

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAID SUPPLIERS FOR
POWER MOBILITY DEVICE CLAIMS
THAT DID NOT MEET
FEDERAL REQUIREMENTS FOR
PHYSICIANS' FACE-TO-FACE
EXAMINATIONS OF BENEFICIARIES**

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January 2015
A-09-12-02068

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

Medicare paid an estimated \$35.2 million in 2010 for suppliers' power mobility device claims that did not meet Federal requirements. Physicians had not conducted the required face-to-face examinations of beneficiaries, or the physicians' medical records did not meet the minimum documentation requirements for face-to-face examinations.

WHY WE DID THIS REVIEW

In calendar year (CY) 2010, Medicare Part B paid durable medical equipment (DME) suppliers approximately \$575.6 million for claims for power mobility devices (PMDs), such as scooters and power wheelchairs. Previous Office of Inspector General (OIG) reviews found that a high percentage of PMD claims were unallowable because they did not comply with Federal requirements. Additional OIG research found that PMD claims without corresponding Part B physician claims were at high risk of being unallowable. For Medicare Part B to pay a DME supplier for a PMD claim, a physician must have conducted a face-to-face examination of the beneficiary to determine the medical necessity of the PMD.

The objective of this review was to determine whether Medicare paid PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries.

BACKGROUND

Federal law and regulations require that before a PMD is covered under Medicare, a physician must conduct and document a face-to-face examination of the beneficiary and write a prescription for the PMD. Generally, the face-to-face examination should be conducted by the same physician who prescribes the PMD and should be billed as an evaluation and management (E&M) service. For most PMDs, the face-to-face examination must have been conducted within 120 days before delivery of the PMD. Additionally, the medical records for the face-to-face examination should, at a minimum, (1) note what the patient's mobility limitation is and how it interferes with the activities of daily living, such as feeding and bathing, and (2) rule out a less expensive alternative to the PMD (i.e., cane, walker, or manual wheelchair).

In 2005, the Centers for Medicare & Medicaid Services (CMS) introduced the optional Healthcare Common Procedure Coding System code G0372 for a physician to establish and document the need for a PMD. The physician who conducts the face-to-face examination may add the G0372 code to the claim when billing the Part B Medicare contractor for the E&M service. (We refer to a physician claim with the G0372 code as a "G-code claim.") Submitting a G-code claim indicates that all information necessary to document the PMD prescription is included in the medical records and that the prescription and supporting documentation have been delivered to the DME supplier. Although the physician is required to conduct a face-to-face examination, the physician is not required to use the G0372 code. In CY 2010, physicians submitted G-code claims when prescribing PMDs only 6 percent of the time.

HOW WE CONDUCTED THIS REVIEW

From the \$575.6 million of paid Medicare claims for PMDs in CY 2010, we removed claims submitted by DME suppliers under investigation (\$66.7 million) and certain other claims, such as those for rental payments, totaling \$17.3 million. (For the purpose of this report, a claim represents a claim line for a PMD.) We matched the remaining PMD claims to physicians' G-code claims and separated the PMD claims into those with and without corresponding G-code claims billed by the same physicians who prescribed the PMDs: (1) From the \$20.2 million in PMD claims with corresponding G-code claims, we randomly selected 100 claims for review, and (2) from the \$471.4 million in PMD claims without corresponding G-code claims, we removed claims that had a corresponding E&M service provided by the prescribing physician within 120 days before delivery of the PMD (totaling \$384 million). We considered the remaining \$87.4 million of PMD claims as high risk, and from these claims we randomly selected 100 claims for review.

We reviewed the claims in both samples to determine whether they complied with Federal requirements for face-to-face examinations of beneficiaries and compared the results to evaluate the effectiveness of the G0372 code in ensuring compliance with those requirements.

WHAT WE FOUND

For PMD claims with corresponding G-code claims, Medicare paid the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Of the 100 sample claims, we reviewed 94 and concluded that all met the requirements. For each of the 94 claims, we contacted the physician and confirmed that he or she conducted the required face-to-face examination and was the same physician who prescribed the PMD. Furthermore, the medical records we reviewed met the minimum documentation requirements. For six claims, the physicians could not be contacted, and we treated these six claims as non-errors.

For PMD claims without corresponding G-code claims, Medicare did not always pay the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Of the 100 sample claims, 53 claims met the requirements, but 47 did not. For the 47 claims, totaling \$115,278, the physicians did not conduct the required face-to-face examinations (19 claims), or the physicians' medical records did not meet the minimum documentation requirements (28 claims). On the basis of physician interviews, we concluded that many physicians were unfamiliar with the G0372 code. After reviewing medical records, we also concluded that many physicians were not aware of the documentation requirements for face-to-face examinations. Furthermore, CMS did not require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims to identify PMD claims that were at high risk of being unallowable. On the basis of our sample results, we estimated that, of the \$87.4 million, Medicare paid approximately \$35.2 million in CY 2010 for PMD claims that did not meet Federal requirements.

Medicare payments for PMD claims with corresponding G-code claims were more likely to have met Federal requirements than PMD claims without corresponding G-code claims. Our findings suggest that Medicare could have saved an estimated \$35.2 million in CY 2010 if (1) CMS had

required physicians to use the G0372 code when prescribing PMDs, (2) physicians had been educated on the use of the G0372 code and the documentation requirements for face-to-face examinations, and (3) CMS had required DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims to identify PMD claims that were at high risk of being unallowable (i.e., those without corresponding G-code claims). These actions would have helped DME Medicare contractors to identify and review suppliers with a large number of high-risk PMD claims and refer, when necessary, suppliers to OIG or CMS for further review or investigation.

WHAT WE RECOMMEND

We recommend that CMS:

- adjust the 47 sample claims representing overpayments of \$115,278 to the extent allowed under the law,
- require physicians to use the G0372 code when prescribing PMDs, and
- require Part B Medicare contractors to educate physicians on the use of the G0372 code and the documentation requirements for face-to-face examinations.

After the second and third recommendations have been implemented, any PMD claims without corresponding G-code claims would be at high risk of overpayment. Therefore, to help realize future savings for Medicare, we recommend that CMS:

- require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims, which would help these contractors to identify and review suppliers with a large number of high-risk PMD claims (i.e., those without corresponding G-code claims) and could have saved an estimated \$35.2 million for the 1-year period we reviewed.

