S. HRG. 108–601

# TAKING TAXPAYERS FOR A RIDE: FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM

## HEARING

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

APRIL 28, 2004

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# TAKING TAXPAYERS FOR A RIDE: FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM

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**WEDNESDAY, APRIL 28, 2004**

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senator Graham.

## OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. I would call the hearing to order.

I give a special thanks to all the witnesses for participating today, but a special thank you to Rebecca Lewandowski, our first witness.

The purpose of today's hearing is to examine a number of fraudulent schemes and costly and abusive practices that are taking place in the sale of motorized wheelchairs, and that would generally be to Medicare and Medicaid recipients.

However, merely identifying problems is not enough. I want today's hearing to be involved with a first step toward fixing those problems. Accordingly, I am asking each witness today if they would offer solutions based on their own experiences.

Therefore, I would like to ask Mr. Kuhn, who is here today representing the Centers for Medicare and Medicaid Services, to remain at the hearing and listen to each of the witnesses' testimony and recommendations.

I want to make it clear from the start that Medicare and Medicaid fulfill vital responsibilities for our seniors and many others. It is part of the fabric of American society.

It is critical, then, that the Centers for Medicaid Services meet the interests and needs of all these individuals in an effective, efficient, economical, and competent manner. However, at the same time, it is imperative that the interests and expectations of the taxpayers be met as well.

Since the inception of the Medicare and Medicaid programs, the government has reimbursed qualified beneficiaries and recipients for the medical equipment they need to function in Society. Overall,

however, it is fair to say that the system has experienced some serious problems with fraud and abuse over the years.

Now, today we are here once again attempting to address yet another serious problem area for the Centers for Medicare and Medicaid Services: fraud, waste, and abuse involving its reimbursement for power wheelchairs.

We have several power wheelchairs in the room here. One type, the K11, these two here on the right and the second from the right, are the main type of chair purchased by Medicare. We will hear that term come up a lot today, so remember the term K11.

Because of the immense size and cost of Medicare and Medicaid programs, it seems that no fraud in these programs is ever small. Rather, it tends to total in the hundreds of millions of dollars, even billions of dollars.

Today, the General Accounting Office and the Office of Inspector General at the Department of Health and Human Services are here to report on many serious problems they have documented. In fact, the Office of Inspector General is releasing two reports during this hearing.

One of these reports looked at those who are receiving the most commonly provided power wheelchair, again, the K11. For this report, the Office of Inspector General examined a statistically valid sample of those who had received the K11, and found that almost one-third did not meet the requirements to have any type of wheelchair. In fact, the Office of Inspector General found that only 13 percent of those it surveyed actually met the coverage requirements for the K11.

That, I submit, is not a very good batting average, and that would be in any league. The Office of Inspector General also conservatively calculated that, just for calendar year 2001 alone, the over-payments for K11 power wheelchairs totaled an estimated $178 million, and this was when the expenditures for power wheelchairs were less than half what they are today.

Another Office of Inspector General report released today looks at the prices that Medicare pays for the K11 versus the prices that others pay. The conclusion? Despite Medicare's huge size and buying power, it actually pays more for the K11s than do other buyers.

So would you please take a look at the chart over here, at the prices that we have? I think you would see that there is really a problem. Going from bottom to top there, you would see a real difference in price.

So, imagine if the Medicare reimbursement amount was set at prices available to consumers and suppliers, then Medicare and its beneficiaries could have saved over $224 million in 1 year.

If Medicare based its reimbursement amount on the median price offered by wholesalers or the median price that suppliers negotiated with manufacturers and distributors, the program could have saved between $459 million and $586 million. That is just in the year 2002.

None of this makes a whole lot of sense to this Senator, and I do not think that it would make a whole lot of sense to the taxpayers to my State of Iowa, or the other 49 States who have just finished sending much of their hard-earned dollars to Washington during this tax season.

Coupling the Office of Inspector General's findings on price and eligibility, and unfortunately to say, there are a lot of schemes out there that are ripping of Medicare when it comes to power wheelchairs.

Let me turn your attention to a one-minute DVD that we have now that we want to play for you. So, if you would turn down the lights so everybody can see this, I would like to have you pay some attention to it. It is very short, so do not miss anything.

[Whereupon, a DVD was shown.]

The CHAIRMAN. All right. What you see there, is you saw a group of people who were defrauding the Medicare program. The Office of Inspector General, as a part of a sting operation, set up a pole camera—that is why you were looking up above—and called what was a sham storefront, "Durable Medical Equipment Supplier," and told them that the Centers for Medicare and Medicaid Services was going to conduct an on-site visit.

Because it was a sham operation, they needed to bring in supplies like desks, chairs, and DME supplies to pass an on-site review. That is what you just saw there, those trucks pulling up and people quickly filling the storefront so it looked like it was a real business.

Today, we have one witness who has agreed to testify and provide us with a real insider's account of how power wheelchair frauds work. The DVD that you saw is one of the sham DMEs in which she was involved. She has agreed to talk to us candidly about her personal experience in a scam that billed Medicare for $25 million.

Now, I would be remiss if I did not say that most suppliers and most manufacturers are putting in an honest day's work and submitting accurate bills to the Federal Government for payment. They are playing by the rules, and we welcome their assistance in combatting fraud.

The General Accounting Office, as well, has some startling findings to report today. Although CMS has noted that there was a 4-year growth rate of about 450 percent in the expenditures for power wheelchairs, only recently has the CMS finally gotten around to asking why there was that big increase, and then begin to attempt to stop it.

I find it very troubling, especially since GAO reports that CMS was advised about the problem some 6 or 7 years ago, that nothing was done about it until just recently.

Fortunately, the Centers for Medicare and Medicaid Services recently initiated "Operation Wheeler Dealer" in an effort to attack the problem of wheelchair fraud. For that, I am grateful. But rest assured, we will not be waiting another 6 or 7 years for the results of that initiative.

The General Accounting Office also has examined CMS's 10-point initiative unveiled last September to address power wheelchair fraud. I am anxious to hear what the General Accounting Office has to say about that proposal, and I am interested in CMS's response to the findings that were presented by both the General Accounting Office and the Office of Inspector General.

Finally, we will have some thoughtful comments from some skilled professionals and representatives of the disability community and the durable medical equipment industry.

Well, with that opening comment, I want to introduce Mrs. Lewandowski. She is with us today to testify about her extensive inside knowledge of the organization and operation of more than a score of bogus durable medical equipment companies.

She will explain to us how, as a 22-year-old office assistant, she first became involved in the durable medical equipment business, and how she helped set up about 20 sham durable medical equipment companies with no training and little experience.

I thank you for her willingness to share your first-hand insights with us, and I thank you very much for your testimony. We will go immediately to you, Ms. Lewandowski.

**STATEMENT OF REBECCA LEWANDOWSKI, A WITNESS/ DEFENDANT WHO PLEAD GUILTY TO DME FRAUD**

Ms. LEWANDOWSKI. Good morning, Senator. My name is Rebecca Lewandowski. What brings me before you today is my involvement in a massive California-based Medicare fraud ring. Several co-defendants and I are currently waiting sentencing on multiple Federal charges in Phoenix, Arizona.

Please allow me to give you some history of how I became involved with my co-conspirators and their company. My younger brother befriended two young men who already had two durable medical equipment companies established in California and Nevada.

As their friendship grew, so did their desire to expand by recruiting new people to assist in opening additional DME companies in partnership with the two brothers. With promises of wealth and a better life, my brother was enticed into applying for a DME provider number and ultimately billed Medicare for over $2 million.

During the spring of 1998, I was introduced to the Edem brothers, who were looking for clerical assistance in their Long Beach, California office. At that time I was unemployed and was thrilled with the opportunity to work for them.

My duties for the Edem brothers began with completing certificates of medical necessity, delivery tickets, and various insurance-related documents. They said physicians gave them power of attorney to sign on behalf of the doctors, and my responsibilities then escalated to forging physicians' and patients' signatures on thousands of documents for several DME companies, all of which were maintained from our Long Beach office.

I was given the title of office manager and was made the direct contact for our two billers. Through my association with the billers and with the assistance of Medicare-provided manuals and booklets, I was eventually coordinating billing for approximately 20 companies.

The Edems instructed me to bill a specific amount each month, and I achieved the goal. In total, our operation defrauded the Medicare program for $25 million. Within 6 months of my first day of employment, at 24 years old, with no medical experience and totally ignorant of how to operate a legitimate DME operation, I was

the sole proprietor of Mercury Medical Supply located in Klamath Falls, Oregon.

The process by which I obtained a DME provider number was fairly simple. I referred to my brother's already approved application as a guide and simply copied the information onto my own application.

The Edems provided me with $3,000 to rent an office space and to finance other related expenses. In order to approve an application, CMS requires a site surveyor to conduct a surprise inspection of each business location. The site surveyor asks several test questions relating to the DME company.

On the day of inspection for my storefront, the surveyor telephoned me for an appointment. That call gave me ample opportunity to prepare for my surprise visit.

After completing the test questions, the surveyor gave me a copy of the list of questions. That mistake set a precedent for every other site inspection that followed.

During a 2-year period, my storefront billed Medicare $1.158 million. Eighty-four percent of that money was paid to the Edems, 6 percent to the biller, and 10 percent was given to me.

The process of creating sham storefronts was repeated, with new people posing as DME suppliers and obtaining new Medicare provider numbers. The Long Beach operation was responsible for over 20 new companies in California, Oregon, Nevada, Arizona, Utah, and Missouri.

In December of 2001, Federal agents raided the Long Beach office and several homes and discovered six supplier applications for new DME companies in the State of Washington.

Key individuals within our organization that made the operation function properly included marketing persons, billers, physicians, nurses, office support staff, delivery drivers, and Medicare beneficiaries. The goal of each role was to benefit all of our DME companies, working as a single unit.

The marketing persons were from a specific ethnic background, and most were related by blood or through marriage. Their mission was to visit similar ethnic communities to solicit information from Medicare beneficiaries. Often, modestly-priced supplies, such as Ensure or walkers, and less often, cash, were offered in exchange for beneficiary information and for their silence.

Marketing persons exploited the language barrier to manipulate and to deceive non-English speaking beneficiaries into giving them identification cards and Medicare numbers, and were paid between $800 and $1,500 for each name and Medicare number they supplied us with.

We provided each beneficiary a toll-free number for any questions or complaints regarding a Medicare statement. All incoming calls from beneficiaries from every location rang directly to our Long Beach office. Our goal was to satisfy the beneficiary and avoid any complaints of fraudulent activity reaching Medicare.

Some of the mistakes and poor decisions that were made within our organization were of such significance, that we should have been exposed much sooner than we were.

All of our "patients" were of similar ethnic background and resided in the State of California. The same doctors were used re-

peatedly for every company. All paperwork for every company was completed by the same staff and had striking similarities. Less than 5 percent of our patients ever visited a doctor or clinic.

At the height of our operation, we billed Medicare for approximately 100 power wheelchairs each month, but delivered only a tiny fraction of that number.

I received a letter from a fraud analyst representing Medicare that stated that a patient complained about not having received the power wheelchair for which we billed Medicare. Offering no explanation, I mailed a refund check to Medicare and billed another $50,000 the following month.

In many instances, a simple telephone call to either a doctor or a patient could have prevented some of this fraudulent activity.

My experience with the whole process of how these sham storefronts operated has given me several ideas how to improve the system that we easily manipulated. Screening new provider applicants for previous violations and/or convictions could eliminate repeat offenders. More thorough investigations should be performed when a beneficiary complains of having been the victim of fraud.

The site surveyor inspections should always be a surprise and should occur more often. Random calls to doctors and patients will help to identify illegitimate claims.

New DME companies should be restricted to submitting paper claims only, as opposed to electronic submissions. This allows Medicare a closer inspection of a patient's file, which could alert them to suspicious paperwork. Lastly, literature written in several languages could assist and educate minorities about fraud and abuse.

If telling my story sheds more light on this rampant problem and assists you in plugging some of these holes in the Medicare system, my time here has been well spent today, and I thank you.

[The prepared statement of Ms. Lewandowski appears in the appendix.]

The CHAIRMAN. Well, I appreciate, very much, your testimony. I have a few questions I would like to ask you.

Just how difficult would you say it is to set up, run, and get a passing grade from CMS on bogus DME companies, or to set up a bogus DME company?

Ms. LEWANDOWSKI. Well, again, referring to my statement, I was 22 years old. I knew absolutely nothing about the durable medical equipment business. I was completely ignorant to all the workings and how to operate a legitimate company.

Yet, I was able to pass the site inspection easily, and I had my provider number within 2 weeks of that inspection. It was only one time that I ever spoke to anybody, any representative from Medicare, and that was it. It was that simple.

The CHAIRMAN. Based on your own experiences of having gone through one or two CMS on-site reviews, what do you think are the best two or three ways to stop fraud?

Ms. LEWANDOWSKI. Well, again, I will refer back to my statement. I think, first and foremost, there should be a much stricter screening process of anyone who applies for a DME provider number.

I have a very specific example for you that I did not include in my statement, which is a question, very thorough and lengthy, on the Medicare provider application. It was, do you have any relatives, family, or friends that are involved in the Medicare program? For me, the answer obviously have been yes, but the answer on my application was "no."

I find it hard to believe that, in this day in age, this computer era, that a simple reference, typing a last name into a system, could not have alerted anyone to the fact that my brother had just received his provider number not even a year before I applied for my own.

The CHAIRMAN. All right. You referred to an 800 number that was set up.

Ms. LEWANDOWSKI. Yes.

The CHAIRMAN. Why was the 800 number set up?

Ms. LEWANDOWSKI. It was set up in order to field any complaints or calls from a beneficiary. It was listed on top of our delivery ticket or authorization form, which is an insurance-related document, so we could have a chance to appease or make happy these beneficiaries that were complaining of not having received a supply, or we were late, or whatever the reason was so they would not directly call Medicare.

So, oftentimes when we received calls like that, we just solved the problem right then and there by offering more supplies, or money, or whatever it is the patient wanted.

The CHAIRMAN. How much fraud would you say there is in DME, based on what you saw in California? I know it is probably your opinion of how much there is, but any sort of quantification you could give to that would be helpful to us.

Ms. LEWANDOWSKI. Well, Senator, let me begin by saying, after my surrender in California to face these multiple Federal charges that I had against me, I had to leave the State of California. I left immediately. The contacts that I made and the people I knew in that business were a tremendous amount, and I just wanted to be away from that. I did not want to be exposed.

I did not want telephone calls, visits to my home begging for my help, asking for assistance, things of that nature. And I think once you are exposed to those people, which are a lot, it really is hard to disconnect yourself from that group.

So for me, I had to leave the State. I moved away from the area. I made myself inaccessible and unavailable to those people. It is a rampant problem. There are clinics and hospitals, and so many things and different aspects involved in this, and it just comes full circle.

The CHAIRMAN. Do you think that there would be fraud in other States like there is in California?

Ms. LEWANDOWSKI. I can speak for our companies. I know that we had fraudulent DME companies established in several other States other than California, which I think I mentioned in my statement to you.

The CHAIRMAN. One person that we spoke to who owned a DME company told us that he was approached by a nurse in a doctor's office with whom he had an established business relationship, and she demanded $10,000 to continue using his company for DME

supplies for patients. Would that be a surprise to you to hear that sort of thing?

Ms. LEWANDOWSKI. Not at all. Not at all. I do not know if you are aware, but we had a certified, registered nurse working in our location in Long Beach completing doctor's progress notes, different forms of a progress note, using different pens and different handwriting. So, reaching the professionals is not unheard of.

I think that their cooperation is, more often than not, necessary, not only to start doing something like this, but to maintain and to continue doing. Their cooperation is something that you have to have. It is something that we had, and it is something that we needed in order to continue doing what we were doing.

The CHAIRMAN. Well, I thank you for your testimony. Those are all the questions I have.

Now, let me make an announcement before you go, for other witnesses as well. Since other Senators are busy with other things today, they may not come here for questions. You may get questions in writing. I would like to have the staff inform members that may have questions submitted within 5 days, and then we will get them out to whomever to respond to them as quickly as we can. If we can get those back 2 weeks after you receive them, I would appreciate it.

In your case, since you may not have gone through a process like this, my staff would be able to help you with the process of responding to those questions in writing. So, I would want to be helpful to you. I think other witnesses probably would know how to do that.

Thank you very much, Ms. Lewandowski.

Ms. LEWANDOWSKI. I thank you.

The CHAIRMAN. I am going to call the second panel. We start with Hon. Dara Corrigan. She is the Acting Principal Deputy Inspector General at the Department of Health and Human Services, the department that oversees the Medicare and Medicaid programs, among others. She will be describing two reports that are being released today, as well as the results of many criminal investigations her office has been conducting.

Also appearing before us today on this panel is the Honorable Leslie Aronovitz, the Director of Health Care, Program Administration and Integrity Issues at the General Accounting Office.

Leslie's staff has been conducting a series of examinations about the steps taken by CMS and its contractors to identify and respond to improper payments for power wheelchairs, and how the recently passed Medicare prescription drug bill of 2003 may affect CMS's ability to set payment rates for DMEs.

Our third witness is Hon. Herbert Kuhn, Director of the Center of Medicare Management for the Centers for Medicare and Medicaid Services. Mr. Kuhn will discuss the policies, procedures and operations that CMS uses to manage, oversee, and control the approval and oversight of DME companies and the claims processing and payment performed by its contractors.

I will have you go in the way that you were introduced, starting with you, Dara. Thanks to all of you for coming.

**STATEMENT OF DARA CORRIGAN, ACTING PRINCIPAL DEPUTY INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Ms. CORRIGAN. Thank you, and good morning, Mr. Chairman.

The facts are certainly startling. If you look at the amount of money spent on power wheelchairs in 2003, the amount exceeds $1.2 billion. But I think we have to also keep in the back of our minds today that power wheelchairs do have the power to transform the lives of our beneficiaries, so it is important for me and for everyone who works in my office to make sure that the right people are getting wheelchairs, that no one is abusing the system, and that we are getting a fair price for the wheelchairs.

Now, I wish I could say there has not been fraud and abuse, but we have been investigating allegations of fraud in the power wheelchair industry since 1994, and it certainly has not stopped. With a benefit as important as power wheelchairs, we have an obligation to make sure that we stop those who take advantage of the system.

So, today I will describe for you the type of scheme that we have been looking at in the power wheelchair industry. I also want to talk to you about the two inspection reports that we will issue today. You did a very good job of describing the reports, but I will go through them in a little bit more detail and I will describe our work on coverage for power wheelchairs, and pricing for power wheelchairs.

But, first, I would like to talk about the work that our investigators have been doing in the power wheelchair area. As you know, the Medicare program has paid significant amounts of money for power wheelchairs, increasing from $259 million in 1999 to over an estimated $1.2 billion in 2003.

Now, I think it is perhaps simplistic, but I also think it is true, that the greater the amount of money in a particular area, the more people will be inspired to commit fraud and to abuse the system. It is certainly true in the DME area, in general, and it is certainly true in the power wheelchair area, in particular.

We have found fraud occurring in all sorts of ways, from the most blatant where people file claims and never deliver a wheelchair to more creative schemes where people will up-code and bill for power wheelchairs, but give the beneficiary a scooter or a manual wheelchair.

The Medicare program, as you mentioned already, pays for medical equipment for beneficiaries who do not need it at all, and we found an almost sad amount of kick-backs to physicians and nurses who are willing to participate in these schemes by signing certificates of medical necessity like the one you have up there, and other types of documentation.

To show you how blatant these schemes are, I would like to describe one particular investigation that our office conducted. In this case, we were looking at two co-owners of two separate DME suppliers. What they did, was they would go around to beneficiaries. They would almost round them up.

They would round up people and they would bring them to central locations like community centers, particular parts of housing areas, and they would tell them to bring their Medicare numbers

with them. And what they did, was they promised them money for their numbers. A lot of people participated. For amounts as low as $200, they would turn over their Medicare numbers.

In addition, they would take turns posing in wheelchairs. It was fairly creative. The co-owners would put the wheelchairs in different parts of the community center or different parts of the housing development so that Medicare would not be able to tell that it was some type of a scam.

In addition, they would solicit either doctors or nurses to sign the certificates of medical necessity or they would forge them themselves. Now, over a nine-month period they billed Medicare for $5 million and they received $2.3 million out of the $5 million that they billed.

Now, this is a successful case because there was a prosecution and they were sentenced to 87 month, and 54 months, in prison for their roles in submitting fraudulent claims for power wheelchairs.

But I think the ability of these criminals to be creative, to lie blatantly to the government, to set up schemes to use and abuse our beneficiaries is, unfortunately, not one example. We have many examples of that happening.

In our office, we felt it was necessary to also look beyond those types of criminal investigations to see what else was happening in the power wheelchair industry. We wanted to do a study on it to see how many claims actually met the criteria set by Medicare in order to qualify for a power wheelchair.

In one of the reports that I am releasing today, as you have already mentioned, our findings show that a lot, the majority, a lot more than the majority, did not meet the coverage criteria for K11 wheelchairs.

For our review, we randomly sampled, as you said, wheelchairs, and we collected documentation in support of those claims. We hired an independent medical reviewer to look at those claims because we do not want to second-guess the doctors, but we are more than willing to have doctors second-guess doctors. They looked at these claims and they determined that only 13 percent met the coverage criteria for K11 power wheelchairs. Thirteen percent.

Thirty-one percent of the claims reviewed did not meet the coverage criteria for any mobility advice at all. So, as you said, a third of them did not qualify for any type of mobility device. Forty-five percent of the claims did not meet the coverage criteria for the power wheelchair, but they would have met criteria for a less expensive type of wheelchair or scooter.

Clearly, there are problems with the coverage criteria that need to be resolved. Our job in the Office of Inspector General is not to say what should be covered. But what we are saying is that what Medicare has said should be covered is not being covered, by a long shot.

The second report I am releasing today compares Medicare reimbursement amounts for K11 power wheelchairs to purchase prices available to consumers and suppliers. I remember one of my employees coming into my office one day, and he was furious. He said, I have been looking around the Internet. It is easy—it is easy—to get a wheelchair cheaper than Medicare pays. He was outraged. It is outrageous.

When you look at the numbers that you have up here, Medicare is paying excessive prices for these wheelchairs. We found that, even if you look at the most generous of prices, the prices available to consumers, retail prices, Medicare is overpaying. The number that you had up there was about $3,800 for consumers. It is about $5,200 under the Medicare program.

