed claims paid in 2001 under the most frequently reimbursed procedure code (K0011) at the time were missing documentation, had incomplete documentation, or had documentation that was dated after the claim's date of service. CMS has since revised and added to Medicare's power wheelchair documentation requirements. For example, in 2006, CMS replaced the Certificate of Medical Necessity with the requirement that suppliers obtain the

[40] Ibid. All options and accessories for power wheelchairs are billed as separate items.

[41] Ibid.

[42] 42 CFR § 424.57(c)(12). Proof of delivery is required by one of the 26 application certification standards that every Medicare DMEPOS supplier must meet to obtain and retain its billing privileges.

[43] Department of Health and Human Services (HHS) OIG, *A Comparison of Prices for Power Wheelchairs in the Medicare Program,* OEI-03-03-00460, April 2004; HHS OIG, *Medicare Payments for Power Wheelchairs*, OEI-03-02-00600, April 2004; HHS OIG, *A Comparison of Medicare Program and Consumer Internet Prices for Power Wheelchairs*, OEI-04-07-00160, October 2007.

prescription and supporting documentation from the prescribing physician.[44]

Office of Inspector General Power Wheelchair Evaluation Series

OIG is conducting a series of evaluations of Medicare's payments for power wheelchairs supplied to Medicare beneficiaries in the first half of 2007. In addition to issuing this report, OIG issued separate reports on suppliers' costs to purchase power wheelchairs and the services that suppliers performed in conjunction with providing the chairs, suppliers' costs to purchase power wheelchair batteries, and miscoded power wheelchair claims.[45] OIG also plans to issue a report on the appropriateness (e.g., the medical necessity) of power wheelchair claims. In addition to determining whether beneficiary medical records supported the medical necessity of the power wheelchair, OIG will determine whether documentation from the suppliers and prescribing physicians was consistent.

METHODOLOGY

Scope

This evaluation focused on standard and complex rehabilitation power wheelchairs supplied to Medicare beneficiaries in the first half of 2007. We reviewed documentation for a random sample of 375 standard and complex rehabilitation power wheelchair claims to determine the extent to which the claims met documentation requirements from the LCD for Power Mobility Devices, as well as the proof-of-delivery requirement from Medicare's supplier standards.

We did not perform a medical record review to determine whether the supporting documentation or written report of the specialty evaluation submitted by suppliers supported the medical necessity of the power wheelchairs. In addition, we did not determine whether notes from the beneficiary examinations indicated that mobility examinations were the

[44] Prior to 2005, suppliers were required to submit a Certificate of Medical Necessity with power wheelchair claims. The Certificate of Medical Necessity collected information relating to the equipment ordered from the supplier and information on the beneficiary's medical condition from the prescribing physician. CMS's Medicare Learning Network, *Medicare Coverage of Power Mobility Devices: Power Wheelchairs and Power Operated Vehicles*, April 2006.

[45] HHS OIG, *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009; *Supplier Acquisition Costs for Power Wheelchair Batteries in the Medicare Program* (in progress); and *Miscoded Claims for Power Wheelchairs in the Medicare Program*, OEI-04-07-00403, July 2009.

reason for the visits. Finally, we did not determine whether specialty evaluations were performed by medical professionals with experience in complex rehabilitation power wheelchair evaluations. Appendix A distinguishes between the requirements that we reviewed and those that we did not review.

Sample Selection

Our population consisted of new, nonrental power wheelchair claims from CMS's National Claims History DME Standard Analytical File with dates of service during the first half of 2007.[46] We removed claims associated with suppliers that were inactive or whose billing privileges had been revoked and claims associated with suppliers or prescribing physicians that were under OIG investigation.[47, 48] After removing these claims, the population from which we sampled included 93 percent of standard and 91 percent of complex rehabilitation power wheelchair claims.[49] We grouped the resulting population into three strata:

1. standard power wheelchair claims submitted by low-volume suppliers (those that submitted fewer than 10 standard power wheelchair claims in the first half of 2007),[50]

[46] The final date to submit claims for power wheelchairs that were provided during the first half of 2007 was December 31, 2008. We analyzed claims CMS processed as of June 30, 2007. Suppliers had submitted 79 percent of claims for power wheelchairs that were provided during the first half of 2007 at the time we selected our sample.

[47] We removed claims according to the suppliers' status at the time that we selected the sample.

[48] 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 to the information provided on the enrollment application.

[49] We removed 3,430 standard and 301 complex rehabilitation power wheelchair claims because of the suppliers' Medicare enrollment status or ongoing investigations. After removing these, our population consisted of 43,133 standard and 3,001 complex rehabilitation power wheelchair claims.

[50] We divided the standard power wheelchair population by supplier volume based on the distribution of suppliers and claims. Twenty-five 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.

2. standard power wheelchair claims submitted by high-volume suppliers (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 total claims by selecting simple random samples of 125 claims from each stratum.[51] Appendix B provides the number of claims, amount of Medicare expenditures, and number of suppliers for the population and sample, by stratum.

Data Collection

We asked suppliers to submit the following documents to support their power wheelchair claims: prescription, supporting documentation, specialty evaluation report (for complex rehabilitation chairs only), detailed product description, home assessment report, and proof of delivery. We also requested documentation identifying the dates the supplier received the prescription, supporting documentation, and the detailed product description from the prescribing physician.

Before mailing the documentation requests, we asked representatives of three power wheelchair suppliers to review the request for clarity and familiarity of language. We made changes to the request based on their feedback.

We obtained suppliers' addresses from the National Supplier Clearinghouse data file. We mailed the documentation requests to the power wheelchair suppliers in our sample. We mailed up to three requests and telephoned nonresponding suppliers to ensure they had received the requests. We did not receive responses from suppliers of 11 claims.[52] Of these, the supplier of one claim did not respond, although we were able to verify the supplier's receipt of our request. We considered this claim as lacking documentation and included it in our analysis. We excluded the remaining 10 claims from our sample because we could not contact the suppliers or verify that they received our request. Therefore, we used a total of 365 claims in our analysis, for a response rate of 97 percent.

[51] All evaluations in the current OIG power wheelchair evaluation series use this sample.

[52] We referred suppliers that did not respond to our request to CMS and shared this information with OIG's Office of Investigations.

Data Analysis

We determined whether suppliers submitted the requested documentation for the 365 claims. We reviewed the documentation to determine the extent to which they met Medicare documentation requirements.

Prescription. We identified all claims for which the suppliers submitted prescriptions. For those that did, we determined whether the prescriptions included all seven required elements: beneficiary name, beneficiary examination date, diagnoses and conditions that support the claim, item description, expected length of time the beneficiary will need the chair, prescribing physician signature, and prescription date.

We determined whether suppliers submitted documentation of the dates they received the prescriptions from the prescribing physicians. For claims that had these dates, we determined whether the suppliers received the prescriptions within 45 days after the beneficiary examinations. To make that determination, we compared the dates the suppliers received the prescriptions with the dates of the beneficiaries' examinations (a required element on the prescription). We compared the dates the suppliers received prescriptions with the claims' dates of service to determine whether the suppliers received the prescriptions before the chairs were delivered.

Supporting documentation. We identified all claims for which suppliers submitted supporting documentation from the beneficiaries' medical records. We did not count physician-completed forms or letters of attestation as supporting documentation because Medicare's LCD states that these do not substitute for the beneficiaries' medical records.