CMS COMMENTS

In written comments on our draft report, CMS partially concurred with our first and fourth recommendations and did not concur with our second and third recommendations. Regarding our first recommendation, CMS stated that upon receiving the overpayment data from OIG, CMS would analyze each overpayment to determine which claims exceeded the CMS recovery threshold and could be collected consistent with its policies and procedures. Regarding our second recommendation, CMS stated that its 3-year demonstration program testing the use of prior authorization for PMDs reduced Medicare expenditures for PMDs and was a better alternative for ensuring accurate payment of PMD claims than requiring use of the G0372 code. Regarding our third recommendation, CMS stated that it did not believe efforts to educate physicians on the use of the G0372 code were appropriate and that the use of prior authorization was the "most ideal method" to ensure that physicians conduct required face-to-face examinations and supply all necessary documentation to suppliers. Regarding our fourth

recommendation, CMS stated that it would encourage the DME Medicare contractors “to add the use of the G-code by physicians to their data analysis of PMD claims.”

OUR RESPONSE

After reviewing CMS’s comments, we maintain that our recommendations are valid. Regarding our first recommendation, we will provide CMS with the requested overpayment data and encourage CMS to recover the identified overpayments in accordance with its policies and procedures. Regarding our remaining recommendations, the results of our audit showed that physicians’ use of the G0372 code strongly indicated that required face-to-face examinations had been conducted and minimum documentation requirements had been met. In addition, a physician’s use of this code substantiated that the physician prescribed the PMD. CMS’s demonstration program allows either physicians or suppliers to submit required documentation for prior authorization of PMDs. Because some of the suppliers in our review provided altered documentation as support for PMD claims, allowing suppliers to submit prior authorization documentation represents a vulnerability to the demonstration program.

Requiring physicians to use the G0372 code when prescribing PMDs and requiring Medicare contractors to educate physicians on the use of this code would lessen the vulnerability to the demonstration program and help identify PMD claims at high risk of overpayment. However, encouraging DME Medicare contractors to analyze G-code claims would not be beneficial if physicians were not required to use the G0372 code. As noted in our report, in CY 2010, physicians submitted G-code claims when prescribing PMDs only 6 percent of the time.

We acknowledge CMS’s statement that the demonstration program reduced Medicare expenditures for PMDs; however, the program may not have been solely responsible for this reduction. Further, we did not verify the merits of CMS’s statements regarding the use and effect of the demonstration program because it was outside the scope of our review.

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INTRODUCTION

WHY WE DID THIS REVIEW

In calendar year (CY) 2010, Medicare Part B paid durable medical equipment (DME) suppliers approximately \$575.6 million for claims for power mobility devices (PMDs), such as scooters and power wheelchairs. Previous Office of Inspector General (OIG) reviews found that a high percentage of PMD claims were unallowable because they did not comply with Federal requirements. Additional OIG research found that PMD claims without corresponding Part B physician claims were at high risk of being unallowable. For Medicare Part B to pay a DME supplier for a PMD claim, a physician or treating practitioner¹ must have conducted a face-to-face examination of the beneficiary to determine the medical necessity of the PMD. (See Appendix A for a list of related OIG reports on Medicare claims for PMDs.)

OBJECTIVE

Our objective was to determine whether Medicare paid PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries.

BACKGROUND

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Medicare Part B covers DME, prosthetics, orthotics, and supplies, which include items such as PMDs, hospital beds, oxygen tents, and medical supplies. To be paid by Medicare, an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or improve the functioning of a malformed body member (the Act, § 1862(a)(1)(A)). The Centers for Medicare & Medicaid Services (CMS) contracted with four DME Medicare administrative contractors (DME Medicare contractors) to process and pay Medicare claims submitted by DME suppliers.

Medicare Part B Coverage of Power Mobility Devices

Before a PMD is covered under Medicare, a physician must conduct and document a face-to-face examination of the beneficiary and write a prescription for the PMD.² During this examination, the physician evaluates the beneficiary to determine the medical necessity of the PMD and, if it is medically necessary, writes a prescription for the PMD. The physician provides to the DME supplier the medical records that support medical necessity.

¹ A physician is a doctor of medicine who is legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (Social Security Act (the Act), § 1861(r)(1)). A treating practitioner is defined as a physician assistant, nurse practitioner, or clinical nurse specialist (42 CFR § 410.38(c)(1)). In this report, references to physicians include treating practitioners.

² The Act, § 1834(a)(1)(E)(iv), and 42 CFR § 410.38(c)(2).

Generally, the face-to-face examination should be conducted by the same physician who prescribes the PMD and should be billed as an evaluation and management (E&M) service. (The claim is submitted to the Part B Medicare contractor.) For most PMDs, the face-to-face examination must have been conducted within 120 days before delivery of the PMD.

Additionally, the medical records for the face-to-face examination should, at a minimum, (1) note what the patient's mobility limitation is and how it interferes with the activities of daily living, such as feeding and bathing, and (2) rule out a less expensive alternative to the PMD (i.e., cane, walker, or manual wheelchair).

Optional G0372 Code for Power Mobility Devices

In 2005, CMS introduced the optional Healthcare Common Procedure Coding System code G0372 for a physician to establish and document the need for a PMD. The physician who conducts the face-to-face examination may add the G0372 code to the claim when billing the Part B Medicare contractor for the E&M service. (We refer to a physician claim with the G0372 code as a "G-code claim.") Submitting a G-code claim³ indicates that all information necessary to document the PMD prescription is included in the medical records and that the prescription and supporting documentation have been delivered to the DME supplier.⁴ Although the physician is required to conduct a face-to-face examination, the physician is not required to use the G0372 code.⁵ In CY 2010, physicians submitted G-code claims when prescribing PMDs only 6 percent of the time.