Now, suppliers have better negotiating power and the prices for suppliers are less. But as you have already highlighted, should Medicare's purchasing power not be better than suppliers'? The amounts of money we could save are significant: $224 million, approximately, in 2002 if we even used the supplier Web site number.

I know I am out of time.

The CHAIRMAN. Proceed. I think without more members being here, we have got some more time to take testimony.

Ms. CORRIGAN. I will try to keep it short.

The CHAIRMAN. Proceed.

Ms. CORRIGAN. But this is perhaps the most important point of me being here today, is to say that we know what the problem is. We have seen the problems with coverage, with pricing, with fraud and abuse, and we have to figure out a way to stop it.

It is much better to stop fraud from occurring in the first place than to go after it on the investigative side, and I think it is very important that we all work together, and in particular our office to work closely with CMS, to try and figure out how to reign in and stop this problem.

My written statement has a number of suggestions, but I would like to highlight just a few that I think are the most important. In some way, coverage policy has to be revised. Our suggestion would be to have more specific information, like medical conditions, that would justify coverage for a power wheelchair.

We also think it is important to both educate physicians, nurses, and beneficiaries about coverage criteria, which I know CMS is always trying to do. But somehow I think we have to take that away from anyone who can say that they do not understand the criteria. As the first witness testified, it is not that hard to defraud the program. We want to be able to find the people who are lying and stealing.

I think we can create a new coding system for K11 power wheelchairs to account for the variety in models, and perhaps save some money. But, most importantly, on the pricing side I think we have to get prices in line with reality, because if they are not in line with reality, there is so much more incentive to exploit the system. We would support any efforts to reduce prices, and we will help anyone who wants to use our data.

On the other hand, we have to be vigilant in the Office of Inspector General, and we will continue to be vigilant in investigating and prosecuting violators. I think, as the first witness highlighted, there is also a tremendous need to look at the way that DME suppliers get into the system in the first place. If we can make those controls stronger, we will prevent a lot of fraud from occurring at all.

I do believe that in this area that is sometimes fraught with a lot of emotion, and for good reason, that we can make positive changes without depriving disabled individuals of the power wheel-

chairs that they need. It is certainly the goal of the Office of the Inspector General, and I am sure everyone here shares that goal. We should be working together to find a solution to this problem.

Thank you very much. I would be happy to answer questions.

[The prepared statement of Ms. Corrigan appears in the appendix.]

The CHAIRMAN. We will go through the entire panel before we have questions.

Ms. Aronovitz?

**STATEMENT OF HON. LESLIE ARONOVITZ, DIRECTOR, HEALTH CARE—PROGRAM ADMINISTRATION AND INTEGRITY ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC**

Ms. ARONOVITZ. Thank you, Mr. Chairman. I am pleased to be here today as you discuss issues regarding Medicare payments for power wheelchairs.

While the Inspector General's information is stunning, we found that this situation has been developing for a long time. As far back as 1997, spending has been rising at a disturbing rate.

As you can see on our chart, power wheelchair spending went from $140 million in 1997 to more than $800 million in 2002, and is expected to top $1.2 billion, when all the numbers are in, for 2003.

These alarming statistics prompt two questions: why did Medicare let power wheelchair claims escalate for so long without ensuring that beneficiaries actually qualified for, and received, the benefit? Why are Medicare's payments for these items so out of line with both wholesale and retail prices?

For 6 years, CMS was warned repeatedly about excessive claims for power wheelchairs. Only in 2003 did it coordinate action to stop the losses and prevent further abuse.

In 1997, its statistical contractor alerted CMS that utilization had tripled in the last year and a half. CMS failed to act, even after the regional carriers twice put their concerns about dramatic payment growth in writing. CMS did issue a fraud alert in 1998 after one of its DME regional carriers launched a major investigation of suppliers in the southeast.

While a fraud alert raises awareness of potential vulnerabilities, it should also help the agency direct its own efforts to address the problem. But in this case, CMS did not act on its own alert by focusing DME regional carriers' attention and resources to this problem.

Meanwhile, funding for Medicare claims review declined relative to the tremendous surge in claims, leaving contractors no choice but to scale back their review efforts.

As a result, a minimal number of power wheelchair claims were scrutinized. Also, CMS's gatekeeping process for determining which suppliers were authorized to bill Medicare did not keep out fraudulent suppliers.

When CMS's enrollment contractor, the National Supplier Clearinghouse, got wind of the situation in 2002, it visited 1,300 suppliers in Harris County, Texas. The clearinghouse found that over

350 of them did not meet Medicare supplier standards and revoked their Medicare billing numbers.

Fueling the unbridled utilization of power wheelchairs were aggressive marketing campaigns by certain suppliers. Suppliers have saturated TV, radio, newspapers, magazines, and the Internet with advertising directed at beneficiaries that portrayed wheelchairs as desirable and easy to obtain. They were even advertised as "free," with Medicare footing the bill.

As you can see on this flyer, beneficiaries are encouraged to act quickly because "time is running out." Also, I should add that advanced technology has made power wheelchairs increasingly useful for beneficiaries, sleek and socially acceptable, which also drove utilization.

Once CMS decided to take action in March, 2003, it was 6 months later that it issued its 10-point plan. The plan itself appears to be a reasonable approach for reducing improper payments.

I read today that CMS put out another press release where they are going to do additional activities, which also seem very positive, except the 10-point plan does not deal with the aggressive marketing issue. CMS has begun, and in some cases completed, actions on all 10 items.

I would like to turn to my second point, briefly, why Medicare's payment rates for power wheelchairs are so irrational. Historically, Medicare has not been successful in setting market-based payment rates. Its inherent reasonableness authority was cumbersome and slow, and used only once. The guidelines supporting a streamlined version of this process are still under way, and CMS is planning to test it first on power wheelchair payment rates.

The Medicaid Prescription Drug Improvement and Modernization Act of 2003 offers hope that future payment rates will be more reasonable. The MMA requires CMS to use competitive bidding to set payment rates for durable medical equipment. CMS has already saved money with this method of payment setting in a demonstration in two areas of the country.

We believe that this hearing is not just about power wheelchair payments. It is also about how CMS is organized to respond to any inappropriate use of Medicare dollars and its ability to set reasonable payment rates for durable medical equipment.

In discussions about power wheelchair payments with the DME regional carriers, they indicated that there is no shortage of items they have identified as meriting immediate attention and possible payment rate adjustments.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you or Mr. Graham might have.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Aronovitz appears in the appendix.]

The CHAIRMAN. Mr. Kuhn?

**STATEMENT OF HERBERT KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE & MEDICAL SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Mr. KUHN. Mr. Chairman, Senator Graham, thank you for inviting me to discuss Medicare's coverage and payment policies for power-operated wheelchairs.

I also want to thank you, Chairman Grassley, for the great working partnership we have had with you to rid the Medicare program of fraud.

Also, Chairman Grassley, I would say I heard your opening statement when you asked me to stay for the entire hearing. You can be assured that I will listen to all the witnesses.

The CHAIRMAN. Thank you.

Mr. KUHN. As you have heard today from other witnesses, growth in total allowed charges for power wheelchairs has outpaced other Medicare economic indicators in recent years.

A number of factors contributed to this growth, including changing needs of the Medicare population, technical progress in power mobility devices that have led to more options for beneficiaries, overuse of the benefit, fee schedule payment levels, limited coding options, increases in supplier enrollment, and the lack of beneficiary, provider, and supplier understanding of coverage.

Unfortunately, fraud and abuse presented a challenge as well. Yet, some beneficiaries who really need these mobility devices were not getting high-quality and timely assistance.

CMS utilized a variety of tools to combat these abuses, culminating with a major national effort last fall. Working with the Health and Human Services office of the Inspector General, CMS launched "Operation Wheeler Dealer" to crack down on fraud and abuse in the wheelchair market.

These efforts succeeded in reigning in payments for improper claims. As you can see from the chart I have displayed here, since the task force to develop Operation Wheeler Dealer convened in March, 2003, utilization and allowed charges for power wheelchairs declined from a monthly high of over $113 million in April to about $69 million in December, 2003.

In Harris County, Texas, CMS witnessed a major spike in Medicare claims. However, as my second chart indicates, the percentage of claims submitted and allowed in Harris County compared to national claims has returned to 2000 levels.

This is down from a high of approximately 23 percent of national claims submitted, and 17 percent of claims allowed in 2003. In the first quarter of 2004, only about 4.5 percent of claims originated in Harris County, and about one-tenth of 1 percent of the national claims were paid to Harris County suppliers. These initiatives have been successful and they continue today.

Now CMS is moving to the next stage in reshaping policies for power mobility vehicles. CMS has a three-pronged approach to focus on coverage, payment, and quality of suppliers of power wheelchairs.

In the first prong of the plan, CMS is developing guidance on the current coverage of power wheelchairs. Beginning next month, CMS's chief medical officer will bring together clinicians from

across HHS and other government agencies to develop draft guidance for determining whether a patient meets the definition of bed- or chair-confined.

The goal is to focus on a set of clinical and functional characteristics that are evidence-based and will better predict who would benefit from a power wheelchair or scooter. The public also will be given an opportunity to comment.

To further ensure that beneficiaries who get mobility devices receive a high-quality and timely evaluation, appropriate device choice and clear guidance in using the device, CMS is also addressing certain requirements for ordering mobility equipment through a proposed regulation which will, among other things, implement the provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, also known as the MMA.

The second area in which CMS has taken action is in the billing payment for power wheelchairs and scooters. The technology, range of products, and market for power wheelchairs has changed substantially since the current codes for power wheelchairs were added in late 1993.

CMS is working with a national coding panel to develop a new set of codes that better describe the wheelchairs currently on the market. CMS will develop individual payment ceilings for each of the new codes.

CMS plans to implement competitive bidding for a number of items of durable medical equipment, as authorized by last year's MMA. CMS expects to include power mobility devices in the competitive bidding program.

The third prong of the new initiative, is to ensure that there are appropriate quality controls for suppliers. Building on existing standards in the industry, CMS will revise the suppliers' standards for enrolling in Medicare to include quality measures, as required by the MMA.

In addition, CMS will develop a proposal for an accreditation program as part of the implementation of competitive bidding to further ensure that power wheelchair suppliers meet industry and community standards for power wheelchair utilization.

Lastly, through its contractor, the National Supplier Clearinghouse, CMS will continue its work to ensure a thorough review of all applications for enrollment so that only qualified suppliers are allowed to build the Medicare program.

In launching Operation Wheeler Dealer, CMS and the OIG had to take dramatic action to stop Medicare fraud, and those actions are having an impact. With CMS's new initiative and with input and feedback from suppliers, beneficiaries, and clinicians, we will do even more to make sure that Medicare funds are spent on patients who need them, and that beneficiaries with disabilities are getting the high-quality, modern services they deserve.

To be successful, CMS must ensure that suppliers are legitimate, beneficiaries are eligible, physicians prescribe correctly, and equipment is priced reasonably. CMS's agenda is consistent with recommendations set forth by the GAO and OIG. Specifically, our forthcoming proposals and regulations will address several areas in the coverage policy.

CMS is also developing changes for the HCPCS codes for power wheelchairs, and, furthermore, we are rolling out educational campaigns for physicians and beneficiaries that, as you have heard this morning, are so important. CMS is well on its way toward addressing these key areas to protect beneficiaries and taxpayers alike.

Mr. Chairman, thank you again for this opportunity to describe CMS's power wheelchair initiatives. I look forward to answering your questions.

[The prepared statement of Mr. Kuhn appears in the appendix.]

The CHAIRMAN. Thank you very much to all you. Thank you for your testimony. Particularly, each of you have given us some ideas of what needs to be changed to get on top of this problem.

I am going to start with Ms. Corrigan. Why does CMS pay so much more for power wheelchairs than others seem to pay, and are taxpayers being well served with the current system?

Ms. CORRIGAN. I think it is because the law, as it currently is, requires CMS to use a fee schedule that is based on historic prices that are not in line with real-world prices. With power wheelchairs, it is even worse because they do not really have a fee base.

They just started using retail prices, and those went up throughout the years. So, I think that CMS is constrained. I think they have tried to use their inherent reasonableness authority, but that has been very slow. There really needs to be some mechanism to jump-start the process.

I am not talking about price controls, but just some fair way that CMS and Medicare can compete in the real world, and perhaps the MMA will be that solution. It will allow them to have competitive projects and competitive bidding for wheelchairs. But I think historically, CMS has not been able to do that easily within the current structure.

The CHAIRMAN. All right. Also for you, Ms. Corrigan, you testified that only 13 percent of those who received K11 power wheelchairs were eligible for them. To what extent is that a result of fraud or aggressive marketing, or just some sort of unclear eligibility requirements?

Ms. CORRIGAN. The way that our study was constructed, it did not evaluate what caused the coverage problems. But my best assumption would be that there is a bit of everything in there, that there is certainly fraud, because you are always going to have the people who will just blatantly lie to the government. I am sure there is some of that in there.

I mean, we heard it this morning. What she described is just blatant lying and forging documents. I am sure there is some of that in there. I am sure there is also just abuse in there as well, and there are probably errors in there, but there is no way to quantify exactly what would compose that percentage.

The CHAIRMAN. You did put some emphasis, though, in your statement on aggressive marketing, did you not?

Ms. CORRIGAN. That was more Ms. Aronovitz than me.

The CHAIRMAN. I am sorry. All right.

Ms. CORRIGAN. But we have certainly looked at that issue.

The CHAIRMAN. All right.

Also for you, Ms. Corrigan, is it legal for suppliers to offer to waive the co-payment in an ad as an inducement in order for some-

body to get a power wheelchair? I think you have seen the TV advertisement that talks about waiving the co-payment.

Ms. CORRIGAN. I will respond to your question in this way. For the most part, that is a kick-back and it is illegal. There are certain instances in which suppliers, or any provider, can waive a co-payment if it is based specifically on a person's financial circumstances. If somebody really cannot afford the co-payment, the law permits any provider to waive that co-payment. But in the majority of situations, that is a kick-back and that is against the law.

The CHAIRMAN. All right.

Ms. ARONOVITZ. I could add there that another situation would be—and Dara is the lawyer at the table, so she could make sure I am saying this right—if a supplier tries to collect the co-payment and fails after really trying very hard to collect that payment, they could write that off as a bad debt.

But one thing that I think the law specifically prohibits is any general solicitation in an ad of the words "waiving a co-payment" and then going ahead and waiving that co-payment. It has to be based on a specific situation where there is due diligence.

The CHAIRMAN. So your judgment is, the statement of that in the ad, that is an illegal act, making that statement.

Ms. ARONOVITZ. This is a little bit of a nuance. My understanding is that it would not be illegal to put it in an ad, but then it would be illegal to act on it once it was in an ad.

The CHAIRMAN. All right.

Ms. ARONOVITZ. For instance, attached to our statement is another example of an ad that we saw posted in a nursing home, or an assisted living facility, where they said that if you only have Medicare, we can waive the 20 percent co-payment. If, in fact, that entity, that supplier then went ahead and did waive the co-payment, it would be illegal.

The CHAIRMAN. All right.

I did have a follow-up question for you in regard to that, Ms. Corrigan. Is there anything that you would suggest that should be done about that waiving of the co-payment?

Ms. CORRIGAN. I think that we have to be aggressive in our investigations. I think that we have to educate people about what advertising can lead to problems. We have certainly started to do that. This is a relatively new area where people are advertising a lot.

It comes up with the uninsured as well. Can hospitals advertise about programs for the uninsured? I mean, it is something that we need to talk to people about and explain where the lines are in the law. So, I think it is two things. I think we really have to watch out for it and make sure we stop it when it happens. Two, we have to really explain to people what their obligations are.

The CHAIRMAN. All right.

Then, also to you, MMA imposes a number of important reforms on CMS for durable medical equipment. What institutional changes must CMS implement now to ensure they can successfully execute what the law says, and what are OIG's plans to oversee, monitor, and report back to us?

Ms. CORRIGAN. Well, I think that we would not tell CMS how to run CMS. But I think with respect to the provisions that we are

talking about with wheelchairs, like the provisions that are in the MMA about making sure that a physician sees a patient before signing a certificate of medical necessity, for making sure that there is competitive bidding with pricing and other obligations like that, our obligation is to go out and make sure that CMS is doing it. In many ways, although I certainly have an opinion, which does not really matter, as long as CMS does it, we do not really care how they do it.

To my mind, it is their program and they should manage it in the best possible way. We have an obligation, on the other hand, to make sure that they are fulfilling their obligation, and if they do not, we will tell you.

The CHAIRMAN. All right.

Ms. Aronovitz, what do you suggest CMS do so that it is better in a position to react to these types of out-of-control payment patterns?

Ms. ARONOVITZ. Actually, there is quite a lot that we could offer. I think CMS has probably at this point, and Mr. Kuhn has probably heard most of this, but we feel very strongly that CMS needs to take more of a leadership role when it finds situations that potentially could be dramatic, like this one, and develop a formal approach to coordinate a consistent focus on the problem with its DME regional carriers.

We think that the gatekeeping process, in terms of giving people supplier numbers, is key here. The out-of-cycle site visits were very important. As the first witness stated, it was the lack of the surprise that really made it so easy for her to pass the site visit.

The way it works right now, is that a supplier receives a site visit when they first enroll in the program, or they apply for a billing number, and then when they re-enroll every 3 years.

Right now, there are not funds in the system to permit out-of-cycle site visits. We think that if the National Supplier Clearinghouse did a risk assessment and then did at least some out-of-cycle visits, it could be very lucrative for CMS in terms of keeping unscrupulous suppliers out of the program.

The third thing, would be to develop more specific standards for suppliers. It became clear, in talking to inspectors when they did their site visits, that there were certain parts of those 21 standards that suppliers are supposed to follow that were ambiguous enough where inspectors did not want to deny a billing number based on an ambiguous standard.

For instance, one standard requires suppliers to have "adequate inventory," but there is no definition of what adequate inventory is. Another one talks about having an "appropriate location." It specifically says that you cannot have a post office box number, but it does not say whether a cubicle in a high-rise would be an appropriate location or an adequate location. We need to clarify those standards, or CMS should, to make it easier for inspectors to deny billing numbers in cases where it is appropriate.

My last area is something that GAO has been saying for a long time. That is, it would be very important for CMS to understand better what it is paying for when it pays for a K11 power wheelchair. Right now, the value of the prices of power wheelchairs real-

ly ranges. It is a very, very wide category in terms of what could be included in the K11.

Medicare pays, as you see, about $5,300 per wheelchair that is in the K11 category. Even if a supplier legitimately supplied exactly what the beneficiary needed, it is possible that they only need a wheelchair that is a low lower priced than that.

The philosophy behind this is, on average, Medicare will pay the right amount. However, if you go into a grocery store and ask Giant or Safeway, they know, with bar codes, every carton of yogurt—the size, the flavor, and the amount—what they are selling. They understand where their inventory is.

Right now, CMS, even on a $5,000 item, really has no idea of whether the lower-priced wheelchair is getting delivered or a high-priced wheelchair is getting delivered. We think they really ought to fix that, also.

The CHAIRMAN. Following up on that, before I ask you another question, I would like to ask Mr. Kuhn then, along the lines of just where she ended up, we understand that CMS does not confirm with beneficiaries exactly what type of wheelchair they were provided. That is obviously a problem. What do you think you can do about that?

Mr. KUHN. That is a good question, Senator.

The CHAIRMAN. First of all, do you think something needs to be done about that?

Mr. KUHN. We absolutely do. What we have here, and I think you have got a couple of examples sitting in front of us right here of a couple of wheelchairs that are quite different, but they both fit the K11 category.

We agree with GAO's recommendation. We need to do a better job of differentiating between the two. When this code was set back in 1993, it pretty well captured the industry. But technology has changed dramatically over the time and we have not kept up.

So, we have already begun the analytical work in order to begin that process of breaking those down into different parts so that if someone gets a power wheelchair that is, say, in a lower price category, that is what we are going to get and that is what we are going to pay for, medium, high, or however we decide to set those categories.

We think it is important to begin the process now, because, again, you have given us this new authority in MMA for competitive bidding. It is a natural ramp-up into competitive bidding.

So if we can get some of this base work now in terms of getting these segregated into the right categories, get the payment prices, it makes it easier as we transition into competitive bidding.

The CHAIRMAN. Leslie, on your point about universal product numbers, does CMS use the UPN number system, and if not, should they?

Ms. ARONOVITZ. Absolutely. They do not right now. About 6 years ago, we recommended that CMS embark on some activities along these lines. We did not recommend that they do this for every piece of durable medical equipment, but ones where there is a very high margin or ones where they really feel that they are vulnerable.

Unfortunately, CMS felt that it would be a much more arduous process to do this than we pretty much felt it would, and it never

really caught on. Then with HIPPA and the standardized transactions, it has gotten a little bit more complicated.

We think, though, at least for power wheelchairs, on some big items, even if you then ask the supplier to submit the model number or some information about what was ultimately delivered, that there are ways that you could collect data, at least to get a sense of what is actually being delivered.

The CHAIRMAN. Leslie, even when Medicare pays about $5,000 for a power wheelchair, is it true that suppliers could legally give the beneficiary a wheelchair of much less value?

Ms. ARONOVITZ. Yes. That is exactly right. That is exactly what we are talking about.

The CHAIRMAN. Does that happen a lot?

Ms. ARONOVITZ. We do not know, and that is exactly the point. I do not think CMS really understands what gets delivered. I think most suppliers are incredibly careful to make sure that their beneficiaries get exactly what they need. But no one really knows what that is and what that should be.

I think the industry has made recommendations in the past to sit down with CMS to work out or to split the K11 code into different categories, and then to be able to look at functionality and say, based on this definition of functionality, this is what the beneficiary needs. It sounds like you are now embarking on that.

The CHAIRMAN. Have you had a chance to look at the 10-point program that CMS has announced, and is there anything missing from it?

Ms. ARONOVITZ. Yes. We have not investigated in detail and we have not looked at its implementation, but we did look at the plan itself and it appears very reasonable, from our first look.

The one area that is missing is the area that I mentioned earlier about regulating marketers. In talking to CMS about this, it said that it does not have the authority to regulate marketers, except to prohibit telephone solicitation.

The CHAIRMAN. If I asked you to this week, could you monitor their use of that 10-point system?

Ms. ARONOVITZ. Absolutely. We would be happy to.

The CHAIRMAN. All right. Thank you.

Mr. Kuhn, why does CMS pay so much for power wheelchairs, and why can CMS not use market clout to negotiate a more favorable rate for the taxpayers?