We determined whether suppliers submitted documentation of the date they received the supporting documentation from the prescribing physicians. For claims that had these dates, we determined whether the suppliers received the supporting documentation within 45 days after the beneficiary examinations using the same approach as for the prescriptions.

Specialty evaluation report. We identified complex rehabilitation power wheelchair claims for which the suppliers submitted specialty evaluation reports.

Detailed product description. We identified all claims for which the suppliers submitted detailed product descriptions. We determined whether the detailed product description listed the specific power

wheelchair base and all options and accessories for which the supplier billed Medicare. For each item the supplier billed, we determined whether the detailed product description included a procedure code, description, Medicare fee schedule amount, and supplier charge.

We determined whether the prescribing physician approved the detailed product description by signing and dating it before the power wheelchair was delivered to the beneficiary. We also determined whether suppliers submitted documentation of the dates they received the detailed product descriptions from the prescribing physicians.

Home assessment report. We identified all claims for which the suppliers submitted home assessment reports. We determined whether the home assessment was performed before or during the chair's delivery. We also determined whether the home assessment report addressed the physical layout of the beneficiary's home.

Proof of delivery. We identified all claims for which the suppliers submitted proof of delivery.

We identified all claims that did not meet one or more of the documentation requirements that we reviewed. We also distinguished between "document not submitted" errors and "incomplete document" errors. We considered a document to be incomplete if it did not meet all Medicare requirements (for example, if it was missing a required piece of information or was not received within the required timeframe). We projected error rates for these claims and compared the error rates by standard versus complex rehabilitation power wheelchairs and, for standard power wheelchairs, by supplier volume.[53]

For claims that had errors, we calculated the expenditures (improper payments) using Medicare-allowed amounts from the National Claims History data.

Limitations

We did not review claims' compliance with all the requirements from Medicare's LCD for Power Mobility Devices. For example, we did not determine whether the supporting documentation or written report of the specialty evaluation supported the medical necessity of the chair. Therefore, our results may underestimate the documentation-related error rate.

[53] We used SAS and SUDAAN survey data analysis software to project our sample results nationally.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

Three out of five claims for standard and complex rehabilitation power wheelchairs did not meet Medicare documentation requirements during the first half of 2007

Sixty percent of claims for standard and complex rehabilitation power wheelchairs that Medicare beneficiaries received during the first half of 2007 did not meet one or more documentation requirement.[54] Medicare requires suppliers to obtain a variety of documents that support the beneficiary's need for, and the appropriateness of, the provided power wheelchairs. Suppliers must also have proof of the power wheelchair's delivery. Claims that did not meet all documentation requirements accounted for $112 million in improper Medicare payments, out of $189 million total allowed by Medicare during the 6-month period. Beneficiaries were responsible for paying $22 million of this amount.

Standard and complex rehabilitation power wheelchair claims were more likely to meet some documentation requirements than others. Two out of five power wheelchair claims had multiple errors. In addition, suppliers submitted incomplete documents almost three times as often as they failed to submit required documents. The specialty evaluation report was one of the documents most often not submitted by complex rehabilitation power wheelchair suppliers.

Appendix C presents error rates for requirements related to the documents' contents and the time frames within which the supplier should create or receive the documents (i.e., incomplete documentation errors). Appendix D provides the confidence intervals for estimates of all documentation error rates and associated improper payments.

Standard and complex rehabilitation power wheelchair claims were more likely to meet some documentation requirements than others

Power wheelchair claims varied in the extent to which they did not meet Medicare requirements for the prescription, supporting documentation, specialty evaluation report, detailed product description, home assessment report, and proof of delivery. Error rates ranged from 1 percent of claims for which the suppliers did not submit proof of delivery to 40 percent of claims for which the supporting documentation and detailed product descriptions were not submitted or were incomplete.

[54] Standard power wheelchairs accounted for approximately three-quarters of Medicare power wheelchair expenditures in the first half of 2007. Complex rehabilitation power wheelchairs accounted for 6 percent.

Table 1 presents the error rates for each documentation requirement and in total.

Table 1: Medicare Documentation Error Rates for Standard and Complex Rehabilitation Power Wheelchair Claims, First Half of 2007

Documentation Requirement	Error Rate
Supporting documentation	40%
Detailed product description	40%
Prescription	32%
Specialty evaluation report*	2%
Home assessment report	18%
Proof of delivery	1%
(Overlapping errors)	(73%)
Total	**60%**

* Requirement does not apply to standard power wheelchairs. Thirty percent of complex rehabilitation power wheelchair claims did not meet the specialty evaluation report requirement.

Note: Overlapping errors are subtracted to obtain the total.

Source: OIG analysis of supplier documentation, 2009.

Supporting documentation. Forty percent of power wheelchair claims did not have complete supporting documentation, such as physician notes or test results, from the beneficiaries' medical records. Instead of a Certificate of Medical Necessity, power wheelchair suppliers must obtain documentation from the beneficiary's medical record that clearly supports the medical necessity for the power wheelchair from the prescribing physician.[55] Claims that did not have complete supporting documentation resulted in $75 million in improper payments by Medicare and its beneficiaries.

Although suppliers of only 2 percent of claims did not submit any supporting documentation, suppliers of another 38 percent of claims submitted supporting documentation that did not meet all of Medicare's requirements. For example, the supporting documentation for 20 percent of claims did not include the physician's notes from the beneficiaries' medical records. Instead, these claims were improperly supported by either physician-completed forms or letters of attestation.

In addition, suppliers did not always meet the 45-day requirement. Specifically, suppliers of 9 percent of claims did not receive the

[55] We did not conduct a medical record review to determine whether this documentation supported the medical necessity of the power wheelchairs. OIG plans to issue a separate report on the appropriateness (e.g., the medical necessity) of power wheelchair claims.

documentation within 45 days after the beneficiary's examination and, for 8 percent of claims, suppliers did not receive the documentation before the delivery date. Other claims did not include the date the supplier received the supporting documentation. For those that did, suppliers received the supporting documentation within a median of 7 days after the beneficiary's examination. However, the maximum amount of time was 405 days, approximately 14 months after the examination.

Detailed product description. Forty percent of power wheelchair claims did not have a complete detailed product description. The detailed product description is the supplier's recommendation of the specific power wheelchair and accessories that are appropriate for the beneficiary. The prescribing physician must approve the supplier's recommendation before the chair is provided. Claims with missing or incomplete detailed product descriptions resulted in $74 million in improper payments by Medicare and its beneficiaries.

Although suppliers of 14 percent of claims did not submit a detailed product description, suppliers of another 26 percent of claims submitted detailed product descriptions that did not meet all of Medicare's requirements. Without a complete detailed product description, Medicare claim reviewers cannot determine whether the physician approved the supplier's suggested power wheelchair and accessories before the beneficiary received his or her power wheelchair.

For example, some detailed product descriptions did not include all items for which the supplier billed Medicare.[56] In addition, detailed product descriptions did not always include the date the supplier received the document from the prescribing physician, and others were received by the supplier after the chair's delivery. Finally, detailed product descriptions were not always signed and dated by the prescribing physician.

Prescription. Thirty-two percent of power wheelchair claims did not have a complete prescription. These claims resulted in $60 million in improper payments by Medicare and its beneficiaries.