HOW WE CONDUCTED THIS REVIEW

From the \$575.6 million of paid Medicare claims for PMDs in CY 2010, we removed claims submitted by DME suppliers under investigation (\$66.7 million) and certain other claims, such as claims under review by Medicare's Recovery Audit Contractors, claims related to PMD rental payments, and claims with immaterial amounts (totaling \$17.3 million⁶). (For the purpose of this report, a claim represents a claim line for a PMD.) We matched the remaining PMD claims to physicians' G-code claims and separated the PMD claims into those with and without corresponding G-code claims billed by the same physicians who prescribed the PMDs:

- From the 7,187 PMD claims with corresponding G-code claims, totaling \$20.2 million, we randomly selected 100 PMD claims for review.

³ The physician receives an additional payment from Medicare for adding the G0372 code. This payment amount is approximately \$9 per G-code claim.

⁴ *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, section 30.6.15.4, "Power Mobility Devices (Code G0372)."

⁵ Although CMS guidance states that the physician *must* bill for the E&M service and the G0372 code for the required face-to-face examination (Medicare Learning Network's *Medicare Coverage of PMDs: Power Wheelchairs and Power Operated Vehicles*, effective March 2009), the Federal Register in implementing 42 CFR § 410.38(c) states that physicians *may* bill the add-on G-code G0372 with the E&M code (71 Fed. Reg. 17021, 17022 (April 5, 2006)).

⁶ The \$17.3 million is the total payment amount for the 49,617 claims that we removed.

- From the 164,300 PMD claims without corresponding G-code claims, totaling \$471.4 million, we removed 133,776 PMD claims that had a corresponding E&M service provided by the prescribing physician within 120 days before delivery of the PMD (totaling \$384 million). We considered the remaining \$87.4 million of PMD claims as high risk, and from these claims we randomly selected 100 claims for review.

We reviewed the claims in both samples to determine whether they complied with Federal requirements for face-to-face examinations of beneficiaries and compared the results to evaluate the effectiveness of the G0372 code in ensuring compliance with those requirements.

We contacted the prescribing physician of each PMD to determine whether the physician had conducted the required face-to-face examination and prescribed the PMD. When physicians stated that they had not prescribed the PMDs or could not provide support that they had prescribed the PMDs, we contacted the DME suppliers to obtain medical records and other documentation related to the PMDs.

Additionally, we reviewed physicians' medical records (i.e., physicians' notes and narratives of examinations) to determine whether the records met the minimum requirements for the examination to be considered a face-to-face examination for the purpose of determining the medical necessity of the PMD. However, we did not determine whether the PMD was medically necessary. We requested that a DME Medicare contractor review its PMD claims that we determined did not meet the minimum documentation requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology. Appendixes C and D contain the details of our statistical sampling methodology for PMD claims with and without corresponding G-code claims, respectively. Appendix E contains our sample results for PMD claims with corresponding G-code claims, and Appendix F contains our sample results and estimates for PMD claims without corresponding G-code claims.

FINDINGS

For PMD claims with corresponding G-code claims, Medicare paid the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Of the 100 sample claims, we reviewed 94 and concluded that all met the requirements. For each of the 94 claims, we contacted the physician and confirmed that he or she conducted the required face-to-face examination and was the same physician who prescribed the PMD. Furthermore, the medical records we reviewed met the minimum documentation requirements. For six claims, the physicians could not be contacted, and we treated these six claims as non-errors.

For PMD claims without corresponding G-code claims, Medicare did not always pay the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Of the 100 sample claims, 53 claims met the requirements, but 47 did not. For the 47 claims, totaling \$115,278, the physicians did not conduct the required face-to-face examinations (19 claims), or the physicians' medical records did not meet the minimum documentation requirements (28 claims). On the basis of physician interviews, we concluded that many physicians were unfamiliar with the G0372 code. After reviewing medical records, we also concluded that many physicians were not aware of the documentation requirements for face-to-face examinations. Furthermore, CMS did not require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims to identify PMD claims that were at high risk of being unallowable. On the basis of our sample results, we estimated that, of the \$87.4 million, Medicare paid approximately \$35.2 million in CY 2010 for PMD claims that did not meet Federal requirements.

Medicare payments for PMD claims with corresponding G-code claims were more likely to have met Federal requirements than PMD claims without corresponding G-code claims. Our findings suggest that Medicare could have saved an estimated \$35.2 million in CY 2010 if CMS had, among other actions, required use of the G0372 code.

FEDERAL REQUIREMENTS

A PMD is covered by Medicare if the physician has conducted a face-to-face examination of the beneficiary to determine the medical necessity of the PMD and has written a prescription for the PMD (the Act, § 1834(a)(1)(E)(iv), and 2 CFR § 410.38(c)(2)(i)). A prescription is defined as a written order completed by the physician who conducted the face-to-face examination (42 CFR §§ 410.38(c)(1) and (c)(2)(ii)). Therefore, the physician who conducted the required face-to-face examination should be the same physician who prescribed the PMD. Payment for the required face-to-face examination will be made through the appropriate E&M code corresponding to the history and physical examination of the patient. The optional G0372 code was established to recognize additional physician services and resources required to establish and document the need for the PMD.⁷ Generally, the delivery of the PMD must be within 120 days following the completion of the face-to-face examination (Local Coverage Determination (LCD) for PMDs⁸).

To support the medical necessity of the PMD, the physician must provide documentation of the face-to-face examination to the DME supplier.⁹ The supplier should obtain as much documentation from the patient's medical record as the supplier determines is needed to ensure

⁷ *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, section 30.6.15.4, "Power Mobility Devices (Code G0372)."

⁸ The LCDs for the four DME Medicare contractors (Jurisdictions A through D) are L21271, L27239, L23613, and L23598, respectively.

⁹ Documentation supporting the medical necessity of a PMD includes pertinent parts of the beneficiary's medical record: "for example, history, physical examination, diagnostic tests, summary of findings, diagnoses, treatment plans, and/or other information as may be appropriate" (42 CFR § 410.38(c)(2)(iii)).

that the coverage criterion for an item has been met.¹⁰ The LCDs for PMDs provide guidance to suppliers concerning the documentation requirements for PMDs. According to the LCDs, the minimum requirements that should be met for each PMD are:

- documentation regarding what the patient’s mobility limitation is and how it interferes with the performance of mobility-related activities of daily living, such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home, and
- documentation that rules out a less expensive alternative to the PMD (i.e., cane, walker, or manual wheelchair). A manual wheelchair is ruled out if the patient does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair¹¹ in the home.