Mr. KUHN. I think, as you heard earlier from Dara, our current authority to set the prices is cumbersome and difficult when we use inherent reasonableness. So, in the past we have had difficulty in kind of moving those prices where we think that they really ought to be set in terms of the market price.

There is no question we announced it. We stated it when we launched Wheeler Dealer last year, and we are stating it again today, that the prices we pay for chairs is excessive. There is no question about it.

But as you asked in that previous question, we are going to begin embarking on that, because now we have this new authority with competitive bidding, in a new way to try to set these prices by trying to break these chairs down into proper coding categories, setting the prices there, trying again to use inherent reasonableness,

and then ultimately getting ourselves to competitive bidding. We think that is going to make a vast improvement, and I think in the future we are going to get prices set where they need to be.

The CHAIRMAN. How would you characterize CMS's Central Office's role in helping to curb these types of billing problems that we have discussed today, primarily the illegal activity that our first witness testified about?

Mr. KUHN. Our history in this area goes back, as you heard from GAO. We did send out a fraud alert in 1998 and began then working with some of the DMRCs, the regional carriers, to begin that process. We have also worked pretty closely with law enforcement in this area as well, to try to help them in that area.

There is no question that the results and what we have seen in the spike show that we could do better in this area, but I think some of the reforms that we are talking about now, not only the 10-point plan that was announced last year, but also the additional areas that we are looking at now in terms of coverage, payment and quality, are going to make a huge difference in this area.

The key here, and I think you heard from the other witnesses, is that if we can make sure that these suppliers are certified and good suppliers, if we are getting good information coming in, it is going to make a big difference.

If we can really work with the physician community to better describe the conditions and describe the benefit more clearly, we can get better prescriptions from physicians by getting better information coming into the system, by getting suppliers out there. We also think that is a huge area where we can make great improvement in this area.

The CHAIRMAN. CMS is now implementing the new drug bill. Does HHS OIG have a seat at the table in those discussions, or do you call them if you think they should be there? My point is, developing a new implementation strategy from the get-go that is fraud-resistant is a good thing, and obviously OIG has some experience in that area. Are they at the table?

Mr. KUHN. We do consult with OIG in terms of implementation areas of the MMA. I think, as you know, last week we did an event with you, and with Dr. Mark McClellan, our administrator, to talk about possible fraud, at least with the new drug card. We appreciate the help and the leadership that you gave us in that area to really get that information out.

So, we are using folks on Capitol Hill, we are using the IG, we are using anybody we can in order to make sure that we can move forward on that program as cleanly and as trouble-free as possible.

The CHAIRMAN. What took your agency so long to get on top of the power wheelchair situation?

Mr. KUHN. I think there are a host of factors here, Senator, that drove this. A lot of it had to do with beneficiaries' misunderstanding of the benefit, and physicians' misunderstanding of the benefit. Obviously, there are a lot of people operating out there that should not have been operating in terms of suppliers, payment prices that were too high, just a lot of factors that were going on.

We had a pretty good process, we thought, in surveillance with our durable medical equipment regional carriers. But what we found when we really started looking at the data, is that we were

capturing the data at a State-wide level, not really at a county level.

So as our surveillance effort went forward, and of course it takes some time to process these bills, as the information came forward, we were finding that sometimes we were a little bit later finding out the real rise and spikes in terms of area.

Since that time, and through that process, we have made a number of important changes in the area, including one, as I said—a very important one—down at the county level, so that if things start happening in this area in a particular county, like Harris County, Texas, we are going to detect it a lot earlier and be much more aggressive in terms of getting after it.

The CHAIRMAN. Do you think CMS is in a better position overall to address the fraud problem throughout the Medicare program?

Mr. KUHN. We do, Senator, I think, in a couple of areas. One, beginning, I think, in 1996, where we really started tracking how well we did in terms of performance in dealing with claims processing. In our testimony, we have really reduced the number of errors by over 50 percent in that time. I think that is a good improvement.

Also, I think with the real good partnership we have with the IG and the great recommendations that are coming forth with the GAO, we are reaching out to others to help us identify problems and suggest improvements. As I said in my statement, we are very much adopting virtually all the recommendations that have been made by these two groups.

On a go-forward basis, you also gave us some new tools in the MMA which are going to be very helpful to us. So, I think we are well positioned. I think we have got a pretty good plan here.

The key here in this plan, is that this is a wonderful benefit. It is a wonderful benefit for those people who need power mobility in their home. What we need to do is make sure that it goes to them, and we think this plan also really drives that important fact home.

The CHAIRMAN. All right.

Senator Graham?

## OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. Thank you for holding this hearing on a very specific issue which raises a lot of broader concerns.

Mr. Chairman, I have got some questions, first, on the issue of fraud, and then, second, on the process by which the Medicare program goes about acquiring these devices.

The CHAIRMAN. Proceed. Just proceed. I do have one more panel, but I took a lot of time. Obviously, you are entitled to equal time.

Senator GRAHAM. On the issue of fraud, unfortunately, I know a lot about this issue. Not too long ago, it was estimated that, of all the fraud committed against the Medicare program in the country, that 10 percent of it came from the State of Florida. We were embarrassed by that, distressed, and were looking for some way to deal with it on a systemic basis.

One thing that I had had some considerable experience with, which was another issue that Florida was particularly impacted with, was the issue of illegal drug trafficking.

What occurred in the late 1980's and early 1990's, was the establishment of a series of what were referred to as joint task forces, made up of federal, State, and local law enforcement agencies which had a responsibility for dealing with drug-related issues. I am not talking about prescription drugs, I am talking about the other kind of drugs.

Those task forces recognized some fundamental principles. One, was that if there was an issue of illegal drugs that affected, let us say, the Drug Enforcement Agency at the Federal level, it probably also affected the sheriff's office at a county level or a police office in a city, and each one of those entities brought something to the table in terms of understanding the network that was contributing to that.

The second, is these tend to be paper-intensive investigations, boxes and boxes of materials that have to be pored over, analyzed, and then determine which can be effective in an anti-drug prosecution.

I was struck that those two qualities also relate to medical fraud. If you see medical fraud in Medicare, you can be pretty well assured that in 6 months to a year you are going to see it in Medicaid. Also, these are very paper-intensive investigations.

So, as a result of those observations, approximately 5 years ago, under the leadership of the U.S. Attorney for the Southern District of Florida, a medical fraud unit, which involved Federal agencies, State, even private sector health insurance companies, was established, based in Miramar, Florida, in the southern part of Broward County, with responsibility for doing the basic investigation on medical fraud in South Florida.

Let me just give you some of the statistics. This is from a letter that I received from Doris J. Giles, who is the program manager for health care fraud for the U.S. Attorney in the Southern District of Florida.

She says in this letter, "We have secured 180 criminal convictions, with over $139 million assessed in restitutions, fines, and forfeitures for the trust fund. In addition, civil proceedings have resulted in restitutions in the amount of $120 million."

Mr. Chairman, I would like to ask that the full letter be entered in the record.

The CHAIRMAN. It will be entered in the record, yes.

[The letter appears in the appendix.]

Senator GRAHAM. My concern is that this program has been so successful in one of the highest regions of the country in terms of medical fraud, why it has not been expanded to other areas of the country, so we did not have to wait 5 or 10 years to find out that we have got a problem.

It got so flagrant in South Florida, that the medical providers, primarily DME providers, were setting up post office boxes. In fact, one of them was so flagrant that they actually used an avenue and street address upon which there was no building. It happened to be the 18th green of the Doral Country Club, was the place they selected to have as their office.

My concern is, with this program being so successful, why do we not aggressively establish similar types of programs in other areas of the country—I gather that Harris County, Texas may be a candidate—which have high incidence of medical fraud?

Mr. KUHN. Senator, actually, it is a good suggestion. It is a good model, and we have actually been trying to use that model in different areas. We used it in Harris County, Texas. We established our task force about a year ago this time to move forward in that area, and some good recommendations and good efforts came out of that.

For example, a 100 percent review of all claims in that county. You talk about being labor-intensive in paper claims, but it worked. The numbers we showed earlier showed real progress in that area. It is a good model to work.

Also, much better coordination when you get something like this between the agencies and law enforcement. We have got to have that coordination if we are going to get at these folks.

The other part that it also gave us a real opportunity to do, was 100 percent education with the suppliers in this area. They all had to come in and do education programs so they could understand the benefit, we could see who they were, that process. Those that did not show up, we knew who they were and we could go talk to them further about it.

So, it is a great model. It worked there. I think we have also used that model in California. It is something I think we need to pursue even further and more aggressively where we find these problems.

Ms. CORRIGAN. I think it is working well in certain areas, and certainly in Texas. We are in the process of almost modeling what is being done in Florida. Texas has one of the highest fraud rates, next to Florida. I think it is a model that works really well. If you do not have the agency working with law enforcement, you can really run into trouble down the road.

I also think different models can work in different places. Like, in Boston, you have a really aggressive U.S. Attorney's office, and they will take resources from anywhere to get their cases done, their pharmaceutical cases, and I think they have been very successful. But I think, in general, having everybody working from the beginning works really well, and we are trying to do it as we have funds to do it, basically.

Senator GRAHAM. Any comment?

Ms. ARONOVITZ. No, sir.

Senator GRAHAM. Let me ask, first, a question, then make a request. In the Harris County example, was that a multi-level effort? For instance, the State has responsibility for administering the Medicaid program, which also is very vulnerable to fraud. Was that involved? Were private health insurers involved in the Harris County example?

Ms. CORRIGAN. I do not think any private insurers were involved, but the medical societies and the State were. The benefit that we were looking at, it would not have been as problematic on the private side so we stuck with the people that were going to be affected, which would be the State, the medical societies, CMS, the

U.S. Attorney's office, probably in different parts of Texas, and the Office of Inspector General, our agents down there.

Senator GRAHAM. I would also suggest, we found that the Department of Defense, through its TRICARE program, and the VA, even, were targets of these malevolent defrauders of health care.

I would like to ask if you might submit to the committee a memorandum of your thoughts about replicating the model that maybe has been used in Harris County, Texas and the Southern District of Florida in an aggressive way in other high medical fraud areas of the country.

I agree with the statement that Ms. Corrigan made, that the principal restraint has been resources, although the savings are so enormous, over $100 million of restitution from this one area of the country.

What I would like to do, frankly, is go before the appropriators and urge them to provide funding to establish other similar medical fraud units in high intensity areas, and I would like a memo as to your recommendations as to whether that is a good idea, and if so, how you would recommend going about phasing it in more broadly, and what would be its cost. Based on the Harris County/South Florida example, what are its likely savings in the reduction of, and deterrence of, medical fraud?

Mr. KUHN. We would be happy to do that for you, Senator.

Ms. CORRIGAN. We will work with them. We should be able to do that.

Senator GRAHAM. Thank you.

I would like to ask if I could possibly have that within the next 20 days so that we do not get caught in the appropriation timetable and miss the window of opportunity.

Now I would like to go to the first question, which is the means by which we purchase DMEs. Again, I hate to be parochial, but you mentioned there were two pilot sites. One of them was San Antonio, Texas, the other one was Lakeland, Florida. So, again, I have had some personal experience with this.

I would like to talk, Mr. Chairman, about some of the provisions in the 2003 Medicare Reform Act as they relate to this. Frankly, Mr. Chairman, I know you are going to be tired of hearing me say this.

But as I discuss the provisions on DME in this act, they again cause me to ask that we have a hearing before the Memorial Day recess on the general topic of the prescription drug Medicare Reform bill. We have known now for several months that there was a very stark disagreement between the Congressional Budget Office upon which we rely for numbers and the auditors within the Executive Branch as to what this program is going to cost.

The Congressional Budget Office said it was going to cost $395 billion over 10 years, and the auditors in the agency estimated it was going to cost between $520 and $530 billion over 10 years. We need to explore that.

A second thing that has happened, is we have gotten the trustees of the Medicare program report, which indicates that the Part A of Medicare, hospitalization part, is going to go broke 7 years earlier than had originally, or even a year ago, had been estimated. That is another serious financial issue.

An area that I would like us to look at which relates to the 2003 act, is the fact that, today, hospitals are spending about 5 to 6 percent of the total cost of patient care on prescription drugs.

In my judgment, there is no reason why hospitals cannot negotiate, under the supervision of the Medicare administration, to secure better prices for prescription drugs that are utilized in a hospital setting. They are a significant part of the overall cost. They, therefore, are a significant reason that the Part A trust fund is under the kind of financial pressure that it is.

I do not like to make policy by anecdote, but this weekend I happened to end up talking with a man who runs the pharmaceutical unit for four hospitals in this region. I asked him, how do you go about paying for the prescription drugs which you use, a substantial amount of which go to Medicare patients? He said, we use the average wholesale price.

Well, frankly, anybody who knows it, knows that the average wholesale sale price is neither an average nor wholesale price. It is a totally fictitious number used for purposes unrelated to what the real market value of these prescription drugs are.

If his statement is true, generally, there is a massive over-payment for the cost of prescription drugs by hospitals, which we are paying for, we, the American taxpayers and those who pay into the Part A trust fund.

We are not taking advantage, as the largest hospital system in the nation is, the VA, of being able to negotiate for substantially better prices. The VA pays less than half of the retail price for the prescription drugs that are made available to American veterans. So, that would be another issue that would be appropriate at such a discussion of the 2003 bill.

Then, based on what we have heard today, there is yet a third issue. We have talked a lot about the fact that the 2003 act sanctions the use of competitive bidding, but there are some big problems. The first, is that the program is being phased in in implementation.

The first wave of that phase-in does not start until 2007, 3 years from now, and it can only apply to 10 of the largest metropolitan statistical areas in the country, so it is late and limited. Then 80 percent of the largest metropolitan statistical areas can be included as of 2009, 5 years from now. How long did it take in Lakeland and San Antonio for those programs to be operational?

Ms. ARONOVITZ. They were very successful programs and they did save a lot of money. I am not exactly sure how long it took. I know there was quite a bit of start-up. I am guessing that it was about six or 8 months, in terms of getting all the infrastructure in place and educating suppliers and beneficiaries about what was going to happen.

Senator GRAHAM. So it not only did not take the 3 years or the 5 years——

Ms. ARONOVITZ. I should say that that is just my recollection. I am not sure that that is correct.

Senator GRAHAM. But it appears as if it was substantially less than either the 3-year period or the 5-year period that we are contemplating, and we now have the experience of San Antonio and Lakeland, so we are not starting from a dead start. We have got

some momentum based on the very purpose of a demonstration project, which is to demonstrate how a different process can be used. So, that is my first concern.

The second concern, is the definition of what can be covered seems to be peppered with exceptions. I think we ought to explore whether the restraints that we are about to impose on using competitive bids are justifiable in the context of the additional cost that we are going to incur.

Then, finally, there is a general exception authority granted to the Secretary for "items and services for which the application of competitive acquisition is not likely to result in significant savings."

I think the presumption ought to be that we are going to competitively bid, and if there is going to be an exception it should be in the reverse, not in whether we are going to start with competitive bids.

So, I think we have some very serious problems with this law, Mr. Chairman, which need to be carefully reviewed, and as quickly as possible. As we are learning here today, every month that we go with this antiquated price list system, the taxpayers of America pay an enormous cost.

So before turning to some more specific questions about this, I would just urge, again, Mr. Chairman, that we have a hearing on this 2003 act before the Memorial Day recess so that we can go into detail in each of those issues, and I am certain other issues that you and other members of the committee would want to explore.

Back to the issue of the process which we use. When was the price list for power chairs established? You mentioned that it was done based on retail prices.

Ms. CORRIGAN. 1994.

Senator GRAHAM. And for the last 10 years, we have been following the trend of the retail price?

Ms. CORRIGAN. Yes. Adjusted every year.

Senator GRAHAM. How much, for instance, does the VA pay for these chairs?

Ms. CORRIGAN. We, at least in our most current study, have not looked at what the VA paid.

Senator GRAHAM. Could you do that and see how it compares with what Medicare is doing?

Ms. CORRIGAN. Yes.

Senator GRAHAM. Who, besides Medicare, pays the "retail price?" How is the retail price established?

Ms. CORRIGAN. You mean, back in 1994, or now?

Senator GRAHAM. Well, I assume if we have kept that as the principle, that we will pay the retail price, as the retail price is adjusted, what Medicare pays is adjusted. Is that correct?

Ms. CORRIGAN. Yes. I would be what the manufacturers told Medicare it was.

Senator GRAHAM. So if they said it cost $100,000, even though the VA could buy it for $1,500, we would say $100,000 is what the retail price is?

Ms. CORRIGAN. That would surprise me.

Senator GRAHAM. That may be an extreme example.

Ms. CORRIGAN. Right. But I think that, at the time, that was the law that CMS has to comply with. They had to have the current prices of the time, and they accepted manufacturers' prices. I mean, manufacturers set retail prices, and that is what they had in 1994.

Senator GRAHAM. And they continued to do that over the last 10 years.

Ms. CORRIGAN. Yes. Although I believe—and CMS can certainly address this—there were attempts during the 1990's to try and use their inherent reasonableness authority to lower prices. I am not sure if that was with power wheelchairs or with other DME.

Mr. KUHN. Other products, but power wheelchairs was an option to deal with that. But, also, in the MMA, as you may recall, Senator, there is a 5-year freeze on prices of these products as well, which we implemented this year. So there have been times when we have really tried to move, based on direction from Congress, to control these prices as well.

Senator GRAHAM. So we are paying egregiously more than we should, but at least we will continue to pay the same egregiously high rate for the next 5 years. Is that what we are doing?

Mr. KUHN. Well, I think, as we stated here in our statement, that we are addressing the issue of payment. With the MMA and with this era of going to competitive bidding, it is going to make a difference. I hear your statement, that it has taken longer than perhaps we would want to go.

But we are going to try again to use our inherent reasonableness process and we are going to try to do better in terms of the coding of this area so that, sooner than 3 years from now, we are going to have better prices. We are going to have people get the chairs who need to get the chairs, someone who needs a chair that is at the lower end of the spectrum versus one that needs a higher, and we are going to pay appropriately.

Senator GRAHAM. Is that freeze both a ceiling and a floor?

Mr. KUHN. There are a range of prices in here, and it just freezes all those payments, period, where they are now.

Senator GRAHAM. So it is both a ceiling, you cannot go higher in payments, but it is also a floor, you cannot go lower.

Mr. KUHN. Yes, sir. Yes, sir. Except we can invoke the IR authority, the inherent reasonableness, to try to drive those prices, because it is pretty obvious where they are now versus where they are currently set, at least in the retail market. If you go on the Internet, you can find that. That gives us the trigger mechanism to go in and make those adjustments.

Senator GRAHAM. We always talk about running government like a business. Why in the world would you put a restraint on yourself that says you have to go in and approve that a product is excessively priced when it is so obvious that it is excessive? I would like you to add the VA as one of the major purchasers of wheelchairs and what they are paying.

Ms. CORRIGAN. Well, actually, I can add it for you. We have not obtained those prices, but Senator Grassley's staff has. If there is no objection, I can share those for the record.

The prices that they obtained, that the VA negotiated for four separate power wheelchairs, ranged from about $1,300 to $2,200.

Senator GRAHAM. And that compares to what? I cannot see that.

Ms. CORRIGAN. It is lower than any of the prices that we found.

Senator GRAHAM. Well, it seems to me that is almost prima facia evidence that what the Medicare program is paying is not reasonable.

Ms. ARONOVITZ. Yes. I should add one thing, though. In looking at VA prices, VA is structured differently. I am not making excuses. I totally agree that CMS really needs to look at what it is paying for power wheelchairs.

But there are additional elements that come into the servicing aspect that Medicare suppliers must comply with that VA does not in terms of delivering the product, assuring that it continues to be maintained, and is working with the beneficiary to educate the beneficiaries in how to use it.

So, there are other costs associated with that and there are some nuances in how VA is able to get those prices. But, clearly, even if you started with the VA price and then marked up from the VA price to accommodate these other needs, it could be a way to proceed.

Senator GRAHAM. Well, Mr. Chairman, I want to thank you for holding this hearing, because I think you have really put the spotlight not only on this specific issue, but on the broader issue of, how do we deal with this enormous overrun of costs that we have got in the 2003 Medicare Prescription Drug Improvement and Modernization Act in this area, not just power wheelchairs, but across the DME front. It could be a significant way of beating down that cost.

One of the issues that is sometimes raised, is we have got to use the Congressional Budget Office number. We cannot look at any other figures. Well, I think Charles Dickens once said, "If the law says that, the law is an ass." I would say we would be subject to that same comment.

In this area, apparently, we have known for a long time that we were egregiously over-paying, but we felt that we were constrained and were forced to continue to do so.

For those of us who consider ourselves to be good, solid capitalists and concerned about the taxpayer money, Mr. Chairman, I think that a hearing on this recent legislation would be a fertile ground to apply some of those basic, good business principles.

The CHAIRMAN. Thank you, Senator Graham.

I am going to call our third panel, now. Dr. Laura Cohen, physical therapist, assistive technology practitioner who works as a consultant reviewing all power wheelchair claims by TriWest, a contractor that handles claim processing and payment for the Department of Defense TRICARE.

Dr. Cohen will detail the process she goes through to assess patients' needs. She will explain to us what information she requires in making those determinations.

Mr. Henry Claypool, co-founder of Advancing Independence, an advocacy group for the disability community. Mr. Claypool brings to this hearing a lengthy prior work experience with CMS and first-hand knowledge of the issues involved.

Then our final witness is Kay Cox, president and CEO of the American Association for Homecare, which represents about 3,000

members who provide all elements of home care, including home medical equipment and rehabilitation technology.

We will start with you, Dr. Cohen, then Mr. Claypool, and then Ms. Cox.

**STATEMENT OF LAURA COHEN, PHYSICAL THERAPIST AND ASSISTIVE TECHNOLOGY PRACTITIONER, CONSULTANT TO TRIWEST REGION OF TRICARE, TUCSON, ARIZONA**

Dr. COHEN. Chairman Grassley and Senator Graham, good morning. Thank you for the opportunity to be here today to discuss how to ensure that individuals with disabilities receive appropriate and necessary wheel mobility devices while guarding against waste and abuse of Federal Medicare funding.

I plan to summarize my written statement now, but request that the full written statement be added to the official record.

My name is Laura Cohen. I am a physical therapist, hold a Ph.D. in rehabilitation science from the University of Pittsburgh, and an assistive technology practitioner certification from the Rehabilitation, Engineering, and Assistive Technology Society of North America, RESNA.