Although suppliers of all but 1 percent of claims submitted the power wheelchair prescription, suppliers of 31 percent of claims submitted

[56] For each billed item, the supplier must include the procedure code, description, Medicare fee schedule amount, and supplier's charge.

prescriptions that did not meet all of Medicare requirements. For example, 16 percent of prescriptions did not include all seven required elements, such as the date of the beneficiary's examination and the length of time the beneficiary needed the power wheelchair.

In addition, suppliers did not always meet the 45-day requirement. Specifically, suppliers of 6 percent of claims did not receive the prescription within 45 days after the beneficiary's examination and, for another 6 percent of claims, suppliers did not receive the prescription before the delivery date. Other claims did not include the date the supplier received the prescription. For those that did, suppliers received the prescription within a median of 7 days after the beneficiary's examination. However, the maximum amount of time was 393 days, approximately 13 months after the examination.

Specialty evaluation report. Beneficiaries who receive complex rehabilitation power wheelchairs must receive a specialty evaluation by a medical professional with experience in complex rehabilitation power wheelchair evaluations.[57] Complex rehabilitation power wheelchair claims that were not supported by a written report of the specialty evaluation represented 2 percent of all standard and complex rehabilitation power wheelchair claims.[58] However, these claims represented 30 percent of complex rehabilitation power wheelchair claims. These claims resulted in $5 million in improper payments by Medicare and its beneficiaries.

Home assessment report. Eighteen percent of power wheelchair claims did not have a complete home assessment report. The supplier's home assessment verifies that the beneficiary can adequately maneuver the power wheelchair in his or her home. Claims with missing or incomplete home assessment reports resulted in $34 million in improper payments by Medicare and its beneficiaries.

Although suppliers of 10 percent of claims did not submit a home assessment report, suppliers of another 8 percent of claims submitted home assessment reports that did not meet Medicare's requirements.

[57] The specialty evaluation requirement does not apply to standard power wheelchairs.

[58] We did not conduct a medical record review to determine whether the specialty evaluation report supported the medical necessity of the complex rehabilitation power wheelchairs and their options and accessories. OIG plans to issue a separate report on the appropriateness (e.g., the medical necessity) of claims for power wheelchairs and certain options and accessories supplied with them.

Specifically, suppliers of 3 percent of claims did not evaluate the physical layout of the beneficiary's home in their reports. These suppliers usually submitted a form certifying that a home assessment was conducted but provided little to no information about the home's dimensions, surfaces, or stairways. In addition, suppliers sometimes conducted the home assessment after the delivery of the chair.

Proof of delivery. Suppliers of 1 percent of power wheelchair claims did not submit proof of the chair's delivery to the beneficiary.[59]

Two out of five claims had multiple documentation errors

Thirty-eight percent of power wheelchair claims had multiple documentation errors. Suppliers of claims with multiple errors did not submit required documents and/or submitted incomplete documents. Incomplete documents did not have all required information or were not received within the required timeframe. Claims with multiple documentation errors accounted for $71 million in improper Medicare payments.

Table 2 presents the percentage of claims and improper payments that Medicare allowed, by the number of documents per claim that did not meet Medicare requirements.

Table 2: Number of Medicare Documentation Errors per Power Wheelchair Claim, First Half of 2007

Number of Documents per Claim That Did Not Meet Medicare Requirements	Claims (Percentage)*	Payments Allowed (Millions)
One	22%	$41
Two	13%	$25
Three	16%	$30
More than three	8%	$16
Total	**60%**	**$112**

* Column does not sum because of rounding.

Source: OIG analysis of supplier documentation, 2009.

Suppliers submitted incomplete documents almost three times as often as they did not submit required documents

Suppliers of 20 percent of standard and complex rehabilitation power wheelchair claims did not submit one or more documents required by

[59] We do not report improper payments by Medicare and its beneficiaries for claims that did not have proof of delivery because the confidence interval contained zero.

Medicare. Suppliers of 56 percent of claims submitted one or more incomplete documents. Sixteen percent of claims had both types of error: suppliers failed to submit at least one document and submitted at least one incomplete document.

Table 3 presents the error rates for claims for which the supplier did not submit all required documents and those for which the supplier submitted an incomplete document.

Table 3: Not Submitted and Incomplete Medicare Documentation Error Rates for Power Wheelchair Claims, First Half of 2007

Type of Documentation Error	Error Rate
Supplier did not submit all required documents	20%
Supplier submitted at least one incomplete document	56%
(Overlapping errors: supplier did not submit all required documents and submitted at least one incomplete document)	(16%)
Total	**60%**

Note: Overlapping errors are subtracted to obtain the total.
Source: OIG analysis of supplier documentation, 2009.

The specialty evaluation report was one of the documents most often not submitted by complex rehabilitation power wheelchair suppliers.
Beneficiaries who require complex rehabilitation power wheelchairs typically have mobility limitations that result from a neurological condition, muscle disease, or skeletal deformity; therefore, Medicare requires that these beneficiaries receive a specialty evaluation, in addition to the physician's initial examination. However, suppliers of 30 percent of complex rehabilitation power wheelchair claims did not submit a written report of the beneficiary's specialty evaluation. The specialty evaluation report and detailed product description were the documents suppliers of complex rehabilitation power wheelchairs most often failed to submit.[60]

[60] Suppliers of 22 percent of complex rehabilitation power wheelchair claims did not submit a detailed product description. The differences between these error rates and other complex rehabilitation power wheelchair error rates are significant at the 95-percent confidence level.

Medicare documentation error rates varied by power wheelchair type and supplier volume during the first half of 2007

Complex rehabilitation power wheelchair claims had a higher documentation error rate than standard power wheelchair claims during the first half of 2007. For standard power wheelchairs, claims submitted by low-volume suppliers had a higher error rate than those from high-volume suppliers.

Complex rehabilitation power wheelchair claims had a higher documentation error rate than standard power wheelchair claims

Complex rehabilitation power wheelchair claims met all documentation requirements less frequently than standard power wheelchair claims.[61] Ninety-three percent of complex rehabilitation power wheelchair claims had multiple errors, while 58 percent of standard power wheelchair claims had multiple errors.

Table 4 presents the error rates associated with each documentation requirement for standard and complex rehabilitation wheelchair claims.

Table 4: Comparison of Medicare Documentation Error Rates for Standard and Complex Rehabilitation Power Wheelchair Claims, First Half of 2007

	Error Rate	
Documentation Requirement	Standard Power Wheelchairs	Complex Rehabilitation Power Wheelchairs
Supporting documentation	39%	61%
Detailed product description	38%	61%
Prescription	30%	58%
Specialty evaluation report*	NA	30%
Home assessment report	18%	28%
Proof of delivery	1%	1%
(Overlapping errors)	(68%)	(146%)
Total	**58%**	**93%**

* Requirement does not apply to standard power wheelchairs.
Note: Overlapping errors are subtracted to obtain the total.
Source: OIG analysis of supplier documentation, 2009.

[61] Difference is statistically significant at the 95-percent confidence level.

Complex rehabilitation power wheelchair claims had higher documentation error rates for all requirements, except proof of delivery.[62, 63] In the first half of 2007, suppliers submitted over 13 times more standard than complex rehabilitation power wheelchair claims. The greater number of standard power wheelchair claims strongly influenced the combined error rates and resulted in higher improper payments for standard power wheelchairs than for complex rehabilitation power wheelchairs. Documentation errors for standard power wheelchairs resulted in $97 million in improper payments, while errors for complex rehabilitation power wheelchair claims resulted in $15 million in improper payments.