POWER MOBILITY DEVICE CLAIMS WITH CORRESPONDING G-CODE CLAIMS MET FEDERAL REQUIREMENTS

For PMD claims with corresponding G-code claims, Medicare paid the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Of the 100 sample claims, we reviewed 94 and concluded that all met the requirements. For each of the 94 claims, we contacted the physician and confirmed that he or she conducted the required face-to-face examination and was the same physician who prescribed the PMD. Furthermore, we reviewed medical records for 30 PMD claims and determined that all 30 met the minimum documentation requirements. For six claims, the physicians could not be contacted, and we treated these six claims as non-errors.

The physician’s submission of a G-code claim indicates that all necessary information to document the PMD prescription is included in the medical record. The prescription, along with the supporting documentation, is delivered to the PMD supplier after the face-to-face examination has been conducted. Our findings suggest that when a supplier’s PMD claim corresponds to a physician’s G-code claim, the physician conducted the required face-to-face examination and prescribed the PMD.

POWER MOBILITY DEVICE CLAIMS WITHOUT CORRESPONDING G-CODE CLAIMS DID NOT ALWAYS MEET FEDERAL REQUIREMENTS

PMD claims without corresponding G-code claims did not always meet Federal requirements for face-to-face examinations of beneficiaries because the physicians did not conduct the required face-to-face examinations (19 claims) or the physicians’ medical records did not meet the minimum documentation requirements (28 claims).

¹⁰ *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, section 5.8, “Supplier Documentation.”

¹¹ An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, and seating options and other appropriate nonpowered accessories.

Face-to-Face Examinations Were Not Always Conducted

Of the 100 PMD claims without corresponding G-code claims, 19 PMD claims (totaling \$57,675) did not meet Federal requirements because the required face-to-face examinations of beneficiaries were not conducted:

- For 13 claims, the beneficiary was not the physician's patient. According to the physicians, they did not conduct the face-to-face examinations or prescribe the PMDs.
- For three claims, although the beneficiary was the physician's patient, the physician did not conduct the face-to-face examination or prescribe the PMD.
- For three claims, although the beneficiary was the physician's patient and the physician prescribed the PMD, the physician did not conduct a face-to-face examination.¹²

The average overpayment amount per claim for the 19 claims was \$3,036. For each claim, we considered the entire paid amount for the PMD an error.

For each of the 19 claims for which the physician did not conduct the face-to-face examination, we attempted to contact the DME supplier that billed for the PMD claim. The DME suppliers for 11 PMD claims could not be contacted because the suppliers were no longer in business.¹³ In some cases, the suppliers had been sanctioned because of a felony conviction or a recommendation by a peer review or quality improvement organization. For the remaining eight PMD claims, we obtained documentation from the DME suppliers and determined the following:

- For six claims, the documentation provided by each supplier was not the physician's documentation or was altered. Specifically, for five claims, each of the physicians confirmed that the documentation, including the physician's signature, was not that of the physician. For the remaining claim, the documentation provided by the supplier included added notes related to a PMD examination that were not in the notes we obtained from the physician. The physician confirmed that the added notes were not in his medical records. (The figure on the following page shows the physician notes provided by the supplier and the sections that were altered.)
- For two claims, the supplier had no documentation of the face-to-face examination.

¹² For one claim, the face-to-face examination was conducted after the delivery date for the PMD.

¹³ Because the physicians stated that they had not prescribed the PMDs and the DME suppliers could not be contacted, we treated these 11 claims as errors.

Figure: Physician Notes Obtained From a Durable Medical Equipment Supplier¹⁴

Physician notes obtained from the physician did not mention a face-to-face examination for a PMD. The physician stated that these sections were not part of his notes.

Patient: [REDACTED]
DOB: [REDACTED]
SSN: [REDACTED]

Date: 08/24/2010 10:15
Provider: [REDACTED]
Encounter: F/U FOLLOW UP- GENERAL AND MOBILITY EVAL

ASSESSMENT

- Working diagnosis of abdominal pain
- Benign essential hypertension
- Urinary tract infection
- Senile dementia

PLAN
FACE TO FACE EVALUATION FOR MOTORIZED WHEELCHAIR
The pt has requested a face to face evaluation for a motorized wheelchair because of her inability to complete adl's in her home. [REDACTED] is having problems completing activities of daily living. The pt cannot complete daily living activities such as bathing, cooking, clothing and using the restroom without the use of a motorized wheelchair. She has upper and lower body ailments that limit her ability to ambulate and cannot get through her day without the use of a power wheelchair. She suffers from Hypertension, Osteoarthritis, and Abnormality of gait. It makes it incredibly hard to complete the daily activities. Due to this the pt is not able to move around without the use of a power wheel chair.
A cane or a walker will not allow the Pt to complete the activities of daily living. This is due to the information listed above. The pt has had recent falls and continues to lose her strength after falls because it takes her so long to recover. She is in need of a power wheelchair to give her some mobility and allow her to get her activities of daily living The Pt does not have the upper body or lower body strength to safely use a cane or a walker and is at high risk of falling and causing more damage to the body.
A manual wheelchair will not allow the pt to maneuver throughout the home to accomplish the activities that the pt needs to sustain daily life. The Pt does not have the upper body strength and is at high risk of danger without the assistance of someone there to push her and watch her every day. The pt cannot propel the wheelchair because of her inability to grab the wheels and propel the wheelchair alone. She needs her family to push her around but she is alone for most of the day. *large* [REDACTED]
The *small* turning radius of a scooter will not be sufficient for the pt needs in the home. A motorized wheelchair would be recommended for [REDACTED] to complete her activities of daily living. The pt is willing and able to use the power wheelchair.

DEPRESSIVE DISORDER NEC
Ariccept 5 MG TABS, 1 every bedtime, 30 days, 2 refills

ESSENTIAL HYPERTENSION BENIGN
Lisinopril 20 MG TABS, twice a day, 30 days, 5 refills

URINARY TRACT INFECTION
Cipro 500 MG TABS, twice a day, 7 days, 0 refills

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Patient can not grip manual wheelchair wheels due to weak UE's and possibility of getting open sore blisters

¹⁴ We redacted personally identifying information.