My experience includes three distinct professional activities, spanning a period of 17 years, including direct and supervisory clinical service, policy development, and claims review.

As a service provider, I evaluated and recommended medically necessary seating and mobility systems and prepared documentation required for equipment to be funded by Medicaid, Medicare, and numerous insurers.

I worked to develop medical necessity guidelines for specialty, manual, and power wheelchairs for the Pennsylvania Medicaid program, and participated in program development for assistive technology service delivery programs in Tucson, Arizona, and for an administrative region of the Department of Veteran's Affairs.

For the past 6 years, I have served as a second-level reviewer of durable medical equipment, DME, claims for the contractor that administers the military medical TRICARE program in 16 States.

Within TRICARE, I review the medical necessity and appropriateness of requests for items of DME that exceed $1,500. These equipment requests include items such as seating systems, manual and power wheelchairs, scooters, and vehicle lifts.

It is my job to determine whether the clinical data submitted, in support of the funding request, identifies a recipient's current and reasonably anticipated future medical needs, and whether the device requested represents the most cost-effective alternative to meet those needs.

In TRICARE, the following written documentation is required for prior authorization: a signed prescription from a physician; an order that specifies and justifies the equipment; and a price quote with HCPCS codes, which is the Health Care Common Procedure Coding System.

When I perform a review of documentation submitted in support of a request, I examine three critical components: the physical evaluation, the assessment of the individual's environment, and the specifications of the technology being requested for payment.

As both a clinician and claims reviewer, I find these three components must be present for the wheelchair funding documentation to be complete and to adequately explain the basis for the device being requested.

Based on the information provided, I make one of four recommendations: I approve the request; I suggest an alternative device; I recommend further assessment to collect needed missing information; or I deny the request. My recommendation then goes to the regional medical director for final determination.

As I work daily with this DME process, I can point out what is missing within the existing Medicare process, in common with other insurers as well. Required documentation lacks assessment information and rationale to justify a request.

Even for the most knowledgeable clinician with seating and wheel mobility technologies, it is difficult to identify and not required as part of the determination of medical need.

There exists an outdated HCPC coding system that does not adequately differentiate mobility technologies, and there is only rare clinical peer review of prior authorization or post-payment audits to make clinical decisions of medical necessity, appropriateness, or cost effectiveness.

Every one of these things can be readily corrected. Existing Medicare coverage policies for lower limb prostheses and speech generating devices are good examples of models that could be used for wheel mobility technologies. It is important to recognize that, historically, policy implemented by CMS is commonly used as a model for other third party payors.

A system consisting of clear coverage guidance, incorporating assessment and documentation requirements sufficient for clinical decision-making, a revised coding scheme that recognizes differences in technologies, focus on skilled decision makers and skilled reviewers as part of the data collection and review process, and a prior authorization procedure is recommended.

Together, these elements have the potential to eliminate both CMS and Congressional concern about waste and abuse regarding Medicare manual and power wheelchair funding by facilitating procedural objectivity, predictability, and consistency.

In closing, I believe it is crucial in the development of policy aimed at reducing waste and abuse that the patient is not left behind. It is imperative that access to the technology that allows for independence and enhances the quality of life not be denied or reduced.

Every effort must be made to ensure access to technology and maintain quality outcomes for the health care dollars spent. Ensuring that patients can perform basic activities of daily living in their homes and in their community, as well as access to community services, is paramount.

An advisory committee with the consumer, and representation from the clinical, supplier, and industry communities to provide guidance on these issues would be useful. I would like to offer my assistance to Congress and CMS as you continue to address these important issues.

Thank you for this opportunity. I will be glad to answer any questions you may have.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Cohen appears in the appendix.]

The CHAIRMAN. Mr. Claypool?

**STATEMENT OF HENRY CLAYPOOL, CO-FOUNDER OF ADVANCING INDEPENDENCE, WASHINGTON, DC**

Mr. CLAYPOOL. Good morning, Chairman Grassley and Senator Graham. Thank you for inviting me to testify today.

I am Henry Claypool, the co-Director of Advancing Independence, a policy forum that advances responsible reforms in Medicare and Medicaid to increase the health, independence, and self-sufficiency of Americans with disabilities of all ages.

I am also a former Medicare beneficiary who is acutely aware of the strengths and severe limitations of the program coverage of manual and power wheelchairs.

The focus of this hearing is on what can be done to curb fraud and abuse in Medicare's purchasing of power wheelchairs. Developing more effective ways to do so is something we all support.

But we believe it must be done without barring beneficiaries from obtaining the medically necessary wheelchairs they need to move about their homes and communities safely and independently.

Unfortunately, CMS is acting as if the only way it can combat fraud is to severely limit the benefit in ways that undermine the health, independence, and dignity of thousands of beneficiaries of all ages. We believe this is wrong, and will prove extremely costly to the trust funds.

Confusion regarding the wheelchair benefit arises from two key factors. First, there is a complete lack of clear, up-to-date clinical standards set by Medicare for determining who needs a manual or power wheelchair. The second, is CMS is, instead, using an overly restrictive interpretation of the statutory phrase "used in the patient's home" to limit when Medicare will buy a wheelchair for someone.

Congress used this phrase when it created the DME benefit to make certain that Part B paid for such equipment only when the person was living at home so as not to duplicate payments for persons that were in a hospital or skilled nursing facility when Part A would cover it.

But CMS has a far more restrictive interpretation of what the phrase means in regard to when Medicare will pay for a manual or power wheelchair, and it is becoming far more restrictive with each passing day.

Today, Medicare will only buy a wheelchair for a person who, (1) is bed- or chair-bound; and (2) needs the specific wheelchair to move about within the four walls of their home. At first glance, this may seem like a reasonable coverage policy that meets the needs of beneficiaries and helps promote the integrity of the program.

Let me highlight why this is not the case by sharing with you snapshots of how this policy has impacted three former and current beneficiaries, and countless more as well.

My personal experience with Medicare. I had Medicare coverage from 1984 to 1994 after I sustained a spinal cord injury in college. Back then, I was eligible for both Medicare and Medicaid. I was

fortunate to have Medicaid, which filled some of the coverage gaps in the Medicare benefit.

Medicare would only pay for a standard manual wheelchair that was suitable for use in my home. Without Medicaid paying for a sturdier, yet lightweight manual wheelchair that enabled me to move about the hilly campus of the University of Colorado, I would not have finished my education.

I eventually returned to work, left the Medicare and Medicaid rolls, and several years later went to work for HCFA Administrator Nancy Ann DeParle. It was when I was at HCFA that I obtained my power wheelchair using my private coverage.

I did so because I needed it to go to work, and because my shoulders would soon wear out from over-exertion. Had I been on Medicare at the time, the claim would likely have been rejected because I do not need a power wheelchair to move about within the four walls of my home.

Mr. Chairman, you are one of the authors of the Ticket to Work Act. I would respectfully ask that you reflect upon whether it was your, or others', intent to extend Medicare coverage as an incentive to return to work, only to have the program deny the wheelchairs they need to get out the door.

April. April is an elderly woman with chronic obstructive pulmonary disease. She has had a portion of her lung removed. She requires continuous oxygen therapy, all day, every day, but lives independently in her own home. She drives her own car, but has difficulty walking distances necessary to complete the tasks that allow her to live at home.

She has been unable to get to the grocery store and complete her shopping for the past 4 months, and relies on others to purchase the food she needs for meals.

When she drives to a doctor's appointment, she waits in her car until someone brings an office-owned manual wheelchair out to her to push her into the office. Medicare will not buy April a wheelchair because she does not need one within the four walls of her home.

Linda. Linda has multiple sclerosis. Her symptoms wax and wane. Most days, Linda can walk from her bedroom, to her bathroom, to her kitchen the whole time using the walls and furniture to steady herself as she moves from room to room in her modest, 750-square foot apartment. On other days, she is hardly able to make it from her bedroom to her bathroom.

If Linda lived in a larger home, she might qualify for a wheelchair since she could not use the walls and furniture to steady herself to move about in a larger home. Then again, she might not.

CMS considers it an abuse for a beneficiary to use Medicare to obtain an appropriate wheelchair, even when their physician certifies that it is medically necessary for them to use to move about safely and independently, both in their home and community.

Mr. Chairman, the agency cannot possibly curb fraud and abuse so long as it continues to assume that its major tool in doing so is to enforce coverage policy that completely ignores the medical and very practical needs of people who use wheelchairs.

We have four brief recommendations that I can share now, or hopefully during the question and answer period.

The CHAIRMAN. Go ahead.

Mr. CLAYPOOL. These are our recommendations basically on how CMS can better curb fraud and abuse. CMS should immediately initiate a process for working with people with disabilities, physicians, clinicians, industries, and others to develop fair and rationale coverage policy that ensures beneficiaries with legitimate medical needs have access to the wheelchairs for use in their homes and community, and address the issue of combatting fraud.

On that point, I would note that CMS mentioned that they were going to move ahead with developing coverage policy, but they were going to use the physicians that were working for the agency and throughout government.

I really did not hear that they were going to bring in outside experts. I think it unfortunate that they would end up coming up with coverage policy that is close to what they have now, which not many people quite understand.

Second, any new coverage policy should include objective medical standards developed by clinicians that specialize in conducting evaluations of people with functional limitations that arise from disability or the aging process. These standards should be consistent with contemporary medical standards or practices.

If CMS believes it is not able to carry out the first two recommendations because it views the statute as not permitting such action, it should report to this committee on what the basis of its interpretation for that is.

Fourth, I am attaching to my written comments a legislative history of the Medicare DME submitted to CMS 3 years ago on behalf of several organizations in follow-up to the President's New Freedom Initiative. This history calls the agency's interpretation into sharp question. CMS said it would address these claims, but never has. I respectfully request that this committee find out why not.

Thank you for this opportunity to raise these critical points. I look forward to answering any questions you might have.

The CHAIRMAN. Thank you, Mr. Claypool.

[The prepared statement of Mr. Claypool appears in the appendix.]

The CHAIRMAN. Now, Ms. Cox?

**STATEMENT OF KAY COX, PRESIDENT AND CEO, AMERICAN ASSOCIATION FOR HOMECARE, ALEXANDRIA, VIRGINIA**

Ms. COX. Thank you. Thank you, Chairman Grassley and Senator Graham, for the opportunity to assist the Finance Committee on this important issue.

The American Association for Homecare is the only national association that represents every line of service within the home care community. We have around 800 member companies, with thousands of associates across the Nation, including providers of durable medical equipment.

AA Homecare joins this committee in refusing to tolerate the stealing of taxpayers' hard-earned dollars set aside for Medicare beneficiaries. We endorse zero tolerance for Medicare fraud and abuse involving power wheelchairs. AA Homecare will continue to assist CMS and Federal law enforcement agencies in an effort to ensure the integrity of the Medicare program.

As the investigations in the power wheelchair area proceed, we respectfully caution about drawing over-generalizations of our providers. The great majority of DME providers and manufacturers in your States are run by hard-working Americans interested in providing products that treat and improve medical conditions for patients.

These honest DME providers understand the importance of the long-term relationships with the Medicare program, not like the fly-by-night operators. AA Homecare and its Rehabilitation and Assistive Technology Council have adopted a code of ethics and have approved a guide of conduct for our membership.

We would like to present the following suggestions for addressing the fraud and abuse. First, the guiding principle should be to provide each Medicare beneficiary with medical equipment that is both medically necessary and appropriate, giving the patient a fuller and healthier life.

Where a beneficiary has a genuine medical need for a power wheelchair, as judged by the patient's attending doctor, the right wheelchair should be provided in accordance with that need. The patient benefits from increased independence.

Second, coverage and coding policies must capture the evolving and improving varieties of power wheelchair technologies and medically necessary accessories. For example, power wheelchairs with significantly different features and product costs should not be lumped together in outdated medical equipment codes that reflect older technology.

AA Homecare has worked with CMS and its Medicare contractors to improve coding for power wheelchair products. More definitive product coding will provide doctors with better information and will also improve Medicare billing and payment policies.

Reimbursement should appropriately reflect Medicare equipment and overhead costs, including the cost of patient assessment and education, delivery and maintenance, and a reasonable return for the provider.

Documentation. We previously submitted detailed recommendations to CMS to improve the use of medical necessity documentation in order to give providers clear guidelines on the criteria necessary to support a power wheelchair Medicare claim.

Quality standards. From the outset, AA Homecare's DME providers embraced the new MMA Federal quality standards and accreditation requirements for DME. AA Homecare will work with CMS to ensure that any new standards complement quality control measures already voluntarily adopted by our industry.

Third, CMS and law enforcement agencies should bear in mind the critical distinction between just billing errors or omissions, on one hand, and the intentional or knowing submission of false claims on the other.

I think we can all agree that the Medicare program is extremely complex. Where errors have been made in billing, coding, or documentation for furnishing a particular power wheelchair, the appropriate over-payment, if any, should be collected, consistent with the Medicare program's legal authorities.

Well-intentioned providers work hard to comply with Medicare requirements, while faithfully serving their patients' needs. They

should neither be unfairly penalized, nor subject to over-generalizations based on the intentional misconduct of abusive operators.

On the other hand, we say, go get them. Where law enforcement agencies obtain reliable evidence of the knowing submission of false claims, AA Homecare and all honest providers in the industry do not tolerate this type of conduct.

Mr. Chairman, AA Homecare and our members are on the front lines of serving Medicare beneficiaries each and every day, in your State and across the Nation. We vigorously advocate ethical and honest conduct in these endeavors, as well as clear, updated, and fair regulation. We continue to serve as an experienced and knowledgeable resource for you in this committee. Thank you.

The CHAIRMAN. Yes. Thank you very much.

[The prepared statement of Ms. Cox appears in the appendix.]

The CHAIRMAN. I am going to remind you that members who were not here may have questions for answer in writing.

I am going to ask some questions orally, and then I am going to, for sure, submit some to you for answer in writing.

I will start with Dr. Cohen. In your opinion, do certificates of medical necessity and the physicians' notes provide adequate information to make accurate determinations about patients' needs?

Dr. COHEN. Well, in my experience, the certificates of medical necessity lack information and rationale that I find necessary to make a clinical decision of medical necessity, appropriateness, or cost effectiveness. It lacks information about the physical evaluation, environmental considerations, or mobility potential for the client that is being evaluated.

The CHAIRMAN. Mr. Claypool, in your judgment, is it possible to have the proper balance that you request in your statement, or at least I think it is implicit in your statement, that we take care of the people that have needs for power wheelchairs, or any other DME device, for that matter, and getting at the fraud and waste? Can CMS, in your judgment, both from your experience with it, as well as your being a client of it, do that?

Mr. CLAYPOOL. I really believe so. I think, referring back to my recommendations, that establishing clear national coverage policy that uses truly objective clinical standards—and it is not an easy process, but we need to be about that work—can be done. That will result in a much clearer or brighter line that would be drawn. People would know when to submit claims and when not.

The current situation really puts the supplier in the position of making a medical determination on whether a claim is going to go forward. A physician really is not very aware at all of what the coverage criteria are. They fill out a form and pass it along.

The supplier is in the position, and that is really unfortunate. We should return this to the physicians, the clinicians, and the other folks that know this work, and they should work with beneficiaries and assess their need.

The CHAIRMAN. Ms. Cox, has AA Homecare developed and promulgated ethical standards that its members must comply with? What happens if someone in your membership would not comply?

Ms. COX. Yes, Mr. Chairman, we do have a code of conduct within our membership, and ethics and standards. If someone did not comply, they would no longer be a member of the association. As

you can imagine, those that are committing these crimes do not want to be associated with those professionals that are on the front lines of caring for patients.

The CHAIRMAN. If a DME company that is a member of AA Homecare runs afoul of the law, what will your organization do? Is your organization willing to actively monitor the industry, including conducting peer reviews of practices and operations?

Ms. COX. We would be involved with any other organizations that would be looking at any criminal behavior. It is not our job, of course, to do that, but we do have standards and we do have councils within our organization that work with our members. But we have not had that situation before.

The CHAIRMAN. All right.

Is that something that you would consider?

Ms. COX. Well, we are limited as an organization. We do not have the authority to go into that area.

The CHAIRMAN. I know that. But I thought you were indicating, as you finished your first statement, that that was a possibility, of moving beyond just what you said you presently do, not to obviously enforcing law, but other things that you could do.

Ms. COX. Well, of course we have seminars on compliance, education, making sure that we work with the DMRCs, which are the DME carriers, and we are involved in those activities with our members.

The CHAIRMAN. Yes.

Well, I thank all of you very much, our witnesses in the second panel, and Ms. Lewandowski, for helping us understand the depth of this problem.

I would like to just speak a little bit about follow-up on the part of this committee before we adjourn. We have really heard some incredible testimony today about power wheelchair fraud, waste and abuse. It has kind of spread like a cancer and has been running virtually rampant and unchecked for many years, it appears.

We also have heard compelling situations of those who truly need power wheelchairs to function, as well as many caring and honest DME companies who are trying to meet those needs every day. Obviously, we applaud those efforts.

While some may want to try to sweep under the run these power wheelchair problems or attribute them to a host of other factors, I think the witnesses we have had today tell us a very different story.

There are real problems going on, and we should make no mistake about it. Our only option is to fix it. It seems to me we must work together to fix it so that con artists and fraudsters cannot continue to steal Medicare money, and fix it so that taxpayers are not left having to pay too much for too little, or for nothing at all.

We also have heard each of our witnesses offer many thoughtful, compelling, and in some cases, I think, easy-to-implement recommendations to improve the situation in which we find ourselves, and we are obviously going to follow up on some of those recommendations.

I want, as Chairman of the committee, to make sure that CMS takes immediate measures towards significant and sustained steps to continue to fix those problems that we have heard about. But re-

member, there is no silver bullet available to anyone to put an end to the problems that we explored here today.

To properly address the situation, we need everyone's help: CMS, GAO, Inspector General, Department of Justice, the DME community itself, and everyday Americans. As we found out, we can get help from them.

Accordingly, I am asking that CMS continue to aggressively attack the problem, taking into consideration the recommendations made here today. I ask that the General Accounting Office continue to monitor CMS implementation of its efforts to reduce fraud and waste in power wheelchairs.

In that regard, I ask the General Accounting Office to report back to me regularly about its findings. As for the Office of Inspector General, please continue to develop the 65 open cases that you are working on related to power wheelchair fraud.

I encourage GAO as well to provide your views and recommendations to CMS as it implements the drug bill that the President signed last year. I also intend, because I am a member of the Judiciary Committee, to encourage the Department of Justice to make this expensive form of Medicare fraud a priority and ask durable medical equipment community suppliers and manufacturers alike to become more aggressive in helping identify fraudsters, and letting the law enforcement community know who they are.

Last, but not least, it seems to me that it is legitimate to ask across America for any American to report suspicious activity when it is a medical supply store that never has anyone in it, or a solicitors asking for your Medicare number, to call the Inspector General at 1–800–447–8477. Taxpayers just do not deserve to be taken for a ride any longer, and I fully intend to put the brakes on that.

In closing, please note that the hearing record will remain open for approximately 3 weeks for further comments and questions. Thank you very much.

The hearing is adjourned.

[Whereupon, at 12:11 p.m., the hearing was concluded.]

# APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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United States General Accounting Office

GAO

Testimony
Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
April 28, 2004

## MEDICARE

## CMS Did Not Control Rising Power Wheelchair Spending

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


GAO-04-716T

April 28, 2004

GAO Highlights

Highlights of GAO-04-716T, a testimony before the Committee on Finance, U.S. Senate

MEDICARE

# CMS Did Not Control Rising Power Wheelchair Spending

## Why GAO Did This Study

Medicare spending for power wheelchairs, one of the program's most expensive items of durable medical equipment (DME), rose 450 percent from 1999 through 2003, while overall Medicare spending rose by about 11 percent for the same period, according to the Centers for Medicare & Medicaid Services (CMS).

This spending growth has raised concerns that Medicare made improper payments and has payment rates that are out of line with market prices. In May 2003, the Department of Justice indicted power wheelchair suppliers in Texas alleged to have fraudulently billed Medicare. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) contains provisions regarding DME, such as changing payment setting methods. GAO was asked to examine (1) steps taken by CMS and its contractors to identify and respond to improper payments for power wheelchairs and (2) how MMA will affect CMS's ability to set payment rates for DME.

To examine these issues, GAO analyzed claims data reports for CMS's four DME regions, reviewed applicable legislation, regulations, and CMS and contractor documents, and interviewed CMS and contractor officials, DME suppliers and manufacturers, DME industry representatives, and beneficiary advocacy groups. GAO focused attention on region C, which includes Texas.

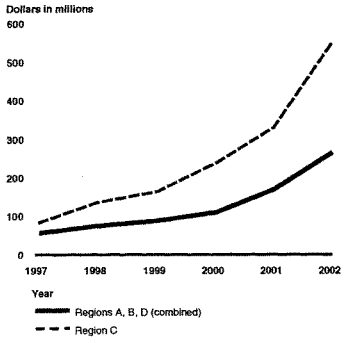
www.gao.gov/cgi-bin/getrpt?GAO-04-716T.

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

## What GAO Found

Although the four contractors that process DME claims identified escalating power wheelchair spending as early as 1997, CMS did not lead a coordinated response until September 2003. Inadequate information to review claims; limited resources, which caused contractors to scale back their claims review efforts; and flaws in the process to screen suppliers before they could bill Medicare left the program vulnerable to millions of dollars in claims paid improperly. Medicare spending for power wheelchairs grew fastest in region C, but resources to review claims were particularly constrained for that region's contractor. CMS has introduced a 10-point plan that appears to be a reasonable approach to reduce improper payments.

**Medicare Power Wheelchair Spending, Region C Compared to All Other Regions**




Source: CMS.

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

The MMA requires CMS to use competitive bidding to set payment rates for DME. Competitive bidding shows potential for CMS to set market-driven payment rates to help keep pace with changes in prices for medical equipment.

GAO discussed these findings with program officials, who provided technical comments.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss issues regarding Medicare program payments for power wheelchairs. Medicare fee-for-service power wheelchair spending is expected to total over $1 billion in 2003. Spending for power wheelchairs rose 450 percent from 1999 through 2003, according to the Centers for Medicare & Medicaid Services (CMS),[1] the agency responsible for managing the Medicare program. In contrast, overall Medicare spending increased by about 11 percent during the same period. At about the same time, the number of beneficiary claims for this item of durable medical equipment (DME) nearly tripled, while the overall Medicare population increased by just 1 percent.[2] Power wheelchairs rank among Medicare's most expensive items of DME, and in 2003, Medicare paid about $5,000 for each basic power wheelchair with standard options, and even more if special accessories were included.