Standard power wheelchair claims submitted by low-volume suppliers had a higher documentation error rate than those from high-volume suppliers

Standard power wheelchair claims submitted by low-volume suppliers met all documentation requirements less frequently than those submitted by high-volume suppliers.[64] Fifty-five percent of claims submitted by suppliers that provided 10 or more standard power wheelchairs in the first half of 2007 (high-volume suppliers) had multiple errors. Seventy-two percent of claims submitted by suppliers that provided fewer than 10 standard power wheelchairs (low-volume suppliers) had multiple errors.

Table 5 presents the error rates associated with each documentation requirement for high- and low-volume suppliers.

[62] Differences are statistically significant at the 95-percent confidence level.

[63] Complex rehabilitation power wheelchair claims are subject to an additional requirement. The specialty evaluation report requirement does not apply to standard power wheelchair claims.

[64] Difference is statistically significant at the 95-percent confidence level.

Table 5: Comparison of Medicare Documentation Error Rates for Standard Power Wheelchair Claims, by Supplier Volume, First Half of 2007

Documentation Requirement	Error Rate	
	High-Volume Suppliers*	Low-Volume Suppliers
Supporting documentation	36%	51%
Detailed product description	36%	48%
Prescription	29%	37%
Home assessment report	17%	18%
Proof of delivery	1%	3%
(Overlapping errors)	(65%)	(85%)
Total	**55%**	**72%**

* Column does not sum because of rounding.
Note: Overlapping errors are subtracted to obtain the total.
Source: OIG analysis of supplier documentation, 2009.

Because high-volume suppliers provide more standard power wheelchairs than low-volume suppliers, claims submitted by high-volume suppliers accounted for more improper payments for documentation errors than did claims submitted by low-volume suppliers.[65] Documentation errors for standard power wheelchairs resulted in $77 million in improper payments for claims submitted by high-volume suppliers and $20 million for claims submitted by low-volume suppliers.

[65] Eighty-three percent of standard power wheelchairs were supplied by high-volume suppliers in the first half of 2007.

RECOMMENDATIONS

Power wheelchairs provide mobility and independence for hundreds of thousands of Medicare beneficiaries. In 2005 and 2006, CMS revised power wheelchair documentation requirements in response to numerous instances of fraud and abuse and the growth in Medicare power wheelchair expenditures. Power wheelchair suppliers must maintain specific documentation to support beneficiaries' need for the provided power wheelchairs. Medicare policy requires that suppliers and prescribing physicians coordinate to ensure that beneficiaries receive the most appropriate equipment to accommodate their mobility needs.

We found that 60 percent of claims for standard and complex rehabilitation power wheelchairs that beneficiaries received in the first half of 2007 did not meet Medicare documentation requirements. These claims accounted for $112 million in improper Medicare payments, out of the $189 million total allowed by Medicare during the 6-month period. Beneficiaries were responsible for paying $22 million of this amount.

Power wheelchair claims were more likely to meet some documentation requirements than others. Two out of five power wheelchair claims had multiple errors. In addition, suppliers submitted incomplete documents almost three times as often as they failed to submit required documents. The specialty evaluation report was one of the documents most often not submitted by complex rehabilitation power wheelchair suppliers.

We found that complex rehabilitation power wheelchair claims had a higher documentation error rate than standard power wheelchair claims. Standard power wheelchair claims submitted by low-volume suppliers had a higher documentation error rate than those from high-volume suppliers.

Based on these findings, we recommend that CMS:

Improve compliance with Medicare's power wheelchair documentation requirements

CMS should consider the following methods for improving compliance:

- *Conduct additional reviews of power wheelchair claims*. When determining the additional claims to review, CMS should consider that complex rehabilitation power wheelchair claims had a higher documentation error rate than standard power wheelchair claims. In addition, standard power wheelchair claims submitted by low-volume suppliers had a higher documentation error rate than those from high-volume suppliers.

- *Recover overpayments from suppliers that do not meet documentation requirements and consider further action as appropriate*. Suppliers are liable for overpayments when they do not submit documentation to substantiate services billed to the program. CMS should deny claims identified during prepayment reviews that do not meet documentation requirements and recover overpayments for claims identified during postpayment reviews. CMS should also consider investigating suppliers that do not meet documentation requirements.
- *Increase education for suppliers and prescribing physicians about documentation requirements*. While suppliers are ultimately responsible for claims they submit, Medicare requires that suppliers obtain documents and receive approval from the prescribing physicians. Therefore, CMS should consider physicians' awareness of power wheelchair documentation requirements.

Take appropriate action on sampled claims found to be in error
We will forward detailed information on these claims to CMS in a separate transmittal.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. CMS noted that it has multiple efforts underway or planned that align with each suggested method to improve compliance with Medicare's power wheelchair documentation requirements. For example, CMS recently awarded a contract that will involve the review of power wheelchair claims submitted by certain suppliers. Additionally, CMS will instruct DME Medicare Administrative Contractors to determine whether required documentation is present, in addition to determining whether beneficiaries are receiving medically necessary power wheelchairs. Further, CMS stated that it will take appropriate action to recover overpayments from suppliers for claims that do not meet documentation and policy requirements or clinical criteria. CMS also stated that it continues to develop educational materials for suppliers and prescribing providers and expects to disseminate additional information on power wheelchair documentation requirements to both of these groups through open-door forums and calls. Finally, CMS will forward the sampled

claims we found to be in error to the appropriate contractors to identify and recover overpayments. We will forward information on these claims to CMS under separate cover.

We did not make changes to the report based on CMS comments. The full text of CMS's comments appears in Appendix E.

Medicare's Power Wheelchair Documentation Requirements

Document	Description	Requirements
Prescription	Physician's order for a power wheelchair	▪ Supplier must maintain on file ▪ The prescription must include: - beneficiary name - beneficiary examination date - diagnoses and conditions that support the claim - item description - expected length of time the beneficiary will need the chair - prescribing physician's signature - prescription date ▪ 45-day requirement - supplier must have documentation of the date the supplier received the prescription from the physician - prescription must be received by the supplier within 45 days after the beneficiary's examination and before the chair's delivery
Supporting documentation	Documentation that will include pertinent parts of the beneficiary's medical record that support the medical necessity for the power wheelchair	▪ Supplier must maintain on file ▪ Must include beneficiary medical records, such as physician's notes from the beneficiary's examination; forms and attestations are inadequate ▪ 45-day requirement - supplier must have documentation of the date the supplier received the supporting documentation from the physician - supporting documentation must be received by the supplier within 45 days after the beneficiary's examination and before the chair's delivery <u>NOT INCLUDED IN REVIEW:</u> ▪ Must support the medical necessity of the power wheelchair ▪ Notes from the beneficiary examination must indicate that the reason for the visit was a mobility examination
Specialty evaluation report*	Written report of the evaluation by physical or occupational therapist or physician justifying the need for the power wheelchair and all accessories	▪ Supplier must maintain on file <u>NOT INCLUDED IN REVIEW:</u> ▪ Must support the medical necessity of the power wheelchair and all options and accessories ▪ Specialty evaluation must be performed by a medical professional with experience in complex rehabilitation power wheelchair evaluations
Detailed product description	Document showing items that will be billed to Medicare and/or beneficiary	▪ Supplier must maintain on file ▪ Must include for all billed items (power wheelchair and any accessories or power options): - procedure code(s) of all billed items - item description(s) - Medicare fee schedule amount(s) - supplier charge(s) ▪ Supplier must have documentation of date the supplier received the detailed product description from physician ▪ Supplier must receive detailed product description before chair's delivery ▪ Must include prescribing physician's signature and date of physician's signature
Home assessment report	Written report documenting the supplier's assessment of the beneficiary's home environment	▪ Supplier must maintain on file ▪ Assessment must have occurred before or during the chair's delivery ▪ Assessment must address the physical layout of the home
Proof of delivery	Documentation showing the power wheelchair was delivered to the beneficiary	▪ Supplier must maintain on file

* Applies only to complex rehabilitation power wheelchairs.