Table 1 shows the number of claims and suppliers for each issue related to the 19 PMD claims for which face-to-face examinations of beneficiaries were not conducted.

Table 1: Durable Medical Equipment Supplier Issues Related to 19 Power Mobility Device Claims for Which Face-to-Face Examinations Were Not Conducted

Supplier Issue	No. of Claims	No. of Suppliers
Supplier was out of business	11	10
Supplier-provided documentation was not the physician's or was altered	6	4
Supplier provided no documentation of face-to-face examination	2	2
Total	19	16

Our results show that Medicare paid multiple DME suppliers for PMD claims in cases where the physicians did not conduct the required face-to-face examinations of beneficiaries. Furthermore, four suppliers provided documentation that was not the physician's as support for PMD claims in our sample. OIG plans to investigate three suppliers and has referred one supplier to a Medicare contractor.

Minimum Documentation Requirements Were Not Always Met

Of the 100 PMD claims without corresponding G-code claims, 28 PMD claims (totaling \$57,603) did not meet the minimum documentation requirements for the examinations to be considered face-to-face examinations for the purpose of determining the medical necessity of the PMDs. After reviewing the physicians' medical records (i.e., the physicians' notes and narratives of the examinations), we determined the following:

- For 14 claims, the documentation did not indicate why a less expensive alternative (i.e., cane, walker, or manual wheelchair) could not meet the patient's needs.
- For four claims, the documentation did not indicate what the patient's mobility limitation was and how it interfered with the performance of mobility-related activities of daily living in the home.
- For 10 claims, the documentation did not meet both requirements.

The average overpayment amount per claim for the 28 claims was \$2,057. Because we did not determine the medical necessity of a less expensive alternative to the PMD, we did not consider the entire paid amount an error; rather, we adjusted the overpayment amount per claim using the price of a manual wheelchair.¹⁵

¹⁵ We subtracted the weighted average paid amount in CY 2010 for a manual wheelchair from the paid amount for the PMD.

We requested that a DME Medicare contractor review its PMD claims that we determined did not meet the minimum documentation requirements. The contractor confirmed that these claims did not meet one or both of the requirements above and that payment for these PMDs would have been denied if the claims had been reviewed by the contractor's medical staff.

Cause and Effect of Overpayments

The overpayments occurred because DME suppliers submitted claims for PMDs for which physicians had not conducted the required face-to-face examinations of beneficiaries or the medical records did not meet the minimum documentation requirements for face-to-face examinations. On the basis of physician interviews, we concluded that many physicians were unfamiliar with the G0372 code. In addition, after reviewing medical records, we also concluded that many physicians were not aware of the documentation requirements for face-to-face examinations. Finally, CMS did not require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims to identify PMD claims that were at high risk of being unallowable.

When our match of suppliers' PMD claims to physicians' G-code claims identified PMD claims without corresponding G-code claims, the PMD claims reviewed did not always meet the applicable Federal requirements. Thus, if CMS had instructed the DME Medicare contractors to match these claims, the contractors would have been able to identify and review PMD claims without corresponding G-code claims and recovery of the overpayments would have resulted. A DME Medicare contractor we contacted stated that it does not perform this match.

On the basis of our sample results, we estimated that, of the \$87,426,682 paid for PMD claims without corresponding G-code claims, Medicare paid \$35,187,606 for PMD claims that did not meet Federal requirements.

CONCLUSION

Medicare payments for PMD claims with corresponding G-code claims were more likely to have met Federal requirements than PMD claims without corresponding G-code claims. Our findings suggest that Medicare could have saved an estimated \$35,187,606 in CY 2010 if (1) CMS had required physicians to use the G0372 code when prescribing PMDs, (2) physicians had been educated on the use of the G0372 code and the documentation requirements for face-to-face examinations, and (3) CMS had required DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims to identify PMD claims that were at high risk of being unallowable (i.e., those without corresponding G-code claims). These actions would have helped DME Medicare contractors to identify and review suppliers with a large number of high-risk PMD claims and refer, when necessary, suppliers to OIG or CMS for further review or investigation.

RECOMMENDATIONS

We recommend that CMS:

- adjust the 47 sample claims representing overpayments of \$115,278 to the extent allowed under the law,
- require physicians to use the G0372 code when prescribing PMDs,¹⁶ and
- require Part B Medicare contractors to educate physicians on the use of the G0372 code and the documentation requirements for face-to-face examinations.

After the second and third recommendations have been implemented, any PMD claims without corresponding G-code claims would be at high risk of overpayment. Therefore, to help realize future savings for the Medicare program, we recommend that CMS:

- require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims, which would help these contractors to identify and review suppliers with a large number of high-risk PMD claims (i.e., those without corresponding G-code claims) and could have saved an estimated \$35.2 million for the 1-year period we reviewed.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS partially concurred with our first and fourth recommendations and did not concur with our second and third recommendations. CMS's comments are included in their entirety as Appendix G.

CMS COMMENTS

CMS had the following comments:

- Regarding our first recommendation, CMS stated that some of the CY 2010 claims in our review had exceeded or would soon exceed the 4-year claim-reopening period mandated by Federal regulations. CMS stated that upon receiving the overpayment data from OIG, CMS would analyze each overpayment to determine which claims exceeded the CMS recovery threshold and could be collected consistent with its policies and procedures.
- Regarding our second recommendation, CMS stated that in September 2012, it began a 3-year demonstration program testing the use of prior authorization for PMDs in seven States and observed a decrease in expenditures for PMDs in both demonstration and nondemonstration States. CMS stated that it believed that prior authorization was a better

¹⁶ Although requiring physicians to use the G0372 code would cost Medicare approximately \$9 per G-code claim, the savings achieved by preventing overpayments on PMD claims would likely exceed the total additional payments for G-code claims.

alternative for ensuring accurate payment of PMD claims than requiring use of the G0372 code.