Escalating spending can be fueled by improper payments and payment rates that are out of line with market prices. Improper payments can result from mistakes on the part of suppliers, beneficiaries, or beneficiaries' physicians. For example, improper payments can occur when suppliers submit claims on behalf of beneficiaries who do not meet Medicare's coverage criteria for power wheelchairs. Improper payments can be due to fraud—intentional misrepresentation—and abuse. For example, in May 2003, the Department of Justice began indicting some physicians and wheelchair suppliers in Texas that were alleged to have billed Medicare for power wheelchairs that beneficiaries never received. Rising spending can also result when Medicare pays above-market prices for power wheelchairs. We and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have reported that Medicare pays more than other insurers and public programs for some items of DME—

[1]Until July 1, 2001, CMS was called the Health Care Financing Administration (HCFA).

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

including power wheelchairs.[3] As we have testified in the past, CMS and its contractors—insurance companies that administer Medicare fee-for-service DME claims, called DME regional carriers—have had difficulty setting payments for DME that reflect current health care market prices.[4] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) contains provisions to address some of the difficulties regarding DME payment setting and requirements that will affect the conditions under which power wheelchairs are provided.[5]

My remarks today will focus on (1) steps taken by CMS and its contractors to identify and respond to improper payments for power wheelchairs and (2) how MMA will affect CMS's ability to set payment rates for DME. Because about two-thirds of power wheelchair payments were made by Palmetto Government Benefits Administrators in 2002—including those in Texas—I will be focusing some of my remarks specifically on that DME regional carrier.

To evaluate the steps CMS and its contractors took in identifying and responding to improper payments, we reviewed DME claims payment data analysis reports on DME claims payment from CMS's statistical contractor; written policies and procedures from CMS and its contractors; budget and expense data for contractor activities; Medicare coverage policies, which explain the criteria for determining whether and under what conditions items are covered; and CMS's plan for responding to payment problems with Medicare's power wheelchair benefit. We also interviewed CMS and contractor officials, suppliers, industry representatives, manufacturers, and beneficiary advocacy groups. For DME claims payment data covering 1997 to 2002, we reviewed CMS and contractor internal control procedures to help ensure that these data were

[3]Testimony of Janet Rehnquist, Inspector General, Department of Health and Human Services, *Medicare Reimbursement for Medical Equipment and Supplies*, before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, 107th Cong., 2nd sess., Washington, D.C.: June 12, 2002; U.S. General Accounting Office, *Medicare Payments: Use of Revised "Inherent Reasonableness" Process Generally Appropriate*, GAO/HEHS-00-79 (Washington, D.C.: July 5, 2000); and U.S. General Accounting Office, *Medicare: Home Oxygen Program Warrants Continued HCFA Attention*, GAO/HEHS-98-17 (Washington, D.C.: Nov. 7, 1997).

[4]U.S. General Accounting Office, *Medicare: Challenges Remain in Setting Payments for Medical Equipment and Supplies and Covered Drugs*, GAO-02-833T (Washington, D.C.: June 12, 2002).

[5]Pub. L. No. 108-173, § 302, 117 Stat. 2066, 2223.

accurate, timely, and complete, and, where appropriate, we tested data for internal consistency. We determined that these data were adequate for addressing the issues in this testimony. Contractor budget and expense data are self-reported by CMS or the contractors, and we did not validate these data. To understand CMS's experience with setting payments for DME that are in line with market prices, we reviewed CMS regulations and other documents, and interviewed CMS staff. We also reviewed our previous reports and reports issued by the HHS OIG and CMS to identify alternative approaches to setting prices for DME. We conducted our work from February through April 2004 in accordance with generally accepted government auditing standards.

In summary, starting as early as 1997, contractors identified problems with power wheelchair payments, but it was not until September 2003 that CMS began to lead a full-scale, coordinated effort to address improper payments. Further, the agency did not address program safeguard shortcomings that contributed to the growth in spending for this benefit. These included inadequate information to properly review and adjudicate claims; limited resources, which caused contractors to scale back their claims review efforts; and flaws in the process to screen suppliers before they could bill Medicare. CMS's recent coordinated effort to reduce improper payments for power wheelchairs through a 10-point plan appears reasonable, and the agency has at least started, and in some cases has implemented, all of its elements.

The MMA requires CMS to use a new approach to setting DME payments by using competitive bidding among suppliers to help determine payment rates.[6] The agency's use of Medicare's prior authority to adjust DME payment rates has not enabled Medicare to keep pace with changes in prices for medical equipment. As a result, Medicare often pays more for a DME item than other public payers. In contrast, competitive bidding shows promise as a way for CMS to use market forces to set more reasonable payment rates.

## Background

Most Medicare beneficiaries purchase part B insurance, which helps pay for certain physician, outpatient hospital, laboratory, and other services; medical supplies and DME; and certain outpatient drugs. A wide variety of DME items—including power wheelchairs—are covered if they are

[6]MMA § 302(b), 117 Stat. 2224.

medically necessary for the beneficiary's use in the home and prescribed by a physician. Medicare part B pays for most DME using state-specific fee schedules based on statewide average supplier charges on Medicare claims paid during 1986 and 1987. Since then, fee schedules have been updated for inflation in some years. Medicare pays 80 percent and the beneficiary pays the balance of either the actual charge submitted by the supplier or the fee schedule amount, whichever is less. If a beneficiary has supplemental insurance, the insurance may cover the 20 percent copayment.

Four DME regional carriers are each responsible for reviewing and paying claims submitted by outpatient providers and suppliers on behalf of beneficiaries living in specific parts of the country.[7] For example, Palmetto is responsible for processing claims for beneficiaries permanently residing in region C, which encompasses 14 states—including Texas and Florida—and Puerto Rico and the Virgin Islands.

The DME regional carriers and other contractors conduct program safeguard activities to identify and respond to improper payments for DME claims (see table 1). In addition to the DME regional carriers, three other contractors play important roles:

- The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) analyzes claims data and identifies and reports trends in billing by item, geographic region, supplier, and physician to DME regional carriers and CMS staff.
- TriCenturion, LLC is a specialized program safeguard contractor responsible for reviewing claims and investigating and developing fraud cases for claims processed by region A. The other three DME regional contractors conduct these activities themselves for the claims they process.
- The National Supplier Clearinghouse (NSC) enrolls and authorizes suppliers to bill Medicare by evaluating supplier applications and performing on-site visits to suppliers' places of business.

[7]The four DME regional carriers are HealthNow New York, Inc. (region A), AdminaStar Federal (region B), Palmetto Government Benefits Administrators (region C), and CIGNA HealthCare Medicare Administration (region D). See app. I for the states in each DME regional carrier's jurisdiction. In this testimony, "states" refers to the 50 states, the District of Columbia, U.S. territories, and the Commonwealth of Puerto Rico.

CMS oversees these contractors' activities through various means, such as performing yearly site visit evaluations, reviewing planned activities, monitoring data and periodic reports, and conducting regular conference calls and other monitoring activities.

**Table 1: Contractors' Activities to Identify and Respond to Improper Payments**

| Responsibility | Contractor | Activities |
|---|---|---|
| Analyze billing | SADMERC | The SADMERC conducts ongoing data analysis and reporting for the DME regional carriers and CMS. Its reports are used to identify trends in payment and potential fraud. |
| | TriCenturion and DME regional carriers for regions B, C, and D | TriCenturion and the DME regional carriers for regions B, C, and D analyze claims payment data to uncover improper payments or to investigate and develop fraud cases. |
| Review claims against coverage criteria | TriCenturion and DME regional carriers for regions B, C, and D | These contractors are responsible for conducting medical reviews of submitted claims either before or after payment to determine if the claims should be, or should have been, paid. Claims are reviewed to see if the beneficiaries' conditions meet Medicare coverage criteria. Medical review can be conducted through automated decisions to pay or deny claims based on coverage criteria or may require complex medical reviews. Complex medical reviews are conducted by clinical staff, such as a nurse or doctor, who examines additional documentation provided by the supplier or the beneficiary's physician, such as copies of the beneficiary's medical records or an evaluation by a physical or occupational therapist of the beneficiary's ability to walk. If medical review identifies claims that should not have been paid, the DME regional carrier that paid the claim is responsible for collecting overpayments and educating the supplier about appropriate billing. |
| Investigate potential fraud | TriCenturion and DME regional carriers for regions B, C, and D | These contractors investigate cases of suspected fraud, which can involve conducting a more detailed analysis of claims and other investigative steps. Once a case has been developed, it is referred to the HHS OIG or to law enforcement for prosecution. |
| Enroll suppliers | NSC | NSC is responsible for verifying information on supplier applications to ensure that suppliers meet 21 standards and that only valid suppliers can bill Medicare. NSC also issues suppliers' billing numbers, maintains a central database of information on DME suppliers, reenrolls active suppliers, and assists with fraud and abuse investigations. |

Source: GAO.

## CMS Slow to Respond to Escalating Power Wheelchair Payments, but Recent Plan Appears Reasonable

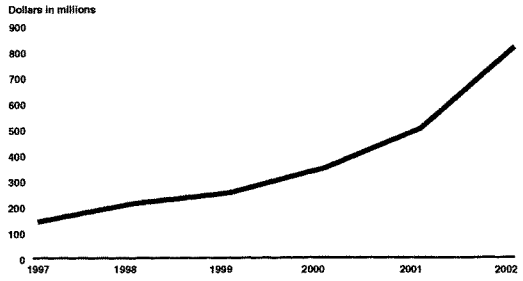
Although there were multiple warning signs over a 6-year period that growth in claims and payments for power wheelchairs may have been excessive, CMS did not lead a full-scale, coordinated effort to address the issue until September 2003. CMS has recently taken actions to reduce improper payments for power wheelchairs through a 10-point action plan. In addition, Congress recently took steps intended to bolster efforts to tackle fraud and abuse in the power wheelchair benefit.

### Despite Recurrent Warnings, CMS Did Not Lead Effort to Reduce Escalating Power Wheelchair Payments Until 2003

In 1997, CMS's data analysis contractor—the SADMERC—issued an alert about rapid increases in the utilization of power wheelchairs. As part of its data monitoring efforts, the SADMERC noted that payments for power wheelchairs had tripled from October 1995 to March 1997, growing from almost $8 million to about $24 million. For the next few years, the SADMERC's reports continued to regularly highlight the abnormally rapid growth in power wheelchair payments, identifying the states and the suppliers for which claims volume was particularly high. Although these reports went to agency officials responsible for ensuring that program funds are safeguarded, CMS staff told us that their contractors—the DME regional carriers—have primary responsibility for using and responding to data indicating rapid increases in utilization.

After reviewing SADMERC data in 1997, all four DME regional carriers' medical directors became concerned and identified possible approaches to address what they described as "tremendous growth" in Medicare power wheelchair spending. In a joint April 1998 memorandum sent to CMS, the medical directors notified the agency of these concerns and requested assistance to address power wheelchair payment growth. The 1998 memorandum cited a 472 percent increase in power wheelchair spending from the first quarter of 1995 compared to the fourth quarter of 1997, and proposed implementing changes in the coverage policy for power wheelchairs. However, because of competing priorities, the DME regional carrier medical directors never completed the policy revision, nor did CMS direct them to do so. Figure 1 illustrates national Medicare power wheelchair spending between 1997 and 2002.

**Figure 1: National Medicare Power Wheelchair Spending**



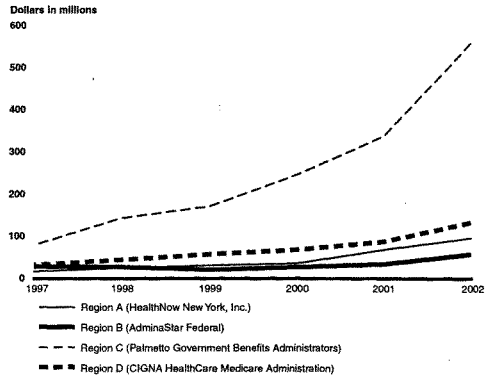

Source: CMS.

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

Between 1998 and 2000, DME regional carriers again tried to address significant increases in power wheelchair payments by using the tools that they already had to address improper payments. The DME regional carriers examined power wheelchair claims through medical review—either before or after claims payment—and investigated potential fraud cases. However, CMS decreased the funding it provided to DME regional carriers to conduct medical review activities about 22 percent, comparing fiscal year 1999 and fiscal year 2003. Funding for medical review covers activities such as computerized claims review and complex medical review. For example, in fiscal year 2003, Palmetto received $3.1 million for medical review activities, about 15 percent less than it received in 1999. The decline in funding for claims review is even more dramatic when weighed against the increase in Medicare claims payment by DME regional contractors. Overall, the amount of medical review funding per $100 in submitted claims dropped over 50 percent from fiscal year 1999 through 2003 for claims processed by the DME regional carriers. Moreover, compared to the three other regions, Palmetto received less medical review funding per $100 in submitted claims each year from fiscal year 1999 through 2003. As figure 2 shows, Palmetto had the highest volume of power wheelchair claims payment and its payment growth was outstripping that of other regions. Although Palmetto had more than tripled the number of submitted power wheelchair claims on which it conducted complex medical review from fiscal year 2000 to 2002, it still

only reviewed about 3 percent of its power wheelchair claims in 2002. The number of claims that received complex medical review in regions B, C, and D fell 39 percent from fiscal years 2001 through 2003.[8] Medical review is one of the activities that CMS has noted as saving Medicare about $17 for every dollar spent.[9]

**Figure 2: Regional Medicare Power Wheelchair Spending**




Source: CMS.

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

In the late 1990s, power wheelchair fraud had also surfaced as a serious problem. Palmetto launched a major fraud investigation of power wheelchair suppliers in Florida and other southeastern states in 1996. This investigation uncovered fraudulent supplier activities, including billing for services not rendered or not medically necessary and delivering a less

[8]This information was not available from region A.

[9]U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2004* (Washington, D.C.: n.d.) CMS reported data on past savings from fiscal years 2002 through 2004.

expensive power-operated vehicle when billing for a more expensive power wheelchair. As a result of this investigation, Palmetto prepared a fraud alert about power wheelchairs for other contractors and investigative agencies, which CMS issued in June 1998. While fraud alerts increase external awareness of potential vulnerabilities, they also help the agency direct its efforts to address potential fraud. In this case, however, CMS did not require DME regional carriers to specifically scrutinize power wheelchair claims or undertake any other efforts to identify fraudulent billing for this item.

In June 2000, the DME regional carriers' medical directors sent a second jointly signed memorandum to CMS officials. They noted that, despite their efforts over a 2-year period to review power wheelchair claims, payments for power wheelchairs continued to increase significantly. The 2000 memorandum noted that Medicare spending for power wheelchairs had grown by 869 percent from the first quarter of 1995 compared to the first quarter of 2000, and identified several problems that the carriers could not address alone. Despite this second warning from the contractors, CMS officials still did not attempt to aggressively address escalating power wheelchair spending—for example, it did not require a coordinated and consistent medical review or fraud investigation strategy by DME regional carriers.

One problem cited in the 2000 memorandum was the disconnect between documentation the physician is required to sign to order a wheelchair and the program's coverage criteria. To be reimbursed for power wheelchairs, suppliers must provide the carrier with a claim form and a supporting document called a Certificate of Medical Necessity (CMN). The physician or other clinician fills out a section of the CMN that answers questions about the beneficiary's physical condition. However, the CMN does not ask about the beneficiary's condition in enough detail for the DME regional carrier to determine whether Medicare's coverage criteria are met. For example, the CMN for power wheelchairs questions whether the beneficiary requires a wheelchair to move about the home. In contrast, Medicare's coverage policy for power wheelchairs is more specific, stating that the item is covered "if the patient's condition is such that without the use of a wheelchair, he would otherwise be bed- or chair-confined."[10] Further, Medicare's coverage criteria state that the patient must be

[10] *Coverage Issues Manual*, rev. 36, Section 60-9, www.cms.gov/manuals/06_cim/ci60.asp.

capable of safely operating the controls of a power wheelchair—a question not asked in the CMN.

Despite the lack of a coordinated effort by CMS to curb rising costs, we found that the DME regional carriers tried to address the problem on their own. For example, several had shifted resources to medical reviews of power wheelchair claims. Around March 2002, Palmetto began to suspect another fraudulent wheelchair scheme was occurring in a different state. Specifically, Palmetto began to suspect that fraudulent power wheelchair claims had been submitted by suppliers in Harris County, Texas, and other parts of the state. A Palmetto fraud analyst had identified highly aberrant billing behavior for one supplier, which he began to monitor. Palmetto analysts also discovered that some suppliers were billing for a power wheelchair or for power wheelchair accessories multiple times on behalf of the same beneficiaries. By January 2003, Palmetto had referred many cases of suspected fraud concerning suppliers of power wheelchairs to the Dallas office of the HHS OIG for potential prosecution. Palmetto conducted additional investigations and made referrals throughout 2003, and investigations continue today. While Palmetto kept CMS informed about its investigations, its efforts to develop suspected fraud cases in 2002 still did not convince CMS officials that it was time to take decisive action.

Also in 2002, legitimate power wheelchair suppliers in Harris County, Texas, became increasingly suspicious about other suppliers' activities in their area. For example, the two suppliers with whom we spoke learned that Medicare had paid other suppliers for power wheelchairs that beneficiaries had never received. Suppliers told us that they, other suppliers, and beneficiaries reported their suspicions to the Palmetto fraud unit, the Medicare fraud hotline, the Federal Bureau of Investigation, and the HHS OIG. The suppliers' suspicions were supported by data indicating that, in 2002, 14 percent of Medicare's power wheelchair spending was for beneficiaries in Harris County, although only 1 percent of Medicare beneficiaries lived in that area in 2001.

Later in 2002, the CMS contractor responsible for DME supplier enrollment—NSC—noted that Texas had an unusually high number of suppliers compared to the number of beneficiaries residing there. Upon CMS's request, NSC stationed one of its own employees in the Harris County area to conduct supplier site visits. During these site visits that began in September 2002, NSC's inspector found instances of suppliers that did not have an appropriate place of business or had moved the business without giving NSC a forwarding address. Based on these

findings, from August 2003 through January 2004, NSC's inspector led an effort to conduct site visits of every active supplier in Harris County, Texas, that had not received a site inspection since January 2003—about 1,300 suppliers.[11] These inspections found additional problems, including suppliers that lacked appropriate inventory or insurance or did not meet other requirements for Medicare DME suppliers. As a result, from September 2002 through March 2004, NSC revoked 367 Medicare power wheelchair supplier billing numbers for suppliers in the Harris County area. Supplier revocations occurred because steps taken by NSC to enroll only legitimate suppliers were unsuccessful. These steps did not protect Medicare from suppliers that failed to meet the supplier standards or committed power wheelchair fraud.[12]

Three weaknesses in the supplier enrollment process left the Medicare program vulnerable to unscrupulous suppliers. First, NSC failed to verify submitted documents. NSC officials told us that they had traditionally accepted copies of key documents, such as liability insurance forms, at face value without verifying them. Failure to verify the accuracy of these documents had enabled supplier applicants to submit falsified papers and allowed them to become enrolled as Medicare suppliers.

Second, the standards NSC uses to evaluate suppliers are not explicit. Officials at CMS and NSC told us that some of Medicare's supplier standards lack specificity as criteria for NSC to use in determining the legitimacy of a supplier and played a role in allowing widespread fraud in Harris County, Texas. For example, one standard requires that the supplier "fills orders, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard." This standard does not specify a reasonable amount or type of inventory that would be expected, given the items the supplier intends to provide to Medicare beneficiaries. Further, NSC staff noted that the standard does not preclude a supplier from using another supplier as its primary source of inventory—even if neither of the two suppliers had enough inventory to

[11]NSC did not visit active suppliers that were large chains, physicians, optometrists, and pharmacies.

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

be viable businesses. According to NSC staff, the broad language used in this standard is difficult to interpret and enforce. In their opinion, the broad language helped allow the widespread fraud in Harris County.

Third, the predictability of site visits may render them less effective. CMS requires NSC to conduct a site visit of a supplier to assess compliance with the 21 standards before authorizing a new supplier to bill Medicare, and to conduct a site visit every 3 years thereafter, which is when suppliers must reenroll.[13] However, applicants know to expect a site visit prior to receiving a supplier number and during a reenrollment period. Therefore, suppliers that are intent on committing fraud can present an illusion of legitimacy long enough to pass the inspection, knowing an inspector is not likely to return for 3 years.

## Recent Steps May Help Curb Improper Payments

CMS officials indicated to us that they first became concerned about power wheelchair billing in early 2003. At that time, CMS created a task force to address abuses of the wheelchair benefit and developed a 10-point plan for addressing this potential abuse. CMS issued the plan in September 2003. In December 2003, Congress passed the MMA, which includes measures that should also help CMS deter improper payments for power wheelchairs and other DME items.

CMS's 10-point plan provides a reasonable framework to strengthen the processes that CMS and its contractors use to identify and respond to improper payments for power wheelchairs. Two points in the plan specifically address fraud, abuse, and utilization issues in Harris County, Texas. They require CMS staff to review all payments for power wheelchairs in the county and conduct mandatory training of all power wheelchair suppliers in the county about Medicare coverage rules. CMS's review of payments in Harris County is ongoing, and all suppliers in Harris County had been trained as of October 2003. Other parts of the 10-point plan are in different stages, from planning or early implementation to completion. Information on each of the 10 points is presented in table 2.