Source: Medicare Power Mobility Device Local Coverage Determination.

APPENDIX ~ B

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****

* Procedure codes K0835–K0864.

** Suppliers' figures do not sum to totals because of overlap (some suppliers in our sample provided both 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.

APPENDIX ~ C

Incomplete Documentation Error Rates, First Half of 2007		
Document	**Incomplete Documentation Error Description**	**Error Rate**
Supporting documentation	Did not include physician's notes from medical record	20.4%
	No documentation of date supplier received supporting documentation	9.9%
	Included documentation of the date the supplier received the supporting documentation, but the supplier did not receive the supporting documentation within 45 days after the beneficiary examination	9.1%
	Included documentation of the date the supplier received the supporting documentation, but the supplier did not receive the supporting documentation before the delivery date	8.1%
	Overlapping errors	(9.2%)
	Total incomplete documentation	**38.3%**
Detailed product description	Did not include all required information for all billed items	17.1%
	No physician signature	0.4%
	No date of physician signature	0.8%
	No documentation of the date the supplier received the detailed product description from the physician	8.4%
	Included documentation of the date the supplier received the detailed product description, but the supplier did not receive the detailed product description before the delivery date	5.4%
	Overlapping errors	(6.0%)
	Total incomplete documentation	**26.1%**
Prescription	One or more required elements missing	15.9%
	No documentation of the date the supplier received the prescription	9.1%
	Included documentation of the date the supplier received the prescription, but the supplier did not receive the prescription within 45 days after the beneficiary examination	5.5%
	Included documentation of the date the supplier received the prescription, but the supplier did not receive the prescription before the delivery date	5.9%
	Overlapping errors	(5.6%)
	Total incomplete documentation	**30.8%**
Home assessment report	Home assessment was conducted after chair's delivery	6.9%
	Home assessment report did not address the physical layout of the beneficiary's home	2.5%
	Overlapping errors	(1.0%)
	Total incomplete documentation	**8.4%**

Note: Overlapping errors are subtracted to obtain the total.
Source: Office of Inspector General analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Medicare Documentation Error Rates for Standard and Complex Rehabilitation Power Wheelchair Claims, First Half of 2007			
Estimate Description	**Sample Size**	**Point Estimate**	**95-Percent Confidence Interval**
All Power Wheelchairs			
Supporting documentation	365	40.3%	33.6%–47.3%
Detailed product description	365	39.7%	33.1%–46.7%
Prescription	365	32.1%	26.0%–38.9%
Specialty evaluation report**	365	2.0%	1.5%–2.6%
Home assessment report	365	18.2%	13.4%–24.3%
Proof of delivery	365	1.2%	0.4%–3.7%
Overlapping errors	365	(73.1%)	(58.8%–87.4%)
Total errors	**365**	**60.4%**	**53.2%–67.2%**
Standard Power Wheelchairs: All Suppliers			
Supporting documentation	241	38.8%	31.7%–46.3%
Detailed product description	241	38.2%	31.2%–45.8%
Prescription	241	30.2%	23.8%–37.6%
Home assessment report	241	17.5%	12.5%–24.1%
Proof of delivery	241	1.2%	0.4%–4.0%
Overlapping errors	241	(67.8%)	(52.6%–83.2%)
Total errors	**241**	**58.1%**	**50.4%–65.4%**
Complex Rehabilitation Power Wheelchairs			
Supporting documentation	124	61.3%	52.5%–69.4%
Detailed product description	124	60.5%	51.7%–68.6%
Prescription	124	58.1%	49.3%–66.4%
Specialty evaluation report**	124	29.8%	22.5%–38.4%
Home assessment report	124	28.2%	21.1%–36.7%
Proof of delivery	124	0.8%	0.1%–5.4%
Overlapping errors	124	(146.0%)	(124.2%–167.8%)
Total errors	**124**	**92.7%**	**86.7%–96.2%**

** Requirement does not apply to standard power wheelchairs.

Note: Overlapping errors are subtracted to obtain the total.

Source: Office of Inspector General (OIG) analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Medicare Documentation Error Rates for Low- and High-Volume Standard Power Wheelchair Claims, First Half of 2007			
Estimate Description	**Sample Size**	**Point Estimate**	**95-Percent Confidence Interval**
Standard Power Wheelchairs: Low-Volume Suppliers			
Supporting documentation	120	50.8%	41.9%–59.7%
Detailed product description	120	47.5%	38.7%–56.5%
Prescription	120	36.7%	28.5%–45.7%
Home assessment report	120	18.3%	12.4%–26.3%
Proof of delivery	120	3.3%	1.2%–8.6%
Overlapping errors	120	(85.0%)	(64.3%–105.7%)
Total errors	**120**	**71.7%**	**62.9%–79.0%**
Standard Power Wheelchairs: High-Volume Suppliers			
Supporting documentation	121	36.4%	28.2%–45.4%
Detailed product description	121	36.4%	28.2%–45.4%
Prescription	121	28.9%	21.5%–37.7%
Home assessment report	121	17.4%	11.5%–25.3%
Proof of delivery	121	0.8%	0.1%–5.8%
Overlapping errors	121	(64.5%)	(46.5%–82.4%)
Total errors	**121**	**55.4%**	**46.3%–64.1%**

Note: Overlapping errors are subtracted to obtain the total.

Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Improper Payments for Power Wheelchair Claims With Documentation Errors, First Half of 2007

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
All Power Wheelchairs			
Supporting documentation	365	$74,702,894	$62,297,706–$87,108,083
Detailed product description	365	$73,530,908	$61,136,655–$85,925,162
Prescription	365	$59,769,646	$48,047,256–$71,492,036
Specialty evaluation report**	365	$4,695,238	$3,422,965–$5,967,511
Home assessment report	365	$33,971,678	$24,166,707–$43,776,648
Overlapping improper payments	365	($136,894,371)	($110,972,878–$162,815,864)
Total improper payments*	365	$111,962,318	$99,272,522–$124,652,115
Beneficiary's copayment	365	$21,742,270	$19,194,534–$24,290,011
Complex Rehabilitation Power Wheelchairs			
Total improper payments	124	$14,704,007	$13,883,853–$15,524,161
Standard Power Wheelchairs: All Suppliers			
Total improper payments	241	$97,258,311	$84,572,801–$109,943,821
Standard Power Wheelchairs: Low-Volume Suppliers			
Total improper payments	120	$19,803,457	$17,550,837–$22,056,078
Standard Power Wheelchairs: High-Volume Suppliers			
Total improper payments	121	$77,454,854	$64,905,544–$90,004,163

* We do not report improper payments by Medicare and its beneficiaries for claims that did not have proof of delivery because the confidence intervals contain zero. Therefore, improper payments do not add to the total.