- Regarding our third recommendation, CMS stated that it did not believe efforts to educate physicians on the use of the G0372 code were appropriate and that the use of prior authorization was the “most ideal method” to ensure that physicians conduct required face-to-face examinations and supply all necessary documentation to suppliers.
- Regarding our fourth recommendation, CMS stated that although it believes that the use of prior authorization is the appropriate tool to ensure that accurate payments are made to suppliers for PMDs, the DME Medicare contractors conduct data analysis in States where prior authorization is not possible. CMS also stated that it would encourage the DME Medicare contractors “to add the use of the G-code by physicians to their data analysis of PMD claims.”

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS’s comments, we maintain that our recommendations are valid.

Regarding our first recommendation, we will provide CMS with the claim data containing the overpayment information that it requested. We encourage CMS to recover the identified overpayments in accordance with its policies and procedures.

Regarding our remaining recommendations, the results of our audit showed that physicians’ use of the G0372 code strongly indicated that required face-to-face examinations had been conducted and minimum documentation requirements had been met. In addition, a physician’s use of this code substantiated that the physician prescribed the PMD. CMS’s demonstration program allows either physicians or suppliers to submit required documentation for prior authorization of PMDs. Because some of the suppliers in our review provided altered documentation as support for PMD claims, allowing suppliers to submit prior authorization documentation represents a vulnerability to the demonstration program.

Requiring physicians to use the G0372 code when prescribing PMDs and requiring Medicare contractors to educate physicians on the use of this code would lessen the vulnerability to the demonstration program and help identify PMD claims at high risk of overpayment. However, encouraging DME Medicare contractors to analyze G-code claims would not be beneficial if physicians were not required to use the G0372 code. As noted in our report, in CY 2010, physicians submitted G code claims when prescribing PMDs only 6 percent of the time.

We acknowledge CMS’s statement that the demonstration program reduced Medicare expenditures for PMDs; however, the program may not have been solely responsible for this reduction. Further, we did not verify the merits of CMS’s statements regarding the use and effect of the demonstration program because it was outside the scope of our review.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Review of Power Mobility Devices Supplied by Marquis Mobility, Inc.</i>	<u>A-05-10-00042</u>	5/3/2012
<i>Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines</i>	<u>OEI-04-09-00260</u>	7/7/2011
<i>Review of Medicare Payments to D and M Sales, LLC, for Power Mobility Devices for Calendar Years 2006–2008</i>	<u>A-09-10-02005</u>	9/15/2010
<i>Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements</i>	<u>OEI-04-07-00401</u>	12/29/2009
<i>Memorandum Report: Miscoded Claims for Power Wheelchairs in the Medicare Program</i>	<u>OEI-04-07-00403</u>	7/13/2009

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From the \$575.6 million of paid Medicare claims for PMDs in CY 2010, we removed claims submitted by DME suppliers that were under investigation (\$66.7 million) and certain other claims, such as claims under review by Medicare's Recovery Audit Contractors, claims related to PMD rental payments, and claims with immaterial amounts (totaling \$17.3 million¹⁷). (For the purpose of this report, a claim represents a claim line for a PMD.) We matched the remaining PMD claims to physicians' G-code claims and separated the PMD claims into those with and without corresponding G-code claims billed by the same physicians who prescribed the PMDs:

- From the 7,187 PMD claims with corresponding G-code claims, totaling \$20.2 million, we randomly selected 100 PMD claims for review.¹⁸
- From the 164,300 PMD claims without corresponding G-code claims, totaling \$471.4 million, we removed 133,776 PMD claims that had a corresponding E&M service provided by the prescribing physician within 120 days before delivery of the PMD (totaling \$384 million). We considered the remaining 30,524 PMD claims, totaling \$87.4 million, as high risk, and from these claims we randomly selected 100 claims for review.

We reviewed the claims in both samples to determine whether they complied with Federal requirements for face-to-face examinations of beneficiaries and compared the results to evaluate the effectiveness of the G0372 code in ensuring compliance with those requirements.

We did not review the overall internal control structure of the DME suppliers. We focused on those internal controls that were significant to the objective of our audit. In addition, we did not determine whether PMDs were medically necessary.

We conducted our fieldwork from March to September 2013, which included contacting physicians and DME suppliers in 32 States and Puerto Rico.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the LCDs adopted by the DME Medicare contractors;

¹⁷ The \$17.3 million is the total payment amount for the 49,617 claims that we removed.

¹⁸ A G-code claim may have had a date of service before, after, or on the same date of service as the PMD claim.

- obtained from the CMS National Claims History (NCH) files the DME suppliers' Medicare Part B claims for PMDs with delivery dates in CY 2010;
- matched the PMD claims for CY 2010 to Part B claims from the prescribing physicians for CYs 2009 and 2010 in the NCH files to identify the PMD claims with and without corresponding G-code claims;
- created a sampling frame from the NCH data and our data analysis results for PMD claims with corresponding G-code claims and randomly selected a sample of 100 PMD claims (Appendixes C and E);¹⁹
- created a sampling frame from the NCH data and our data analysis results for PMD claims without corresponding G-code claims and also without corresponding claims for E&M services provided by the prescribing physician within 120 days before delivery of the PMD;
- randomly selected a sample of 100 PMD claims without corresponding G-code claims (from the sampling frame described above) to estimate the amount that Medicare paid to suppliers for PMD claims that did not meet the Federal requirements for face-to-face examinations of beneficiaries (Appendixes D and F);
- interviewed prescribing physicians, office managers, and health care professionals²⁰ and reviewed supporting documentation (e.g., beneficiary medical records) to determine whether the prescribing physicians had conducted face-to-face examinations of the beneficiaries before prescribing PMDs and had prescribed the PMDs;
- obtained medical records and other documents from DME suppliers in instances where the physicians stated they had not prescribed the PMDs or could not provide support that they had prescribed the PMDs to confirm that the PMD claims did not meet Federal requirements for face-to-face examinations of beneficiaries;²¹
- reviewed medical records (i.e., physicians' notes and narratives of examinations) to determine whether the PMD claims met the minimum documentation requirements for PMDs;²²

¹⁹ Because we determined that there were no errors, we did not estimate the number and dollar amount of unallowable PMD claims.

²⁰ For six claims, the physicians or the health care facility could not be contacted, and we treated these six claims as non-errors.