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

**Table 2: CMS's 10-Point Plan**

| Point | Purpose | Plans and actions |
|---|---|---|
| 1 | Prevent fraudulent suppliers from enrolling in Medicare for the sole purpose of receiving inappropriate payments. | CMS stated that it would begin to aggressively scrutinize all new applications. NSC stopped issuing new supplier numbers in Harris County, Texas, in April 2003 and nationally in September 2003. NSC began issuing supplier numbers again in November 2003. |
| 2 | Identify and prevent inappropriate enrollment of suppliers by providing a more detailed screening process, allowing CMS the time needed to properly review applications, and providing sanctions against suppliers abusing the enrollment process. | CMS stated its intent to publish regulations to enhance the ability to screen new supplier applications. |
| 3 | Address rampant fraud and abuse in the Harris County, Texas, area. | CMS stated that, effective with the plan's issuance, all payments for power wheelchairs in the Harris County, Texas, area would be individually approved by CMS staff in the Dallas regional office. |
| 4 | Ensure that all wheelchair suppliers in Harris County, Texas, know and understand Medicare coverage rules. | CMS stated that it would require all wheelchair suppliers in Harris County, Texas to attend mandatory training on wheelchair coverage and medical review policies. |
| 5 | Quickly identify and punish fraudulent suppliers and stop the improper "hemorrhaging" of Medicare dollars. | CMS, DME regional carriers, and law enforcement agencies will collaborate to process civil and criminal prosecutions. CMS also pledged to use payment suspensions. |
| 6 | Ensure that national policy accurately defines the conditions under which Medicare will cover mobility products. | CMS stated that it would finalize regulations revising coverage policy for power wheelchairs and scooters; the policy will require a medical provider to see a patient before prescribing a power wheelchair or scooter. |
| 7 | Accurately portray the clinical conditions for which mobility products are reasonable and necessary and facilitate correct billing and payment for mobility devices. | CMS stated that DME regional carriers would immediately adopt local medical review policies to educate suppliers and beneficiaries on Medicare's coverage criteria for wheelchairs. |
| 8 | When national billing and utilization trends are identified, ensure that only claims that are reasonable and necessary are paid and resolve national billing problems in a consistent manner. | CMS stated that the DME regional carriers would adopt a consistent approach to medical review. |
| 9 | Ensure that Medicare is paying appropriately for power wheelchairs. | CMS stated that it would develop inherent reasonableness guidelines and apply this process first to power wheelchairs. |
| 10 | Put physicians and beneficiaries back in charge of their mobility equipment decisions. | CMS stated that it would clarify physicians' responsibilities for prescribing power wheelchairs and educate beneficiaries about Medicare's coverage criteria. |

Source: GAO analysis of CMS's 10-point plan.

In December 2003, following release of the plan, the DME regional carriers issued a bulletin outlining coverage criteria for power wheelchairs. The bulletin sparked controversy among suppliers, beneficiary advocates, and industry representatives, who argued that it reflected a new, overly restrictive coverage policy for power wheelchairs. CMS countered that the bulletin clarified long-standing national policy, but because of the

concerns raised, it rescinded the bulletin. CMS is still considering whether change to coverage criteria for power wheelchairs is needed.

One area beyond the scope of the 10-point plan is the marketing of power wheelchairs to Medicare beneficiaries. Many individuals with whom we spoke contended that abusive and misleading marketing have further escalated utilization nationwide. A Texas supplier and CMS staff reported that companies were soliciting business door-to-door or promising free power wheelchairs to beneficiaries. Supplier advertisements on the Internet, in print, and on television have used the word "free" in connection with beneficiaries' receiving power wheelchairs. Appendix II shows an example of an Internet advertisement that appears to illegally offer to waive Medicare copayments.[14] A statutory provision prohibits suppliers from calling beneficiaries to solicit their business[15] and this is reflected in the supplier standards. CMS has authority, however, to impose additional requirements[16] and has not utilized this authority to ensure that supplier marketing is not abusive or misleading.

The MMA includes two provisions that are intended to help CMS curb improper payments for power wheelchairs. First, it requires CMS to develop a new set of quality standards for suppliers[17] that should complement the 21 standards suppliers must currently meet. The MMA also includes a provision that requires a face-to-face examination of a beneficiary by a physician, physician assistant, nurse practitioner, or clinical nurse specialist to certify the medical need for a power wheelchair.[18] This provision is more stringent than the prior regulation, which did not necessitate a face-to-face appointment between a beneficiary and his or her prescribing health care professional. CMS is now developing quality standards for oxygen services and diabetic shoes, and regulations to implement the provision regarding a face-to face examination.

[14]Medicare prohibits suppliers from waiving copayments routinely or when waiver is offered as part of an advertisement or solicitation. 42 U.S.C. § 1320a-7a(a)(5) and (i)(6)(A) (2000).

[15]42 U.S.C. § 1395m(a)(17) 2000.

[16]42 U.S.C. § 1395m(j)(1)(B)(ii)(IV) (2000).

[17]MMA § 302(a)(1), 117 Stat. 2223.

[18]MMA § 302(a)(2), 117 Stat. 2224.

## New Authority Holds Promise for Improving CMS's Success in Adjusting DME Payment Rates

New authority and requirements for CMS in the MMA show more promise than past agency authority for setting market-driven payment rates. In the past, CMS generally was not successful in adjusting Medicare payments for DME to keep pace with changes in prices for medical equipment.[19] As a result, Medicare often pays substantially more for an item than other public payers. The MMA requires CMS to begin using competitive bidding to set payment rates for DME.[20] Competitive bidding has shown promise as a way to use market forces to reduce payment rates for selected items.

### Agency Attempts to Adjust DME Payment Rates to Reflect Market Prices Largely Unsuccessful

Prior to 1997, CMS could adjust DME payment rates that were inherently unreasonable, but the process required was slow, cumbersome, and used successfully only once. In the Balanced Budget Act of 1997,[21] Congress responded to concerns about CMS's difficulties in adjusting excessive payment rates by authorizing use of a streamlined inherent reasonableness process for part B services (excluding physician services) and equipment. Under this authority, CMS could adjust payments by up to 15 percent per year using the streamlined process or could use a process with formal notice and comment to make larger adjustments. CMS published an interim final rule with comment period in order to allow the DME regional carriers to use the authority as soon as possible.[22] CMS did not respond to comments before its rule became effective.

DME regional carriers collected price data for eight groups of items and then took the first steps in applying the inherent reasonableness process to change payment rates for those items by publishing a notice to suppliers in September 1998. At that point, industry groups and suppliers expressed concerns about how the streamlined process had been implemented and the appropriateness of how price data were collected. Congress directed that we review the implementation of the streamlined inherent reasonableness process and in 1999, suspended any use of this authority until we issued our report and the agency issued a final rule taking into account our findings and public comments.[23] Our July 5, 2000, report

[19]GAO-02-833T.

[20]MMA § 302(b), 117 Stat. 2224.

[21]Pub. L. No. 105-33, § 4316, 111 Stat. 251, 390.

[22]63 Fed. Reg. 687 (Jan. 7, 1998).

[23]Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, § 223, 113 Stat. 1501, 1501A-352 (signed into law November 29, 1999).

recommended, among other things, that CMS clarify criteria for using its inherent reasonableness authority, strengthen carrier data collection methodology, and monitor beneficiary access after any payment changes.[24]

Since issuance of that report, CMS has not used its inherent reasonableness process to adjust payment rates. CMS issued an interim final regulation to implement its authority on December 13, 2002, which responded to comments on its previous regulation and our report.[25] The agency is still completing more specific guidelines for revising payments, including how to collect data that are valid and reliable. CMS and a contractor are developing the guidelines and the agency intends to issue them by the end of 2004, after which it can begin using the inherent reasonableness process. In its 10-point plan, CMS has pledged to collect data on power wheelchair prices as soon as these guidelines are finalized.

In our report, we recommended that CMS define in its regulation when payment rates would be considered what the statute calls "grossly excessive" and "grossly deficient." It is in these situations that CMS may use its inherent reasonableness authority. CMS indicated in its regulation that it would adjust payment rates only when they were at least 15 percent above or below a "realistic and equitable" amount. By doing so, CMS limited its authority to adjust payment rates, since the agency has statutory authority to adjust fees when the difference is less than 15 percent.

## New Authority Holds Promise to Help CMS Set Payment Rates Closer to Market Prices

The MMA gave CMS new authority and the requirement to begin using competitive bidding to set payment rates for DME. Through competitive bidding, suppliers provide information on amounts they would accept to gain business from Medicare beneficiaries, and their bids are used as a basis for the payment rate. In a demonstration of competitive bidding for DME and other part B-covered items in two localities that concluded in December 2002, fees set through bids were generally lower than fees otherwise paid by Medicare. As a result, Medicare should achieve estimated reductions in payments and beneficiary cost sharing that should

[24]GAO/HEHS-00-79.

[25]67 Fed. Reg. 76,684.

result in gross savings of $8.5 million.[26] Products chosen for the demonstration were among those with the highest Medicare spending and considered by the agency to have the potential for savings. The products chosen did not include power wheelchairs. Estimated savings from the demonstration were accomplished without significant reported effects on beneficiaries' access to competitively bid products.

The MMA requires CMS to implement competitive bidding for DME, off-the-shelf orthotics, and supplies in at least 10 of the largest metropolitan areas by 2007, and 80 of these areas by 2009. CMS has the authority to choose the items to be bid and the specific localities for bidding. CMS has not decided whether power wheelchairs are among the items to be included in its initial implementation. Having suppliers offer bid prices appears to be a promising approach to achieve closer to market prices, compared to the experience CMS has had with the inherent reasonableness process. The MMA allows CMS to use information from the competitive bidding process to adjust payment rates in other localities.

We discussed our findings with program officials, who provided us with technical comments, which we incorporated as appropriate.

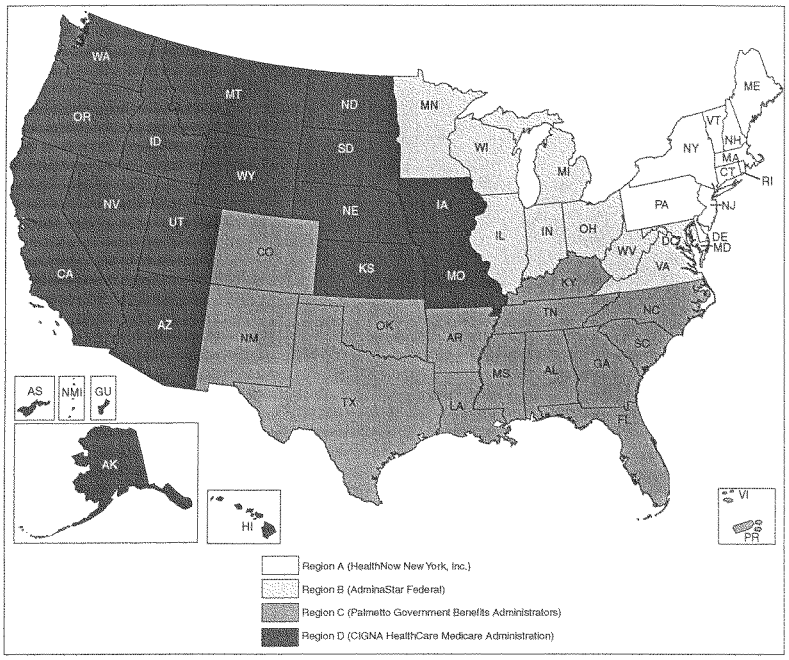
Mr. Chairman, this completes my prepared statement. I will be happy to answer questions you or other Members of the Committee may have.

## Contact and Acknowledgments

For further information regarding this testimony, please contact Leslie G. Aronovitz at (312) 220-7600. Sheila K. Avruch, Jennie Apter, Emily Gamble Gardiner, Sandra Gove, Joy L. Kraybill, Elizabeth T. Morrison, Lisa Rogers, and Craig Winslow contributed to this statement.

[26]CMS conducted the demonstration in Polk County, Florida, and in the San Antonio area in Texas for selected items of DME, orthotics, prosthetics, and supplies (DMEPOS). Two evaluations of the demonstration have been published. See U.S. Department of Health and Human Services, Health Care Financing Administration, *Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS: First Year Annual Evaluation Report* (Baltimore, Md.: September 2000, Revised January 2001) and U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS: Second Year Annual Evaluation Report* (Baltimore, Md.: April 2002).

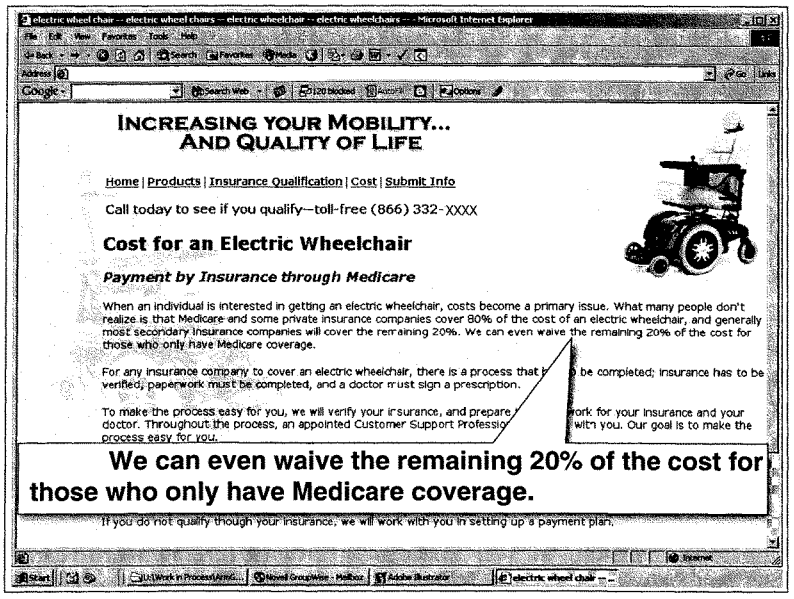
# Appendix I: States in DME Regional Carriers' Jurisdiction




Source: CMS.

Note: AS = American Samoa; GU = Guam; NMI = Northern Mariana Islands; PR = Puerto Rico; and VI = Virgin Islands.

# Appendix II: Internet Advertisement for Power Wheelchairs




Source: Internet Web site.

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TESTIMONY OF
HENRY CLAYPOOL, CO-DIRECTOR
ADVANCING INDEPENDENCE
ON
"FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM"
BEFORE THE
SENATE COMMITTEE ON FINANCE
APRIL 28, 2004

Good morning, Chairman Grassley, Senator Baucus, and other Committee members. Thank you for inviting me to testify today. I am Henry Claypool, the Co-Director of Advancing Independence, a policy forum that advances responsible reforms in Medicare and Medicaid to increase the health, independence, and self-sufficiency of Americans with disabilities of all ages. I am also a former Medicare beneficiary who is acutely aware of the strengths and severe limitations of the program coverage of manual and power wheelchairs.

The focus of this hearing is on what can be done to curb fraud and abuse in Medicare's purchasing of power wheelchairs. Developing more effective ways to do this is something that we all support. But, we believe this must be done without barring beneficiaries from obtaining the medically necessary wheelchairs they need to move about their homes and communities safely and independently. Unfortunately, CMS is acting as if the only way it can combat fraud is to severely limit the benefit in ways that undermine the health, independence and dignity of thousands of beneficiaries of all ages. We believe that this is wrong and will prove extremely costly to the Trust Funds.

Confusion regarding the wheelchair benefit arises from two key factors. The first is there is a complete lack of clear, up to date clinical standards set by Medicare for determining who needs a manual or power wheelchair. The second is CMS is instead using an overly restrictive interpretation of the statutory phase "used in the patient's home" to limit when Medicare will buy a wheelchair for someone. Congress used this phrase when it created the DME benefit to make certain that Part B paid for such equipment only when the person was living at home, so as not to duplicate payments for persons when they were in a hospital or skilled nursing facility and Part A would cover it.

But, CMS has long had a far more restrictive interpretation of what the phrase means in regard to when Medicare will pay for a manual or power wheelchair. And, it's becoming far more restrictive with each passing day. Today, Medicare will only buy a wheelchair for someone when the person: 1. Is "bed or chair bound"; and 2. Needs that specific wheelchair to move about within the 4 walls of their home.

At first glance, this may seem like a reasonable coverage policy that meets the needs of beneficiaries and helps promote the integrity of the program. Let me highlight why this is not the case by sharing with you snapshots of how this policy has impacted 3 former and current beneficiaries and countless more as well.

My personal experience with Medicare: I had Medicare coverage from 1984-1994 after I sustained a spinal cord injury in college. Back then I was eligible for both Medicare and Medicaid. I was fortunate to have Medicaid, which filled some of the coverage gaps in Medicare benefits. Medicare would only pay for a standard manual wheelchair that was suitable for use in my home. Without Medicaid paying for a sturdier, yet lightweight, manual wheelchair that enabled me to move about the hilly campus of the University of Colorado I would not have finished my education.

I eventually returned to work, left the Medicare and Medicaid rolls and several years later went to work for HCFA Administrator Nancy-Ann DeParle. It was when I was at HCFA that I obtained my power wheelchair using my private coverage. I did so because I needed it to go to work and because my shoulders would soon wear out from over exertion. Had I been on Medicare at the time, the claim likely would have been rejected because I do not need a power wheelchair to move about the four walls of my home. Mr. Chairman, you were one of authors of the Ticket to Work Act. I would respectfully ask that you reflect upon whether it was your or others' intent to extend Medicare coverage as an incentive to return to work only to have the program deny the wheelchair they need to get out the door.

April: April is an elderly woman with Chronic Obstructive Pulmonary Disease (COPD), and has had a portion of her lung removed. She requires continuous oxygen therapy; all day every day, but lives independently in own home. She drives her own car but has difficulty walking the distances necessary to complete the tasks that allow her to live at home. She has been unable to get to the grocery store to complete her shopping for past four months and relies on others to go purchase the food she needs for meals. When she drives to doctor's appointments, she waits in the car until someone brings an office-owned manual wheelchair out to her car to push her into the office. Medicare will not buy April a wheelchair because she does not need one within the 4 walls of her house.

Linda: Linda has Multiple Sclerosis. Her symptoms wax and wane. Most days Linda can walk from her bedroom to the bathroom, to the kitchen the whole time using the walls and furniture to steady herself as she moves from room to room in her 750 square foot apartment. On other days she is hardly able to make it from her bedroom to the bathroom. If Linda lived in a larger home, she might qualify for a wheelchair since she cannot use walls and furniture to steady herself to move about a larger home. Then again she might not.

CMS considers it an abuse for a beneficiary to use Medicare to obtain an appropriate wheelchair even when their physician certifies that it is medically necessary for them to use to move about safely and independently both in their home and community. Mr. Chairman, the agency cannot possibly curb fraud and abuse so long as it continues to assume that its major tool in doing so is to enforce a coverage policy that completely ignores the medical and very practical needs of people who use wheelchairs.

We have 4 brief recommendations that I can share now or hopefully during the question and answer period on what Medicare can do to better fight fraud and abuse without harming beneficiaries.

Recommendations:

1. CMS should immediately initiate a process for working with people with disabilities, physicians, clinicians, industry and others to develop a fair and rational coverage policy that ensures beneficiaries with legitimate medical needs have access to wheelchairs for use in their homes and communities and addresses the issue of combating fraud.

2. Any new national coverage policy should include objective medical standards developed by clinicians that specialize in conducting evaluations of people with functional limitations that arise from disability or the aging process. These standards should be consistent with contemporary standards of medical practice.

3. If CMS believes it is not able to carry out the first two recommendations because it views the statute as not permitting such actions, it should report to this Committee on what the basis of its interpretation for this is.

4. I am attaching to my written comments, a legislative history of the Medicare DME submitted to CMS 3 years ago on behalf of several organizations in follow up to the President's New Freedom Initiative. This history calls the agency's interpretation into sharp question. CMS said it would address these claims but it never has. I respectfully request that this Committee find out why not.

Thank you for this opportunity to raise these critical points, I look forward to answering any questions you might have.

*TESTIMONY BEFORE THE UNITED STATES SENATE COMMITTEE ON FINANCE*

*Laura Cohen PT, PhD, ATP*

*Physical Therapist and Assistive Technology Practitioner Consultant*

*Tucson, AZ*

*April 28, 2004*

Chairman Grassley and Members of the Committee: Good morning. Thank you for the opportunity to be here today to discuss how to ensure that individuals with disabilities receive appropriate and necessary wheeled mobility devices, while guarding against waste and abuse of federal Medicare funding.

My name is Laura Cohen. I am a physical therapist and hold a Ph.D. in Rehabilitation Science from the University of Pittsburgh. I am also credentialed by the Rehabilitation Engineering & Assistive Technology Society of North America (RESNA), as an assistive technology practitioner.

My experience includes three distinct professional activities spanning a period of 17 years: direct and supervisory clinical service; policy development; and claims review. I have provided direct clinical physical therapy services and have supervised other professionals and students throughout my career. These services included evaluations and recommendations for medically necessary seating and mobility systems. As part of these duties, I prepared documentation required for equipment to be funded by Medicaid, Medicare and numerous insurers. I worked to develop "medical necessity" guidelines for specialty manual and power wheelchairs for the Pennsylvania Medicaid program; participated in the development of a multi-agency and multi-task assistive technology services delivery program in Tucson, Arizona and proposed a similar model assistive technology services delivery program for an administrative region of the Department of Veterans Affairs. For the past six years, I have served as a second level reviewer of durable medical equipment claims for the contractor that administers the military medical TRICARE program in 16 states.

I believe my experience with these diverse medical benefits programs gives me a broad perspective regarding durable medical equipment evaluation and recommendation practices.

I am pleased to have this opportunity to discuss with you the policies, methods and procedures that I employ as a physical therapist and assistive technology consultant to ensure that individuals with need for power wheelchairs receive equipment that meets their immediate and future anticipated mobility needs in a cost effective manner.

**My Testimony Does Not Address Medicare Fraud**

My testimony will include suggestions for modifying the Medicare process to ensure needed services are provided while protecting against waste and abuse of resources. By contrast, my testimony will not address Medicare fraud. Fraud, in my opinion, is not impacted by regulation or the claims review process. Neither will it control falsification of claims and documents or other fraudulent acts. However, much can be done to ensure that Medicare only pays for the most medically necessary, appropriate, and cost effective devices.

**My Role As A Second Level Reviewer**

I was hired by a TRICARE contractor to review the medical necessity and appropriateness of requests for items of durable medical equipment that exceed $1,500. These equipment requests include items such as seating systems, manual and power wheelchairs, scooters and vehicle lifts. These categories of devices represent multiple Healthcare Common Procedure Coding System (HCPCS) codes. This means that there

are numerous individual device choices within each code. More specifically, it is my job to determine whether the clinical data submitted, in support of the funding request, identifies the recipient's current and reasonably anticipated future medical needs; and whether the device requested represents the most cost effective alternative to meet those needs.

My review functions arise as part of a prior authorization (prior approval) procedure, which is utilized by TRICARE. Prior authorization also is commonly used by insurers and Medicaid programs. It requires the recipient or provider to submit documentation in advance of delivery of the item or service. Only if the documentation is complete and the recommendation is well justified is the request approved. If gaps in the data exist, or if the data raise questions about the recommendation, the reviewer can insist that additional information or explanation is provided before any financial obligations or commitments are created.