** Requirement does not apply to standard power wheelchairs.

Note: Overlapping errors are subtracted to obtain the total.

Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Number of Medicare Documentation Errors per Power Wheelchair Claim, First Half of 2007

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of claims that met all Medicare documentation requirements	365	39.6%	32.8%–46.8%
Percentage of claims with one document that did not meet all Medicare documentation requirements	365	22.2%	16.9%–28.5%
Percentage of claims with two documents that did not meet all Medicare documentation requirements	365	13.4%	9.3%–18.8%
Percentage of claims with three documents that did not meet all Medicare documentation requirements	365	16.4%	11.8%–22.3%
Percentage of claims with more than three documents that did not meet all Medicare documentation requirements	365	8.5%	5.5%–12.9%
Percentage of claims with multiple Medicare documentation errors	365	38.2%	31.7%–45.2%
Improper payments for claims with one document that did not meet all Medicare documentation requirements	365	$40,682,641	$30,244,946–$51,120,336
Improper payments for claims with two documents that did not meet all Medicare documentation requirements	365	$24,873,263	$16,351,987–$33,394,540
Improper payments for claims with three documents that did not meet all Medicare documentation requirements	365	$30,048,940	$20,676,710–$39,421,170
Improper payments for claims with more than three documents that did not meet all Medicare documentation requirements	365	$16,357,474	$9,760,665–$22,954,282
Improper payments for claims with multiple Medicare documentation errors	365	$71,279,677	$59,005,460–$83,553,895

Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Not Submitted and Incomplete Medicare Documentation Error Rates for Power Wheelchair Claims, First Half of 2007			
Estimate Description	**Sample Size**	**Point Estimate**	**95-Percent Confidence Interval**
Supporting Documentation			
Document not submitted	365	2.0 %	0.8%–5.0%
Incomplete documentation	365	38.3%	31.7%–45.3%
Total errors	365	40.3%	33.6%–47.3%
Detailed Product Description			
Document not submitted	365	13.6%	9.7%–18.7%
Incomplete documentation	365	26.1%	20.4%–32.8%
Total errors	365	39.7%	33.1%–46.7%
Prescription			
Document not submitted	365	1.3%	0.8%–2.2%
Incomplete documentation	365	30.8%	24.7%–37.6%
Total errors	365	32.1%	26.0%–38.9%
Home Assessment Report			
Document not submitted	365	9.9%	6.4%–14.8%
Incomplete documentation	365	8.4%	5.2%–13.2%
Total errors	365	18.2%	13.4%–24.3%
Specialty Evaluation Report			
Complex rehabilitation power wheelchair claims for which the supplier did not submit a specialty evaluation report	124	29.8%	22.5%–38.4%
All power wheelchair claims for which the supplier did not submit a specialty evaluation report	365	2.0%	1.5%–2.6%
Proof of Delivery			
Document not submitted	365	1.2%	0.4%–3.7%
All Documents			
At least one document not submitted	365	19.9%	15.1%–25.6%
At least one document incomplete	365	56.5%	49.3%–63.4%
Overlapping errors	365	(15.9%)	(11.1%–20.7%)
Total errors	**365**	**60.4%**	**53.2%–67.2%**
Ratio of claims with incomplete document(s) to claims with document(s) not submitted	365	2.84	2.09–3.60

Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Comparisons of Medicare Documentation Error Rates by Wheelchair Type and Supplier Volume, First Half of 2007

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	P-Value
Comparisons by Wheelchair Type				
Difference in percentage of power wheelchairs for which the supplier did not submit complete supporting documentation	365	22.5%	11.3%–33.7%	0.0001
Difference in percentage of power wheelchairs for which the supplier did not submit a complete detailed product description	365	22.3%	11.0%–33.5%	0.0001
Difference in percentage of power wheelchairs for which the supplier did not submit a complete prescription	365	27.9%	16.8%–38.9%	<0.0001
Difference in percentage of power wheelchairs for which the supplier did not submit a complete home assessment report	365	10.7%	1.0%–20.4%	0.0309
Difference in percentage of power wheelchairs for which the supplier did not submit one or more complete documents	365	34.7%	25.9%–43.4%	<0.0001
Comparisons by Supplier Volume				
Difference in percentage of standard power wheelchairs for which the supplier did not submit complete supporting documentation	241	14.5%	2.0%–26.9%	0.0228
Difference in percentage of standard power wheelchairs for which the supplier did not submit one or more complete documents	241	16.3%	4.3%–28.3%	0.0082

Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Incomplete Medicare Documentation Error Rates, First Half of 2007			
Estimate Description	**Sample Size**	**Point Estimate**	**95-Percent Confidence Interval**
Supporting Documentation			
Did not include physician's notes from medical record	365	20.4%	15.6%–26.1%
No documentation of date supplier received supporting documentation	365	9.9%	6.5%–14.9%
Included documentation of the date the supplier received the supporting documentation, but the supplier did not receive the supporting documentation within 45 days after the beneficiary examination	365	9.1%	5.8%–13.9%
Included documentation of the date the supplier received the supporting documentation, but the supplier did not receive the supporting documentation before the delivery date	365	8.1%	4.9%–13.2%
Overlapping errors	365	(9.2%)	(5.0%–13.4%)
Total incomplete documentation	**365**	**38.3%**	**31.7%–45.3%**
Median number of days for supplier receipt of supporting documentation after beneficiary examination	365	6.8	5.0–10.9
Detailed Product Description			
Did not include all required information for all billed items	365	17.1%	12.5%–22.9%
No physician signature	365	0.4%	0.2%–1.2%
No date of physician signature	365	0.8%	0.4%–1.6%
No documentation of the date the supplier received the detailed product description from the physician	365	8.4%	5.2%–13.3%
Claim included documentation of the date the supplier received the detailed product description but the supplier did not receive the detailed product description before the delivery date	365	5.4%	2.9%–9.8%
Overlapping errors	365	(6.0%)	(2.9%–9.1%)
Total incomplete documentation	**365**	**26.1%**	**20.4%–32.8%**
Prescription			
One or more required elements missing	365	15.9%	11.6%–21.4%
No documentation of the date the supplier received prescription	365	9.1%	5.7%–14.1%
Included documentation of the date the supplier received the prescription, but the supplier did not receive the prescription within 45 days after the beneficiary examination	365	5.5%	3.1%–9.5%
Included documentation of the date the supplier received the prescription, but the supplier did not receive the prescription before the delivery date	365	5.9%	3.3%–10.3%
Overlapping errors	365	(5.6%)	(2.6%–8.5%)
Total incomplete documentation	**365**	**30.8%**	**24.7%–37.6%**
Median number of days for supplier receipt of prescription after beneficiary examination	365	6.6	4.6–12.0

Note: Overlapping errors are subtracted to obtain the total.
Source: OIG analysis of supplier documentation, 2009.

Estimates and Confidence Intervals: Incomplete Medicare Documentation Error Rates, First Half of 2007 (continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Home Assessment Report			
Home assessment was conducted after chair's delivery	365	6.9%	4.0%–11.7%
Home assessment report did not address the physical layout of the beneficiary's home	365	2.5%	1.2%–5.2%
Overlapping errors	365	(1.0%)	(0.0%–2.3%)
Total incomplete documentation	**365**	**8.4%**	**5.2%–13.2%**

Note: Overlapping errors are subtracted to obtain the total.
Source: OIG analysis of supplier documentation, 2009.