²¹ When the supplier of the PMD could not be contacted, we considered the PMD claim to be an error.

²² We reviewed medical records for 30 PMD claims with corresponding G-code claims, and all 30 claims met the minimum documentation requirements. However, we reviewed medical records for 81 of the 100 PMD claims without corresponding G-code claims. We did not review medical records for the remaining 19 PMD claims because there were no medical records for us to review.

- requested that a DME Medicare contractor review its PMD claims that we determined did not meet the minimum documentation requirements to confirm that these claims did not meet the minimum requirements and that the payments for these PMDs would have been denied if the claims had been reviewed by the contractor's medical staff;
- calculated the overpayment amount for each sample claim;²³ and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

²³ For the 19 claims for which the physicians had not conducted the required face-to-face examinations, we disallowed the entire paid amount for the PMD. For the 28 claims that did not meet the minimum documentation requirements, because we did not determine the medical necessity of a less expensive alternative to the PMD, we did not consider the entire paid amount an error; rather, we adjusted the overpayment amount per claim using the price of a manual wheelchair.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY FOR POWER MOBILITY DEVICE CLAIMS WITH CORRESPONDING G-CODE CLAIMS

POPULATION

The population consisted of CY 2010 DME claims for PMDs.²⁴

SAMPLING FRAME

We obtained PMD claim data from the CY 2010 DME NCH database, consisting of 243,559 claims for PMDs that had payments of \$575,677,458. From these claims, we removed a total of 49,617 claims, consisting of:

- 31,488 claims with a payment amount equal to zero;
- 351 claims for PMD maintenance and servicing fees;
- 279 claims related to beneficiaries who received more than 1 PMD in CY 2010;
- 12,245 claims related to PMD rentals;
- 662 claims with a payment amount of less than \$700;
- 739 claims related to physicians' National Provider Identifiers (NPIs) that could not be matched to OIG's Data Warehouse NPI data as of June 4, 2012 (720 claims), physicians with military addresses (14 claims), or physicians with addresses in Canada or Guam (5 claims); and
- 3,853 claims under review by Medicare's Recovery Audit Contractors.

After we removed these claims, the sampling frame consisted of 193,942 claims for PMDs for 193,942 unique beneficiaries in CY 2010.

We then obtained CYs 2009 and 2010 Part B claim data (including payment amounts equal to zero) from NCH for the 193,942 beneficiaries related to the 193,942 PMD claims. Each of the Part B claims was billed by the same physician who prescribed the PMD.

We matched the PMD claims to the G-code claims (paid and zero paid) and determined that 11,892 PMD claims totaling \$34,289,968 had at least 1 corresponding G-code claim that was billed by the same physician who prescribed the PMD. The G-code claim may have had a date of service before, after, or on the same date of service as the PMD claim.

²⁴ A claim may have multiple claim lines. A claim line represents a service (i.e., a PMD or a PMD accessory, such as a battery) on a PMD claim. Because each PMD claim has only one PMD, we refer to the claim line for the PMD as a "claim."

Finally, we removed 4,705 PMD claims totaling \$14,082,631 that were related to DME suppliers under investigation. Therefore, our sampling frame was 7,187 PMD claims totaling \$20,207,337.

SAMPLE UNIT

The sample unit was a CY 2010 PMD claim with a corresponding Part B G0372 claim billed by the same physician who prescribed the PMD.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 PMD claims.

SOURCE OF RANDOM NUMBERS

We used the OIG, Office of Audit Services (OAS), statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE UNITS

To select the sample units, we sorted the items in the frame by the beneficiary Health Insurance Claim number and numbered the items from 1 through 7,187. Using the random numbers generated, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

Because we determined that there were no errors, we did not estimate the dollar amount of unallowable PMD claims.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY FOR POWER MOBILITY DEVICE CLAIMS WITHOUT CORRESPONDING G-CODE CLAIMS

POPULATION

The population consisted of CY 2010 DME claims for PMDs. (For the purpose of this report, a claim represents a claim line for a PMD.)

SAMPLING FRAME

We obtained PMD claim data from the CY 2010 DME NCH database, consisting of 243,559 claims for PMDs that had payments of \$575,677,458. From these claims, we removed a total of 49,617 claims, consisting of:

- 31,488 claims with a payment amount equal to zero;
- 351 claims for PMD maintenance and servicing fees;
- 279 claims related to beneficiaries who received more than 1 PMD in CY 2010;
- 12,245 claims related to PMD rentals;
- 662 claims with a payment amount of less than \$700;
- 739 claims related to physicians' NPIs that could not be matched to OIG's Data Warehouse NPI data as of June 4, 2012 (720 claims), physicians with military addresses (14 claims), or physicians with addresses in Canada or Guam (5 claims); and
- 3,853 claims under review by Medicare's Recovery Audit Contractors.

After we removed these claims, the sampling frame consisted of 193,942 claims for PMDs for 193,942 unique beneficiaries in CY 2010.

We then obtained CYs 2009 and 2010 Part B claim data (including payment amounts equal to zero) from NCH for the 193,942 beneficiaries related to the 193,942 PMD claims. Each of the Part B claims was billed by the same physician who prescribed the PMD.

We matched the PMD claims to the G-code claims (paid and zero paid) and determined that 182,050 PMD claims totaling \$524,075,007 did not have corresponding G-code claims.

We then matched the PMD claims that did not have a corresponding G-code to the Part B claims that contained a Current Procedural Terminology code for an E&M service and determined that 133,776 PMD claims totaling \$384,001,516 had a corresponding E&M service within 120 days before the delivery of the PMD billed by the same physician who prescribed the PMD. We removed these claims, resulting in 48,274 PMD claims totaling \$140,073,491.

Finally, we removed 17,750 PMD claims totaling \$52,646,809 that were related to DME suppliers under investigation. Therefore, our sampling frame was 30,524 PMD claims totaling \$87,426,682.

SAMPLE UNIT

The sample unit was a CY 2010 PMD claim without a corresponding Part B G0372 claim that also did not have a Part B Current Procedural Terminology code for an E&M service provided by the prescribing physician within 120 days before the delivery of the PMD.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 PMD claims.