By contrast, Medicare is a claims based system, in which the item must be delivered or the service provided before a claim for payment is submitted. This procedure does not utilize a skilled reviewer, and it does not facilitate correction of documentation related flaws or analytic gaps.

Despite these procedural differences, TRICARE defines "durable medical equipment" in a manner that is not materially different from the Medicare definition of this phrase. Also, TRICARE's definition of "medically necessary" is substantively equal to the Medicare standard of "reasonable and necessary."

For DME requests for power wheelchairs, the TRICARE Central Region requires the following written documentation for review and prior authorization: a signed

prescription from a physician; an order that specifies and justifies the equipment; and a price quote with HCPCS codes. In addition, there may be other supporting documents submitted including physician notes, test results, and therapy reports. Presently, there are no guidelines that identify the specific data that must be assessed or reported.

In addition, there are no specific qualifications with regard to the professionals who can submit documentation in support of a manual or power wheelchair funding request. One constraint on imposing requirements for specific professionals as data sources is the need for TRICARE recipients in rural areas to have adequate access to covered items and services.

When I perform a review of documentation submitted in support of a manual or power wheelchair funding request, I examine three critical components of the assessment and reporting process: the physical evaluation; the assessment of the individual's environment; and the specifications of the technology being requested for payment. As both a clinician and claims reviewer, I find these three components must be present for the wheelchair funding documentation to be complete and to adequately explain the basis for the device being requested. As an aside, copied physician notes not specific to the wheelchair request and certificates of medical necessity are not particularly useful to me.

Based on the information provided, I make one of four recommendations: I approve the request; I suggest an alternate device; I recommend further assessment to collect needed missing information; or I deny the request. My recommendation then goes to the regional Medical Director for final determination.

## OBSERVATIONS

### The Clinical Decision Making Process

A clinical evaluation of an individual's physical, functional and environmental characteristics is the cornerstone of the inter-related decision making processes in which an individual's mobility needs are documented. The average licensed clinician, given a list of required elements, would be skilled to fill this role. However, specialty knowledge of the plethora of equipment options and features is required to link an individual's mobility needs to specific equipment features. In addition, a supplier with specialty knowledge is needed as an integral member of the team to link equipment features to a specific device that will work in an individual's environment. The outcome of this team process is a recommendation for a manual or power wheelchair system that is appropriate to meet the individual's present and anticipated mobility needs. This information in total is submitted for third party funding approval. When properly documented, this process leads to efficient decision making within the third party funding process.

My observation is that the documentation I review frequently lacks information and rationale to justify the request. Therefore I often am unable to make a clinical decision of medical necessity, appropriateness or cost effectiveness without requesting additional information.

### Clinical Assessment and Reporting Guidance are Needed

One solution to assessment or documentation omissions is for funding programs such as Medicare to adopt coverage criteria that spell out the data required to be assessed and reported as part of the decision making process. The Medicare coverage policies for

"lower limb prostheses" and "speech generating devices" are good examples of such coverage policies [posted at: http://www.cignamedicare.com/dmerc/lmrp_lcd/LLP.html and http://www.cignamedicare.com/dmerc/lmrp_lcd/SGD.html]. Each of these guidelines state clear expectations regarding clinical assessment and data reporting.

Clearly stating the assessment and data reporting expectations provide several benefits. The publication of assessment and reporting guidelines helps to ensure all necessary data have been gathered; relevant topics addressed and documented to support funding requests. Of equal importance, a clinician with general experience will be able to recognize when collaboration with a specialist is needed.

**A Means to Identify Skilled Professionals is Needed**

There is a documented shortage of skilled and trained professionals competent to evaluate, recommend and supply seating and mobility devices. It is very difficult to identify qualified and knowledgeable clinicians and suppliers. Another way to improve the quality of assessment and documentation supporting manual and power wheelchair funding requests is to focus on the professionals who are involved in the data gathering and reporting process.

In efforts to help identify skilled assistive technology professionals RESNA has instituted voluntary credentialing programs for providers who have demonstrated a combination of education, experience and minimal competency. There are three credentials available: the ATP for Assistive Technology Practitioner that includes clinicians such as physicians, occupational and physical therapists; the ATS, for Assistive

Technology Suppliers, and the RET for Rehabilitation Engineering Technologists and professionals.

As of March 31, 2004 there are 2169 credentialed professionals (1328 ATPs, 817 ATSs, and 24 RETs). By and large, despite the increasing number of credentialed clinical practitioners, this voluntary credential has not been widely pursued by the clinical community. Although it is not a perfect test of wheelchair and seating assessment skill, it is the only existing means by which clinicians interested and experienced in these areas of practice can distinguish themselves.

In efforts to identify skilled suppliers to provide DME for Medicaid recipients, approximately ten states are considering consumer protection legislation that requires suppliers to employ RESNA credentialed staff (ATSs) for the delivery of seating and mobility equipment. One state (Tennessee) has adopted consumer protection legislation for wheeled mobility. In response, there has been a rise in the number of credentialed suppliers in efforts to meet this service demand.

Although numbers are small right now, the RESNA credentialing program serves as a vehicle for which clinicians and suppliers that are specialists in the area of assistive technology can be identified. While the RESNA credentialing program is currently entry level, it is a beginning and could be enhanced. No other specialty certification process exists for this field.

Further consideration should be given to the idea of specialty certification and/or credentialing for individuals involved in the decision making process for manual and power wheelchairs. These discussions should occur with the American Occupational Therapy Association (AOTA), American Physical Therapy Association (APTA), and

RESNA so that there is a higher degree of confidence regarding the skill and experience of those involved in this decision making process.

**Functional Classifications and Coding**

The CMS coding and coverage policy with regard to wheeled mobility has not kept pace with changes in technology. Stated most generally, coding for manual and power wheelchairs focuses primarily on the chair's weight, and gives inappropriate attention to other important equipment characteristics. In my opinion, wheeled mobility lends itself to a policy similar to that established by CMS for lower limb prostheses (LLP). Sophisticated technology is supported by a coding scheme that is linked to functional classifications. The LLP policy acknowledges different levels of function of beneficiaries first, and then based on clinical indicators, links functional classifications to HCPCS codes. Wheeled mobility policy lends itself to a similar classification system that is based on an individual's physical ability, environmental considerations, and mobility potential. If the technology is adequately defined by HCPCS codes, then appropriate payment for the product provided should occur. Moreover, if there is a clear Medicare coverage policy, the review of medical need becomes objective, consistent, and predictable.

**Prior Authorization and Peer Review**

Given the sophistication of wheeled mobility technologies, certain devices should be subjected to a prior authorization process including review by an independent clinical peer reviewer. Determining what will be paid prior to purchase will add much needed

predictability to the system. As noted previously, prior approval is the standard operating procedure for TRICARE, Medicaid and many insurers. A system consisting of: (a) clear coverage guidance; (b) focus on skilled decision makers and skilled reviewers; and (c) a prior authorization procedure, has the potential to eliminate both CMS and Congressional concern about waste and abuse regarding Medicare manual and power wheelchair funding.

A true prior authorization process differs from the current Advanced Determination of Medical Coverage (ADMC) process. The latter does not guarantee authorization of payment. It is designed only to determine establishment of medical need. With the ADMC process if complete documentation for clinical decision making is not included the application is denied. It leaves the consumer and supplier in a position where the provision of supplemental documentation that may support a request cannot be submitted for another 6 months.

I am not suggesting that, nor is it necessary, for Medicare to re-design its entire administrative structure to accommodate a prior authorization procedure. To the contrary, prior authorization for selected items, such as certain manual and power wheelchairs is all that is proposed here.

**RECOMMENDATIONS FOR SAFEGUARDING CMS SYSTEM**

In order to make meaningful recommendations for safeguarding the CMS system, it is important to outline the key elements in the overall process. Any gap or inadequacy in the process can cause the system to fail in its efforts to curtail waste and abuse.

The foundation for the process requires adequate coding, coverage and appropriate payment. These elements are truly the foundation the rest of the process is built upon. It is also important to recognize that, historically, policy implemented by CMS is commonly used as a model for other third party payors.

In my opinion, the committee should look at the existing CMS policy for the lower limb prosthesis as a model for safeguards in the present system for manual and power wheelchairs. I advocate for a new wheeled mobility policy that emulates the lower limb prosthesis coverage policy. This policy would provide for wheeled mobility technology that is: reasonable and necessary for the diagnosis or treatment of illness or injury; and required to improve or augment functioning due to an unmet functional mobility need.

A **new coverage policy** would incorporate the development of a functional classification system that would be linked to a revised coding scheme. Corresponding clinical indicators would be employed to adequately categorize various mobility technologies. Unique codes must be established that recognize differences in technology and keeps pace with the development of new technologies. Distinct coding also provides for payment to be appropriate for the actual level of technology being provided.

The medical equipment industry (Power Mobility Coding Task Force under the auspices of AAHomecare) submitted a power wheelchair code application to CMS in

March 2002 and again in March 2003. The proposal reflects a system consistent with this recommendation. I suggest that this proposed coding scheme be adopted and implemented in a timely fashion. [Exhibits A, B and C]

Similarly, when addressing the issue of knowledgeable professionals I would direct the Committee to existing CMS policy regarding Speech Generated Devices (SGD). For SGDs, Medicare recognized that the speech-language pathologist is the professional best able to make determinations of medical need. Presently, the SGD coverage policy represents the only Medicare covered item or service for which a non-physician is permitted to make this determination. Manual and power wheelchairs should be another. For seating and mobility systems, it is far more likely that the most knowledgeable professional is the occupational or physical therapist. A coverage policy that reinforces the role of the most knowledgeable professional will increase the overall quality and credibility of the recommendations being presented to Medicare for funding. Although I have proposed a re-evaluation of the physician's dominant role in the data gathering and decision making process, I advocate a procedure in which the physician remains involved.

Procedurally, I would encourage a clear **requirement for written documentation** that will be useful and sufficient in making clinical decisions about medical necessity and appropriateness. Minimally this should include the elements of the physical evaluation, environmental considerations, technology specification and rationale for selection. Documentation would not need to be submitted with a claim; however, would need to be in the supplier's files and subject to preauthorization review or post payment audit. The data to be submitted for payment should include information about

the patient's diagnosis code, functional level, environmental mobility needs, equipment specifications (manufacturer and model) with technology codes and Medicare's Fee Schedule. This information, when signed by the physician will serve as the prescription and request.

This documentation will be submitted to Medicare as part of a limited or focused prior authorization process. A **prior authorization process, utilizing a qualified clinical peer reviewer**, who determines whether the documentation is complete and the recommendation adequately justified, should be limited to certain sophisticated technologies for those beneficiaries with the most complex functional needs. These beneficiaries happen to be the smallest group in the Medicare population. This system will protect consumers and ensure that they acquire the most appropriate equipment that will meet their mobility needs. A preauthorization and analogous **post payment audit process** will facilitate procedural objectivity, predictability and consistency.

In closing, I believe it is crucial in the development of process requirements, regulatory guidelines, and other important policy development aimed at reducing waste and abuse that the patient is not left behind. It is imperative that access to the technology that allows for independence and enhances the quality of life not be denied or reduced. Every effort must be made to ensure access to technology and maintain quality outcomes for the healthcare dollars spent. Ensuring that patients can perform basic activities of daily living in their homes and in their community as well as access to community services is paramount.

Lastly, what could be useful is having an advisory committee provide guidance on these issues. A committee would need representation from the clinical, supplier and industry communities and include a consumer as well.

I would like to offer my assistance to Congress and CMS as you continue to address these important issues. Thank you for this opportunity to express my opinions.

**RESOURCES**

Region D DMERC Local Medical Review Policy for lower limb prostheses (L11453)
http://www.cignamedicare.com/dmerc/lmrp_lcd/LLP.html

Region D DMERC Local Medical Review Policy for speech generating devices (L108)
http://www.cignamedicare.com/dmerc/lmrp_lcd/SGD.html

Rehabilitation Engineering and Assistive Technology Association of North America
http://www.resna.org

Georgia Department of Community Health Division of Medical Assistance policy and procedures for durable medical equipment services
https://www.ghp.georgia.gov/wps/output/en_US/public/Provider/MedicaidManuals/Durable_Medical_Equipment_Services_DME_01_2004.pdf

**Purpose**

The purpose of this document is to detail a proposal for a new HCPCS powered wheelchair coding structure. The Power Mobility Coding Task Force, comprised of power wheelchair suppliers and manufactures under the auspices of AAHomecare, developed this coding proposal as an alternative to the existing HCPCS power wheelchair codes.

**Intent of the Code Proposal**

The HCPCS codes for power wheelchairs currently consists of four codes (K0010, K0011, K0012 and K0014), each of which neither defines the clinical requirements of current power wheelchair consumer nor appropriately characterizes existing powered wheelchair technology. As a result, dilution of the codes original definition has occurred and products designed for very different intents and applications are being categorized in exactly the same manner, regardless of differing technologies designed to meet different consumer needs. The intent of this proposal is to establish a power wheelchair code structure that adequately delineates among real consumer requirements and is ultimately reflected in real and relevant technology differences.

**Scope**

The scope of this document covers all powered wheelchairs, including the base, seat, drive electronics, armrests and footrests. The document does not currently cover pediatric powered mobility devices. Also, the document does not cover power wheelchair accessories, including powered seating devices such as powered tilt systems, alternate control devices, or other power wheelchair accessories. Power wheelchair accessory codes are currently being established through the on-going work of the DMERC Medical Directors and SADMERC. The proposed codes have been designed to interface with the accessory codes currently under review by CMS. The coding structure has also been designed such that pediatric codes would fit into the structure at a future time.

**Rationale**

There are two equally relevant methods for categorizing powered wheelchairs. The first deals with the clinical presentation of the patient characterized by diagnosis, prognosis and symptomotology. The second is to delineate the specific differences among existing technologies to create appropriate coding categories. The most relevant coding strategy includes creating code descriptors and definitions that intersect both clinical requirements and technical specifications for the widest variety of patient diagnosis, prognosis and symptomotology.

The process of developing the codes proposed in this document involved a careful examination of the clinical needs of patients who require powered wheelchairs along with a comprehensive survey of current powered wheelchair technologies.

This document proposes seven new powered wheelchair "E" codes (designated E1 – E7 for purposes of this proposal) and the elimination of the current power wheelchair "K" codes. This is not a hierarchical coding structure. The patient who requires a power wheelchair included in the E2 code, for example, would not derive additional clinical benefits from the features provided by products included in the E3, E4, E5 or E6 code. The underlying premise of this coding proposal is to provide the patient with the most cost-effective powered wheelchair that meets both his and her current and long-term needs. In order to meet the needs of all patient populations we will

require a code to upgrade the weight capacity of E2, E3, E4 and E5 to accommodate patient weights of 251 to 399 ponds.

The following section is a general overview of the proposed coding scheme. The details of product definition and clinical indicators are included later in this document.

- **E1 - Non-modular powered wheelchair**
    - Describes a traditional powered wheelchair with a fixed or folding, tubular design frame. This code describes a wheelchair that is appropriate for a patient who requires powered mobility but does not require any specialized seating other than possibly a cushion for support and pressure reduction.
- **E2 –General Purpose Modular Powered Wheelchair**
    - *NOTE: The "modular" designation describes a powered wheelchair design that includes a base unit containing the motors and batteries and a separate section that includes the seat/back and in codes E3, E4, E5 and E6 also includes other postural positioning components.*
    - The General Purpose Powered Modular Wheelchair code includes products that are designed to meet the needs of individuals who require powered mobility and also have single-plane, fixed orthopedic deformities that require posterior support. These powered wheelchairs accommodate for these deformities by allowing for a range of seat-to-back angle settings. These chairs also allow a seating surface to floor height can be set to meet the patient's specific functional needs, e.g., facilitating transfers, appropriate positioning relative to surfaces such as tables or sinks, etc.
- **E3 –Positioning Modular Powered Wheelchair**
    - This code includes powered wheelchairs that provide all the capabilities described in the E2 code and add the following features as well:
    - More aggressive postural seating support allowing the mounting of secondary positioning components to meet patient's physiologic and functional needs, including any of the following: lateral thoracic supports; lateral hips supports, medial thigh supports (abduction wedge); adjustable head supports; seats and backs fabricated to patient measurement; anterior thoracic supports; anterior knee supports, etc.
    - Meeting the needs of the patient who cannot, due to diagnosis or symptomotology, operate a powered wheelchair using a traditional joystick control interface by accommodating, as needed, alternative means of controlling the movements of the powered wheelchair.
    - Accommodates the patient who is unable to perform independent weight shifts, or for whom a cushion alone does not provide adequate pressure reduction/distribution by accommodating either a power tilt or power recline seating function.

- The adaptability of the chairs included in this code allow a proactive approach to providing equipment that meet the patient's current needs yet allow for changes in both electronic and powered seating options as the patient's condition dictates over time.

- **E4 –Multi-function Positioning Modular Powered Wheelchair**

  - This code includes powered wheelchairs that provide all the capabilities and adaptability described in the E3 code and adds the following features as well:

  - Accommodate more complex pressure distribution/reduction and positioning needs by allow at least two power seating function, e.g., power tilt and power recline. In order to accommodate multiple power seating functions, the powered wheelchairs included in this code represent a distinctly different technology that incorporates structural and other design changes that enhance stability and performance to meet these added demands.

  - The chairs included in this code also accommodate the needs of a client who requires ventilator and/or other respiratory technology by providing appropriate on-chair mounting of this equipment.

  - As in the E3 code, the adaptability of the chairs included in this code allow a proactive approach to providing equipment that meet the patient's current needs yet allow for changes in both electronic and powered seating options as the patient's condition dictates over time.

- **E5 –Active Performance Modular Powered Wheelchair**

  - The powered wheelchairs represented in this code contain most of the features in the E3 and E4 codes but incorporate specific design and technology characteristics that allow for significant increases in the functional capability of the wheelchair, including: added speed; enhanced negotiation of uneven and rough terrain; increased incline climbing performance and obstacle climbing, e.g., higher door sills, etc.

- **E6 – Heavyweight Capacity Powered Wheelchair**

  - The powered wheelchairs included in this code include many of the features described in E1 and E2 but are specifically designed to meet the needs of clients who weigh more than 400 but less than 500 pounds. These weight requirements are not available as add-on or adaptation of the chairs included in the previous codes. To accommodate the additional weight capacity these chairs incorporate specific parameters in structural, electronic and motor design.

- **E7 – Not otherwise Classified Powered Wheelchair**

- This code is intended to provide access for the patient to powered wheelchairs that are not included by design parameters or clinical and functional capabilities in codes E1 – E6. The chairs in this code are the "outliers" – the lower utilization products that are critical to the patient who needs their specific capabilities.

**E1 - Non-modular powered wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her residence; AND
2. Patient performs main activities of daily and instrumental living in environments with smooth, level surfaces; AND
3. Patient's weight and anatomical measurement requirements can be met with product dimensions for width, depth, seat-to-floor height and back heights available in products meeting the description of this code; AND
4. Patient has demonstrated that he/she can use a joystick safely and effectively and does not require any additional electronic interface; AND
5. There are no clinical or functional indications, based upon diagnosis, prognosis or symptomotology, that any additional electronic interface upgrades will be required within five years of powered wheelchair provision; AND
6. Patient does not require positioning assistance; e.g., trunk, pelvic or head support, etc. AND
7. Patient requires only a seat cushion or other appropriate seating surface to meet support or pressure relief requirements.

**E2 - General Purpose Modular Powered Wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her residence; AND
2. Patient performs main activities of daily and instrumental living in environments with smooth, level surfaces; AND
3. Patient's weight and anatomical measurement requirements can be met with product dimensions for width, depth, seat-to-floor height and back heights available in products meeting the description of this code; AND
4. Patient has demonstrated that he/she can use a joystick safely and effectively and does not require any additional electronic interface; AND
5. There are no clinical or functional indications, based upon diagnosis, prognosis or symptomotology, that any additional electronic interface upgrades will be required within five years of powered wheelchair provision; AND
6. Patient requires a seat cushion or other appropriate seating surface to meet support or pressure relief requirements; AND
7. Patient requires a power elevating seat; OR
8. Patient requires a seat and back that can be set within a range of 12 degree angle of posterior recline to accommodate thoracic kyphosis, fixed extensor contractures of the hip, etc. OR:
9. Patient requires a functional height from the seating surface to the floor of greater than or equal to 20" but less than or equal to 24" with 2" of adjustment to facilitate transfers or other functional activities.

**E3 - Positioning Modular Powered Wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her residence; AND
2. Patient performs main activities of daily and instrumental living in both indoor and outdoor environments with smooth surfaces; AND
3. Patient's weight and anatomical measurement requirements can be met with product dimensions for width, depth, seat-to-floor height and back heights available in products meeting the description of this code; AND
4. Patient requires more aggressive seated positioning and the mounting of secondary positioning components to meet patient's physiologic and functional needs, including any of the following: lateral thoracic supports; lateral hips supports, medial thigh supports (abduction wedge); adjustable head supports; seats and backs fabricated to patient measurement; anterior thoracic supports; anterior knee supports, etc.; AND
5. Patient is unable, as a result of diagnosis or symptomotology, to operate powered wheelchair with a standard joystick and requires additional alternative electronic interface; OR
6. There are clinical or functional indications, based on diagnosis, prognosis and/or symptomotology, that the client may require additional electronic interface upgrades within five years of powered wheelchair provision; OR
7. Patient does not have the ability to perform independent weight shifts and a seat cushion or other seating surface alone does not meet pressure relief requirements; AND
8. Patient requires a minimum of one power seating options, including power recline, power tilt or standing system.; OR
9. There are clinical or functional indications; including diagnosis and prognosis, that the patient will require the addition of at least one power seating options, including power recline, power tilt or power standing system within five years of powered wheelchair provision.