APPENDIX ~ E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 19 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements" (OEI-04-07-00401)

Thank you for the opportunity to review and comment on the OIG's draft report, "Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which standard and complex rehabilitation power wheelchair claims met Medicare documentation requirements.

The CMS requires suppliers to maintain specific documentation that supports the beneficiary's need for a power mobility device. The OIG found that 60 percent of claims for standard and complex rehabilitation power wheelchairs did not meet all Medicare documentation requirements. These claims accounted for $112 million in improper payments. The OIG also found complex rehabilitation wheelchairs had a higher documentation error rate than standard power wheelchair claims.

The CMS recognizes the complexity of power wheelchair claims and is committed to continually reviewing and refining its processes to reduce improper payments. We are also committed to ensuring that Medicare contractors follow and apply our policies and documentation requirements while reviewing claims.

The OIG made the following recommendations.

OIG Recommendation

Improve compliance with Medicare's power wheelchair documentation requirements.

Conduct additional reviews of power wheelchair claims.

Page 2 – Daniel R. Levinson

CMS Response

The CMS concurs. CMS has multiple efforts underway to improve compliance. A contract was recently awarded to a Program Safeguard Contractor (PSC) to conduct additional medical review on power mobility device (PMD) claims submitted for payment by certain providers/suppliers. In conducting this additional review, the contractor will review claims in accordance with statute, CMS guidelines and coverage requirements. In addition, the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) are required to conduct surveillance and review of submitted PMD claims through the medical review progressive corrective action process by way of analysis, probe reviews, and follow up reviews (if warranted to do so by questionable billing patterns, etc.).

The CMS will instruct the DME MACs to examine whether beneficiaries are receiving the appropriate wheelchair (standard or complex) based on their clinical condition and if required documentation is present. Additionally, CMS will forward this issue to the Recovery Audit Contractors (RACs). The RACs review Medicare claims on a post payment basis and are tasked with identifying inappropriate payments. While CMS does not mandate the areas for RAC review, we will share this information with them so that they may also review PMD claims submitted after October 1, 2007.

OIG Recommendation

Recover overpayments from suppliers that do not meet documentation requirements and consider further action as appropriate.

CMS Response

The CMS concurs. As the DME MACs and possibly RACs conduct reviews, they will take appropriate action to recover overpayments from suppliers. Longstanding CMS policy requirements state documentation provided for medical review shall support the medical necessity of the items or services rendered. Therefore, in cases where the information submitted does not support the patient's clinical condition and treatment, claims shall be denied and overpayments collected. CMS will continue to direct contractors to follow national instructions in Chapter 3 of the Program Integrity Manual (PIM) that outlines this process. CMS issued a Joint Signature Memorandum/Technical Direction Letter on March 30, 2009 instructing contractors that clinical review judgment may not override statutory, regulatory, ruling, national coverage decision or local coverage decision provisions and that all documentation and policy requirements must be met before clinical review judgments applies.

OIG Recommendation

Increase education for suppliers and prescribing physicians about documentation requirements.

CMS Response

The CMS concurs. CMS is in the process of developing a MLN Matters article on documentation requirements for validating the face to face interview and evidence of the longitudinal medical history supporting the need for power mobility devices to provide another education resource for providers and suppliers. CMS expects that additional education efforts including open door forums and calls with DME suppliers and providers will further educate them on how to properly document and submit claims for payment.

Furthermore, the education policy staff conducted education in March 2009 pertaining to power wheel chair documentation requirements. Specifically, the attached Brochure (last revised March 2009) was marketed through the Centers for Medicare Management's Provider Communications Group's Provider Partnership, Provider-Specific, Regional Office, and Medicare Contractor listservs. We will also update the brochures to ensure they address documentation requirements for PMD devices.

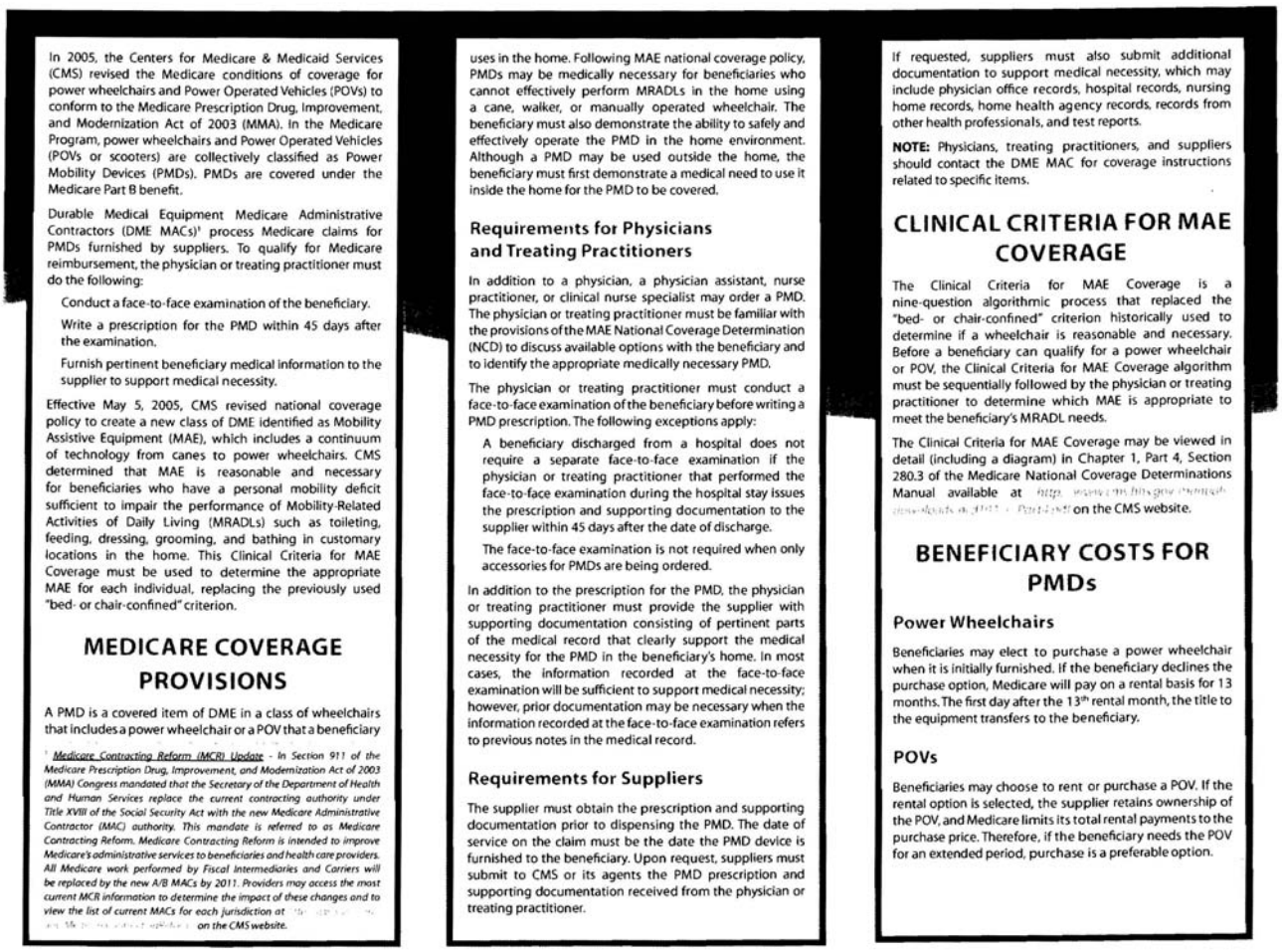
OIG Recommendation

Take appropriate action on sampled claims found to be in error.