SOURCE OF RANDOM NUMBERS

We used the OIG/OAS statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE UNITS

To select the sample units, we sorted the items in the frame by the beneficiary Health Insurance Claim number and numbered the items from 1 through 30,524. Using the random numbers generated, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the dollar amount of unallowable PMD claims.

**APPENDIX E: SAMPLE RESULTS FOR POWER MOBILITY DEVICE CLAIMS
WITH CORRESPONDING G-CODE CLAIMS**

Table 2: Sample Results²⁵

No. of Claims in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
7,187	\$20,207,337	100	\$287,422	0	\$0

²⁵ Because we determined that there were no errors, we did not estimate the dollar amount of unallowable PMD claims.

**APPENDIX F: SAMPLE RESULTS AND ESTIMATES FOR POWER MOBILITY
DEVICE CLAIMS WITHOUT CORRESPONDING G-CODE CLAIMS**

Table 3: Sample Results

No. of Claims in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Claims	Value of Unallowable Claims
30,524	\$87,426,682	100	\$290,544	47	\$115,278

**Table 4: Estimated Value of Unallowable PMD Claims
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$35,187,606
Lower limit	28,030,402
Upper limit	42,344,811

APPENDIX G: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

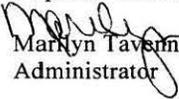
Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: SEP -4 2014

TO: Daniel R. Levinson
Inspector General

FROM: 
Marklyn Tavsmir
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Paid Suppliers for Power Mobility Device Claims That Did Not Meet Federal Requirements for Physicians' Face-to-Face Examinations of Beneficiaries (A-09-12-02068)*

Thank you for the opportunity to review and comment on OIG's draft report titled, "Medicare Paid Suppliers for Power Mobility Device Claims That Did Not Meet Federal Requirements for Physicians' Face-to-Face Examinations of Beneficiaries" (A-09-12-02068).

The OIG's main objective of the audit was to determine whether (1) Medicare paid power mobility device (PMD) claims in accordance with Federal requirements for face-to-face examinations of beneficiaries, and (2) the G0372 code is effective in ensuring compliance with those requirements.

The significance of this issue is evident in the fact that Medicare Part B paid durable medical equipment (DME) suppliers approximately \$575.6 million for claims for PMD in calendar year (CY) 2010. OIG considers a proportion of those PMD claims (\$87.4 million) to be high risk. Of the \$87.4 million, OIG estimated that in CY 2010, Medicare paid \$35.2 million for PMD claims that did not meet Federal requirements.

The OIG determined that Medicare paid the PMD claims with corresponding G-code claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Ninety-four percent of sampled claims met the face-to-face examination and minimum documentation requirements. In contrast, Medicare did not always pay the PMD claims without corresponding G-code claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. Only 53 percent of sampled claims met the face-to-face examination and minimum documentation requirements. Interviews with physicians revealed a basic unfamiliarity with the G0372 code.

The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG invested to produce this analysis. CMS reviewed the report and responded to your recommendations below.

Recommendation 1

Adjust the 47 sample claims representing overpayments of \$115,278 to the extent allowed under the law.

CMS Response

The CMS partially concurs with this recommendation. OIG reviewed claims that had dates of service during calendar year (CY) 2010. Some of the CY 2010 claims have or will soon exceed the 4-year claim reopening period as mandated by 42 CFR 405.980(b)(2). OIG should furnish CMS with the claims data that includes, at a minimum, the provider number, claim payment amount, the correct code for each claim, the overpayment amount, Medicare contractor number, claim paid date, HICN, and claim/document control number. Upon the receipt of the overpayment data from OIG, CMS will analyze each overpayment to determine which claims exceed the CMS recovery threshold and can be collected consistent with agency's policies and procedures.

OIG Recommendation 2

Require physicians to use the G0372 code when prescribing PMDs.

CMS Response

The CMS does not concur with this recommendation. While CMS appreciates the work OIG undertook to complete the audit, the payment of PMD claims has changed since this audit began. In September 2012, CMS began a three year demonstration program testing the use of prior authorization for PMDs in seven states. Since implementation, CMS observed a decrease in expenditures for power mobility devices in the demonstration states and non-demonstration states. Based on claims processed from the inception of the pilot on September 1, 2012 through April 4, 2014, monthly expenditures for the power mobility device codes included in the demonstration decreased from \$20 million in September 2012 to \$6 million in December 2013 in the non-demonstration states and from \$12 million to \$3 million in the demonstration states. CMS also announced in May 2014 that the demonstration will be expanding to 12 additional states beginning October 1, 2014. With this expansion CMS will be using prior authorization in 19 states and CMS believes that suppliers in the non-demonstration states have also changed their behavior because of the use of prior authorization. Based on the initial data from the demonstration CMS believes prior authorization is a better alternative for ensuring accurate payment than the requirement of the G0372 code.

OIG Recommendation 3

Require Part B Medicare contractors to educate physicians on the use of the G0372 code and the documentation requirements for face-to-face examinations.

CMS Response

The CMS does not concur with this recommendation. Based on the results of the PMD Prior Authorization Demonstration, CMS does not believe education efforts to physicians on the use of the G0372 code is appropriate. CMS believes the use of prior authorization is the most ideal method to ensure physicians conduct the face-to-face requirement and supply all necessary documentation to suppliers.

Recommendation 4

Require DME Medicare contractors to match suppliers' PMD claims to physicians' G-code claims, which would help these contractors to identify and review suppliers with a large number of high-risk PMD claims (i.e., those without corresponding G-code claims) and could have saved an estimated \$35.2 million for the 1-year period we reviewed.

CMS Response

The CMS partially concurs with this recommendation. While CMS believes the use of prior authorization is the appropriate tool to ensure accurate payments are made to suppliers for PMDs, the DME Medicare Administrator Contractors do conduct data analysis in states where prior authorization is not possible. This data analysis helps the DME MACs identify outlier claims and/or suppliers for possible review. CMS will encourage the DME MACs to add the use of the G code by physicians to their data analysis of PMD claims.

The CMS thanks the OIG for their efforts on this report and looks forward to continuing to work with the OIG on safeguarding the Medicare program.