CMS Response

The CMS concurs. CMS requests that the OIG share the information on providers/suppliers they believe have billed the Medicare program incorrectly and have been inappropriately paid. CMS will take action to forward the claims the appropriate Medicare contractors to identify and recover overpayments.

Attachment (PMDBrochure07_Quark11.pdf)



In 2005, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare conditions of coverage for power wheelchairs and Power Operated Vehicles (POVs) to conform to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In the Medicare Program, power wheelchairs and Power Operated Vehicles (POVs or scooters) are collectively classified as Power Mobility Devices (PMDs). PMDs are covered under the Medicare Part B benefit.

Durable Medical Equipment Medicare Administrative Contractors (DME MACs)[1] process Medicare claims for PMDs furnished by suppliers. To qualify for Medicare reimbursement, the physician or treating practitioner must do the following:

- Conduct a face-to-face examination of the beneficiary.
- Write a prescription for the PMD within 45 days after the examination.
- Furnish pertinent beneficiary medical information to the supplier to support medical necessity.

Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs. CMS determined that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair the performance of Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. This Clinical Criteria for MAE Coverage must be used to determine the appropriate MAE for each individual, replacing the previously used "bed- or chair-confined" criterion.

MEDICARE COVERAGE PROVISIONS

A PMD is a covered item of DME in a class of wheelchairs that includes a power wheelchair or a POV that a beneficiary uses in the home. Following MAE national coverage policy, PMDs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, or manually operated wheelchair. The beneficiary must also demonstrate the ability to safely and effectively operate the PMD in the home environment. Although a PMD may be used outside the home, the beneficiary must first demonstrate a medical need to use it inside the home for the PMD to be covered.

Requirements for Physicians and Treating Practitioners

In addition to a physician, a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD. The physician or treating practitioner must be familiar with the provisions of the MAE National Coverage Determination (NCD) to discuss available options with the beneficiary and to identify the appropriate medically necessary PMD.

The physician or treating practitioner must conduct a face-to-face examination of the beneficiary before writing a PMD prescription. The following exceptions apply:

- A beneficiary discharged from a hospital does not require a separate face-to-face examination if the physician or treating practitioner that performed the face-to-face examination during the hospital stay issues the prescription and supporting documentation to the supplier within 45 days after the date of discharge.
- The face-to-face examination is not required when only accessories for PMDs are being ordered.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home. In most cases, the information recorded at the face-to-face examination will be sufficient to support medical necessity; however, prior documentation may be necessary when the information recorded at the face-to-face examination refers to previous notes in the medical record.

Requirements for Suppliers

The supplier must obtain the prescription and supporting documentation prior to dispensing the PMD. The date of service on the claim must be the date the PMD device is furnished to the beneficiary. Upon request, suppliers must submit to CMS or its agents the PMD prescription and supporting documentation received from the physician or treating practitioner.

If requested, suppliers must also submit additional documentation to support medical necessity, which may include physician office records, hospital records, nursing home records, home health agency records, records from other health professionals, and test reports.

NOTE: Physicians, treating practitioners, and suppliers should contact the DME MAC for coverage instructions related to specific items.

CLINICAL CRITERIA FOR MAE COVERAGE

The Clinical Criteria for MAE Coverage is a nine-question algorithmic process that replaced the "bed- or chair-confined" criterion historically used to determine if a wheelchair is reasonable and necessary. Before a beneficiary can qualify for a power wheelchair or POV, the Clinical Criteria for MAE Coverage algorithm must be sequentially followed by the physician or treating practitioner to determine which MAE is appropriate to meet the beneficiary's MRADL needs.

The Clinical Criteria for MAE Coverage may be viewed in detail (including a diagram) in Chapter 1, Part 4, Section 280.3 of the Medicare National Coverage Determinations Manual available at [illegible] on the CMS website.

BENEFICIARY COSTS FOR PMDs

Power Wheelchairs

Beneficiaries may elect to purchase a power wheelchair when it is initially furnished. If the beneficiary declines the purchase option, Medicare will pay on a rental basis for 13 months. The first day after the 13th rental month, the title to the equipment transfers to the beneficiary.

POVs

Beneficiaries may choose to rent or purchase a POV. If the rental option is selected, the supplier retains ownership of the POV, and Medicare limits its total rental payments to the purchase price. Therefore, if the beneficiary needs the POV for an extended period, purchase is a preferable option.

[1] *Medicare Contracting Reform (MCR) Update - In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at [illegible] on the CMS website.*

SUMMARY OF BENEFICIARY COSTS

If the beneficiary...	Then Medicare Part B will pay...	And the beneficiary will pay...*
Chooses to purchase the power wheelchair or POV...	80% of the allowed purchase price in one lump sum payment.	20% of the allowed purchase price.
Chooses to rent the power wheelchair...	80% of the allowed rental price for months 1 through 13.	20% of the allowed rental charge.
Chooses to rent the POV...	80% of the allowed rental price. Total Medicare payments cannot exceed 80% of the allowed purchase price.	20% of the allowed rental charge.

*Beneficiary payment responsibility is based upon receiving equipment from a provider that accepts assignment. Beneficiary costs are higher when obtaining wheelchairs from suppliers that do not accept assignment. If the beneficiary is enrolled in a Medicare Managed Care Plan, the beneficiary will need to contact the plan to determine his or her costs. In addition, the managed care plan may require preauthorization and have a limited number of participating DME suppliers.

Note: If the power wheelchair or POV is purchased, Medicare will pay 80% of the allowable service and maintenance charge each time the equipment is actually serviced.

FOR MORE INFORMATION ABOUT PMDs, DME, OR MEDICARE, PLEASE VISIT ONE OF THE FOLLOWING ONLINE REFERENCES:

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at [illegible] on the CMS website.

Medicare Coverage – Mobility Assistive Equipment Web Page

[illegible]

This web page contains links to numerous policy and Q&A documents related to MAE and PMD policy.

Medicare Coverage Database

[illegible]

The Medicare coverage database permits searching of NCDs, LCDs, and DME MAC provider education articles regarding coverage policies.

Medicare Claims Processing Manual – Chapter 20

[illegible]

The Medicare Claims Processing Manual describes the basic billing requirements. Chapter 20 focuses on DME billing.

This brochure was prepared as a service to the public and is not intended to grant rights or impose obligations. This brochure may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

ICN# 006265

Centers for Medicare & Medicaid Services

Overview of Medicare Coverage of Power Mobility Devices (PMDs):

Power Wheelchairs and Power Operated Vehicles (POVs)

[illegible]

CMS

Medicare Learning Network

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne F. Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office.

Sarah Ambrose and Mina Zadeh served as team leaders for this study. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to this report include Peggy Daniel. Berivan Demir, Kevin Farber, and Scott Manley from the central office; Carolyn Kenline from the Boston regional office; and Robert A. Vito from the Philadelphia office also contributed.