**E4 - Multi-function Positioning Modular Powered Wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her residence; AND
2. Patient performs main activities of daily and instrumental living in both indoor and outdoor environments; AND
3. Patient activities of instrumental and daily living require speeds of 5 mph or greater and/or range on a single charge of at least 20 miles; AND
4. Patient's weight and anatomical measurement requirements can be met with product dimensions for width, depth, seat-to-floor height and back heights available in products meeting the description of this code; AND
5. Patient requires more aggressive seated positioning and the mounting of secondary positioning components to meet patient's physiologic and functional needs, including any of the following: lateral thoracic supports; lateral hips supports, medial thigh supports (abduction wedge); adjustable head supports; seats and backs fabricated to patient measurement; anterior thoracic supports; anterior knee supports, etc.; AND
6. Patient is unable, as a result of diagnosis or symptomotology, to operate powered wheelchair with a standard joystick and requires additional alternative electronic interface; OR
7. There are clinical or functional indications, based on diagnosis, prognosis and/or symptomotology, that the client may require additional electronic interface upgrades within five years of powered wheelchair provision; OR
8. Patient does not have the ability to perform independent weight shifts and a seat cushion or other seating surface alone is not sufficient to meet pressure relief requirements.; AND
9. Patient requires 2 or more power seating options, including power recline, power tilt, or power standing system; OR
10. There are clinical or functional indications that the patient will require the addition of at least two power seat functions within five years of powered wheelchair provision; OR
11. Patient is ventilator dependent and requires a powered wheelchair equipped with a vent tray. OR
12. Patient has the physiologic or functional need, as a result of diagnosis or symptomotology, to minimize the transfer of forces from the driving surface/terrain to the patient's body therefore requiring drive wheel suspension.

**E5 - Active Performance Modular Powered Wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her residence; AND
2. Patient performs main activities of daily and instrumental living in both indoor and outdoor environments with uneven terrain and rough surfaces, inclines up to 9 degrees and/or environmental obstacles up to 2.4" in height; AND
3. Patient activities of instrumental and daily living require speeds greater than 7 mph and/or range on a single charge of at least 20 miles; AND
4. Patient's weight and anatomical measurement requirements can be met with product dimensions for width, depth, seat-to-floor height and back heights available in products meeting the description of this code; AND
5. Patient requires more aggressive seated positioning and the mounting of secondary positioning components to meet patient's physiologic and functional needs, including any of the following: lateral thoracic supports; lateral hips supports, medial thigh supports (abduction wedge); adjustable head supports; seats and backs fabricated to patient measurement; anterior thoracic supports; anterior knee supports, etc.; AND
6. Patient is unable, as a result of diagnosis or symptomotology, to operate powered wheelchair with a standard joystick and requires additional alternative electronic interface; OR
7. Patient requires more than one drive profile to accommodate different driving environments or varying physiologic or functional capabilities required as a result of diagnosis or symptomotology; OR
8. There are clinical or functional indications, based on diagnosis, prognosis and/or symptomotology, that the client may require additional electronic interface upgrades within five years of powered wheelchair provision; OR
9. Patient does not have the ability to perform independent weight shifts and a seat cushion or other seating surface does not meet pressure relief requirements; AND
10. Patient requires either power recline or power tilt seating options; OR
11. There are clinical or functional indications, based on diagnosis, prognosis and/or symptomotology, that the patient will require the addition of either power tilt or power recline options within five years of powered wheelchair provision.
12. Patient has the physiologic or functional need, as a result of diagnosis or symptomotology, to minimize the transfer of forces from the driving surface/terrain to the patient's body therefore requiring drive wheel suspension . OR

**E6 - Heavyweight Capacity Powered Wheelchair**

**Clinical Indicators:**

1. Patient cannot ambulate safely, effectively, or efficiently nor can he/she functionally self propel any manual mobility device around his/her primary residence; AND
2. Patient performs main activities of daily and instrumental living in environments with smooth, level surfaces; AND
3. Patient has demonstrated that he/she can use a joystick safely and effectively and does not require any additional electronic interface; AND
4. There are no clinical or functional indications that any additional electronic interface upgrades will be required in five years of powered wheelchair provision; AND
5. Patient requires only a seat cushion or other appropriate seating surface to meet pressure relief requirements; AND
6. Patient does not require positioning assistance; e.g., trunk, pelvic or head support, etc.; AND
7. Patient's weight is more than 400 but less than 500 pounds.

**E7 - Other motorized/powered wheelchair**

If a product does not meet the parameters and clinical indicators included in the first six codes, is considered a power wheelchair, and is not considered a powered add-on device to a manual wheelchair, the product shall be coded as E7.

## Powered Wheelchair Codes Matrix (draft 3/6/03)

| **Code Descriptor** (Note: the shaded/bolded areas highlight a change from the preceding code.) | Non-Modular Powered Wheelchair | General Purpose Modular Powered Wheelchair | Positioning Modular Powered Wheelchair | Multi-Function Positioning Modular Powered Wheelchair | Active Performance Modular Powered Wheelchair | Heavyweight Capacity Powered Wheelchair | Not Otherwise Classified Powered Wheelchair |
|---|---|---|---|---|---|---|---|
| **Proposed Code** | **E1** | **E2** | **E3** | **E4** | **E5** | **E6** | **E7** |
| 1.) User Weight Limit | 250 lbs. | 250 lbs. | 250 lbs. | 250 lbs. | 250 lbs. | **500 lbs.** | |
| 2.) Frame Style | Fold or Rigid | **Power Base** | Power Base | Power Base | Power Base | **Fold, Rigid or Power Base** | |
| 3.) Seat Style (A), (B) | Non-Positioning Seat | **Basic Positioning Seat (A)** | **Advanced Positioning Seat (B)** | Advanced Positioning Seat (B) | Advanced Positioning Seat (B) | **Basic or Advanced Positioning Seat** | |
| 4.) Removable or flip-up armrests | Yes | Yes | Yes | Yes | Yes | Yes | |
| 5.) Swing-away footrests or center-mount footplate | Yes | Yes | Yes | Yes | Yes | Yes | |
| 6.) Std Proportional Joystick- ability to program speed, acceleration, deceleration | Yes | Yes | Yes | Yes | Yes | Yes | |
| 7.) Upgradeable with Alt Drive and Other Electronic Controls | No | No | **Yes** | Yes | Yes | **No** | |
| 8.) Allows Power Seating System | No | **May Offer - Power Seat Elevator Only** | **Minimum of 1 system** | **Minimum of 2 systems** | **Minimum of 1 system** | **No** | |
| 9.) Allows Ventilator Tray | No | No | No | **Yes** | **No** | No | |
| 10.) Drive Wheel Suspension (C) | No | No | No | **Yes** | Yes | **No** | |
| 11.) Seat Width | 16, 18" | **16 to 18"** | 16 to 18" | 16 to 18" | 16 to 18" | **22 to 24"** | |
| 12.) Seat Depth | 16" | 16" | 16" | 16" | 16" | **19 to 20"** | |
| 13.) Functional Seat Height (D) | ≥ 20 and ≤ 24" | ≥ 20 and ≤ 24" | ≥ 20 and ≤ 24" | ≥ 20 and ≤ 24" | ≥ 20 and ≤ 24" | ≥ 20 and ≤ 24" | |
| 14.) Back Height | 16" | **16 and 18"** | 16 and 18" | 16 and 18" | 16 and 18" | 16 and 18" | |
| 15.) Allows for Settable Posterior Seat to Back Angle Adjustment | No | **Yes ≥ 12 degrees** | Yes ≥ 12 degrees | Yes ≥ 12 degrees | Yes ≥ 12 degrees | Yes ≥ 12 degrees | |
| 16.) Allows for Seat Depth Adjustment | No | No | **Yes ≥ 2"** | Yes ≥ 2" | Yes ≥ 2" | **No** | |
| 17.) Allows For Seat Height Adjustment | No | **Yes ≥ 2"** | Yes ≥ 2" | Yes ≥ 2" | Yes ≥ 2" | **No** | |
| 18.) Maximum Speed | ≥ 3 mph | ≥ 3 mph | **≥ 4 mph** | **≥ 5 mph** | **≥ 7 mph** | **≥ 3 mph** | |
| 19.) Minimum Range (E) | 8 miles | **10 miles** | 10 miles | **20 miles** | 20 miles | **8 miles** | |
| 20.) Minimum Obstacle Climb (F) | 20 mm | 20 mm | **40 mm** | 40 mm | **60 mm** | **20 mm** | |
| 21.) Maximum Rated Incline (F) | ≥ 6 degrees | ≥ 6 degrees | ≥ 6 degrees | **≥ 9 degrees** | ≥ 9 degrees | **≥ 6 degrees** | |

## Powered Wheelchair Codes Matrix (draft 3/6/03)

| **Code Descriptor** (Note: the shaded/bolded areas highlight a change from the preceding code.) | Non-Modular Powered Wheelchair | General Purpose Modular Powered Wheelchair | Positioning Modular Powered Wheelchair | Mutli-Function Positioning Modular Powered Wheelchair | Active Performance Modular Powered Wheelchair | Heavyweight Capacity Powered Wheelchair | Not Otherwise Classified Powered Wheelchair |
|---|---|---|---|---|---|---|---|
| **Proposed Code** | **E1** | **E2** | **E3** | **E4** | **E5** | **E6** | **E7** |
| 22.) Two Drum Fatigue Test (F) | ≥ 200K cycles | ≥ 200K cycles | **≥ 220K cycles** | ≥ 220K cycles | **≥ 200K cycles** | **≥ 200K cycles** | |
| 23.) Drop Test (F) | ≥ 6,666 cycles | ≥ 6,666 cycles | **≥ 7,333 cycles** | ≥ 7,333 cycles | **≥ 6,666 cycles** | **≥ 6,666 cycles** | |
| 24.) Frame Warranty | ≥ 12 months | ≥ 12 months | **≥ 36 months** | ≥ 36 months | ≥ 36 months | **≥ 12 months** | |
| 25.) Motor/gearbox Warranty | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | |
| 26.) Electronics Warranty | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | ≥ 12 months | |
| 27.) Additional code applications required | | **Upgrade code needed for wt capacity > 250 and < 400 lbs.**<br><br>**May offer seat widths of ≥ 14 to 24"** | Upgrade code needed for wt capacity > 250 and < 400 lbs.<br><br>**Must offer seat widths of ≥ 14 to 24"** | Upgrade code needed for wt capacity > 250 and < 400 lbs.<br><br>Must offer seat widths of ≥ 14 to 24" | Upgrade code needed for wt capacity > 250 and < 400 lbs. | | |

**Comments:**

(A) Basic Positioning Seat- seat and back that provides for a settable posterior seat to back angle ≥ 12 degrees to accommodate thoracic kyphosis, fixed extensor contractures of the hip, etc.

(B) Advanced Positioning Seat- system that provides for aggressive seated positioning and the mounting of secondary positioning components to meet patient's physiologic and functional needs, including any of the following: lateral thoracic supports; lateral hip supports, medial thigh supports (abduction wedge); adjustable head supports; seats and backs fabricated to patient measurement; anterior thoracic supports; anterior knee supports, etc.

(C) Drive wheel suspension- a power wheelchair shall be considered to have suspension if the product incorporates a structural element whose primary function is to insulate the rider from drive wheel vibrations.

(D) Functional seat height- for Captain's Chair, measurement from floor to top of most forward seat edge; for other seating, measurement from floor to top of most forward edge of seat pan plus 3"; all measurements are at 0 degree horizontal to floor.

(E) Range- the distance the wheelchair can be driven on a single charge with manufacturer's recommended batteries.

(F) Where applicable, criteria was based on relevant ANSI/RESNA standards. See accompanying Powered Wheelchair Code Characteristics document.

# Medicare:
## Medicare Reimbursement for Power Wheelchairs and Scooters

Testimony of
Dara Corrigan
Acting Principal Deputy Inspector General

Hearing Before:
Senate Committee on Finance
Chairman Charles E. Grassley

April 28, 2004


Office of Inspector General
Department of Health and Human Services

**TESTIMONY OF DARA CORRIGAN**
**ACTING PRINCIPAL DEPUTY INSPECTOR GENERAL**

Good morning, Mr. Chairman and Members of the Committee.

Many Medicare beneficiaries with impaired mobility have a legitimate need for wheelchairs and benefit greatly from their use. However, we have found significant and troubling abuses of the Medicare wheelchair benefit that deplete the Medicare Trust Fund of scarce dollars and harm beneficiaries. Today, I will describe some particularly worrisome fraud schemes that our investigators recently have uncovered. I also am issuing two inspection reports on wheelchair problems in the Medicare program. In one study, we found that most power wheelchair claims for Medicare beneficiaries did not meet the program's coverage criteria. The second study addresses Medicare's excessive reimbursement amounts for power wheelchairs.

**POWER WHEELCHAIRS IN THE MEDICARE PROGRAM**

Our office has devoted considerable resources to conducting investigations, evaluations, and audits in the area of medical equipment and supplies. This area of the Medicare program has been particularity susceptible to fraud, waste, and abuse over the years. We have identified problems related to a wide range of items and equipment including oxygen, transcutaneous electrical nerve stimulators, seat lift chairs, orthotic body jackets, wound care supplies, incontinence supplies, and lymphadema pumps. We have found that many medical equipment and supplies: (1) have been susceptible to fraud and abuse; (2) fail to meet coverage criteria and prescription requirements for particular items and supplies; (3) and have been reimbursed at excessive amounts. When we do shut down the fraud and abuse for one item or supply, it is only a matter of time before we see similar issues associated with other medical equipment and supplies.

The three vulnerabilities mentioned above are now present with respect to power wheelchairs. To preserve the integrity of the power wheelchair benefit and prevent excessive payments, Medicare must ensure that suppliers are legitimate, beneficiaries are eligible to receive the equipment, physicians are prescribing equipment appropriately, and equipment is reasonably priced.

Over the past several years, Medicare has seen notably dramatic growth in expenditures for power wheelchairs, particularly for the power wheelchair with Healthcare Common Procedure Coding System (HCPCS) code K0011, which is for a standard-weight power wheelchair with programmable control parameters. Spending for power wheelchairs increased approximately 350 percent from 1999 to 2003, while total Medicare expenditures have increased only 23 percent for that same time period. Between 2001 and 2002 alone, Medicare payments for procedure code K0011 rose from $513 million to $829 million, a 62 percent increase. Payments for K0011 power wheelchairs continue to rise and have already reached $1.2 billion for 2003, which is 12 percent of total Medicare Part B expenditures for medical equipment and supplies. Beneficiaries are responsible for 20 percent of the allowed payment amount in the form of coinsurance.

Medicare also has seen an increase in utilization of the power wheelchair benefit. The number of Medicare beneficiaries with at least one claim for a motorized wheelchair rose from approximately 55,000 in 1999 to an estimated 274,000 in 2003, an increase of almost 400 percent. During the same time period, the overall Medicare population rose only 1 percent per year. We recognize that some of this rise may be attributable to such things as technological improvements or successful beneficiary outreach rather than solely fraud and abuse issues. However, as I will discuss below, we believe that the wheelchair benefit is a significant vulnerability to the Medicare program.

There are three main controls in place to help limit abuse of the wheelchair benefit. First, in order to qualify for power wheelchairs, beneficiaries must meet Medicare's coverage criteria. Beneficiaries must be bed or chair confined, unable to operate a wheelchair manually, and capable of safely operating the controls of the power wheelchair. A Medicare beneficiary who qualifies for a power wheelchair usually is totally non-ambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition.

Second, to help ensure the appropriateness of the equipment prescribed, suppliers who submit claims for power wheelchairs must include a Certificate of Medical Necessity (CMN). A physician is required to sign, date, and complete the medical justification portion of the CMN. This is perhaps the most fundamental safeguard that the program relies on to ensure that Medicare pays for wheelchairs that are medically necessary and reasonable. Suppliers must maintain copies of signed CMNs in their records along with documentation showing that items were delivered to beneficiaries. Typically, CMNs are submitted electronically to the Durable Medical Equipment Regional Carriers (DMERCs) who are responsible for processing the claims. Original copies of CMNs are not reviewed unless DMERCs specifically request this information from the supplier on a pre- or post-payment basis. Similarly, suppliers are not required to submit proof of delivery with the initial claim for payment, and DMERCs only collect delivery documentation as part of a pre- or post-payment review.

Finally, over the past several years, the National Supplier Clearinghouse has strengthened the supplier enrollment process in an effort to limit ease of entry by fraudulent suppliers. In order to obtain a Medicare billing number, suppliers must complete an application, submit to an onsite inspection of the business location, and meet 21 standards that help ensure that the suppliers are operating legitimate businesses. Although there is no Federal licensure requirement, States can require licensure, and some States have adopted such a requirement for home medical equipment suppliers.

**PAYMENT TO FRAUDULENT SUPPLIERS**

Despite CMS's efforts, we have found that fraudulent suppliers continue to bill the Medicare program. Our investigative activity continues to disproportionately (based on program expenditures) be focused on medical equipment and supplies. From 2002 through 2004, we excluded from the Medicare and Medicaid programs 277 providers associated with medical equipment supply companies. However, there is evidence that unscrupulous

wheelchair suppliers have gained a foothold in the Medicare program, and greater effort must be made to prevent these types of suppliers from gaining admission to the Medicare program.

The fraud we have uncovered generally falls into the following categories: (1) filing claims for equipment that was never delivered; (2) billing for high cost equipment when lesser cost equipment was actually provided (upcoding); (3) billing for the component parts of a piece of equipment instead of the entire unit (unbundling); (4) delivering medical equipment to beneficiaries who do not need it; and (5) paying kickbacks to physicians and other sources in return for the referral of beneficiaries, access to beneficiaries and/or signing CMNs. We have been working on some of these investigations since as early as 1996.

I have attached summaries of several investigations of power wheelchair suppliers that we have conducted. I would like to highlight two cases that involved schemes to fraudulently bill Medicare and Medicaid for medical equipment, including power wheelchairs. Although the first case is not nearly the largest wheelchair scheme in the country, nor even in South Florida where it occurred, it provides some insight into the elaborate schemes that individuals will concoct to defraud Federal health care programs.

The Government's investigation revealed that co-owners of two medical equipment supply companies used recruiters to enlist beneficiaries to participate in a scheme to defraud Medicare. The recruiters told beneficiaries to bring their Medicare information to a central location, such as a community center in a housing development, where they were instructed to sign phony documents. These documents included post-dated delivery tickets. The CMNs in support of the false claims were procured from physicians who received kickbacks or were forged.

The beneficiaries would take turns posing on one wheelchair, used as a prop, while their pictures were taken with a Polaroid camera, purportedly to document that a wheelchair had been delivered to them. On one occasion, the recruiters had planned staged deliveries in a second-story apartment with no elevator access. They could not lift the heavy power wheelchair up the building's stairs. To overcome this problem, the beneficiaries were walked down the stairs so that the phony deliveries could be staged in the building's parking lot. Remember, the beneficiaries were supposedly non-ambulatory. The beneficiaries never expected actually to receive a wheelchair. In exchange for their participation, beneficiaries were paid $200 to $800 cash or given nutritional products.

Over a 9-month period, the co-owners billed Medicare for over $5 million in wheelchairs that were never delivered, and received $2.3 million in stolen payments. These co-owners were sentenced to 87 months and 54 months in prison, respectively, for their roles in submitting fraudulent power wheelchair claims to Medicare.

The second case illustrates the significant dollar amounts at stake in these schemes. The owner of a group of companies and his co-conspirators billed for medical equipment, including power wheelchairs, that was either not provided at all or upcoded. For

example, beneficiaries were provided temporarily with a K0011 wheelchair. The program was billed for the K0011, but the K0011 ultimately was swapped for a less expensive scooter. In other cases, Medicare was billed for wheelchair accessories that never were provided. The conspirators involved in this scheme sent proceeds to an overseas bank account. They netted over $25 million. The owner was sentenced to seven years in prison and ordered to pay $14.4 million in restitution, jointly and severally with his co-conspirators. In addition, the court ordered a $14.8 million forfeiture against the owner.

An independent sales representative from that same company targeted beneficiaries in low income housing areas to receive medical equipment, including power wheelchairs. He forged paperwork, including CMNs, and submitted it to the owner of the companies. This same sales representative was also involved in a separate scheme with a different DME company owner. The two submitted claims for power wheelchairs, but switched the equipment out for less expensive scooters, falsified CMNs, including forging physician signatures, and submitted claims for medical equipment that was never delivered. This sales representative was sentenced to 18 months in prison and ordered to pay $2.2 million in restitution for his role in the conspiracy to defraud the Medicare and Medicaid programs.

**MEDICARE COVERAGE FOR POWER WHEELCHAIRS**

Not only have we uncovered fraud and abuse related to the wheelchair benefit through our investigations, but we also have found that many beneficiaries do not meet current coverage criteria for K0011 power wheelchairs. One of the reports that we are releasing today addresses whether claims for K0011 power wheelchairs met Medicare's coverage and documentation requirements.

For our review, we selected a simple random sample of 300 claims for procedure code K0011 from the year 2001. We then collected CMNs and delivery documentation from suppliers and medical records from ordering physicians. Using Medicare coverage criteria, an independent medical review contractor conducted a coverage review of medical records received from physicians or suppliers. We also contacted the beneficiaries who received our sampled power wheelchairs.

We found that 31 percent of reviewed claims did not meet Medicare's coverage criteria for any type of wheelchair. An additional 45 percent of reviewed claims did not meet Medicare's coverage criteria for the K0011 power wheelchair, but may have met criteria for another, less expensive mobility device. Ultimately, only 13 percent of reviewed claims actually met the coverage criteria for K0011 power wheelchairs. For another 11 percent, the reviewer could not determine whether the claims met the coverage criteria for the K0011 power wheelchair due to insufficient documentation. Based on our review, we estimate that Medicare and its beneficiaries paid $178 million in 2001 for K0011 power wheelchairs that did not meet Medicare's coverage criteria.

Our review also identified other problems with Medicare claims for K0011 power wheelchairs. For over half of the claims reviewed, CMNs and/or delivery documentation were missing, incomplete or dated after the date of service. In addition, some beneficiaries reported either not using their power wheelchairs or using them outside the home only.

There may be a number of reasons why Medicare is paying for claims that do not meet coverage and documentation requirements. Problems might arise because coverage criteria for different types of mobility devices may not be explicit enough, and physicians may not be familiar with Medicare's coverage criteria when ordering mobility devices for their patients. Ordering providers play a key role in determining the need for and utilization of equipment billed to Medicare. This is recognized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which states that payment may not be made for power wheelchairs unless a physician, physician's assistant, nurse practitioner, or clinical nurse specialist has conducted a face-to-face examination of the patient and written a prescription for the item. CMS relies on the clinical judgment of these health care professionals to ensure that Medicare only pays for items that are most appropriate for beneficiaries. However, the only document that provider is required to review and complete when ordering a wheelchair is the CMN. Coverage guidelines are not listed on the CMN for power wheelchairs, and medical necessity questions on CMNs are not completely consistent with coverage policy. A lack of provider education about Medicare's coverage criteria for wheelchairs could adversely affect physicians' ability to make informed decisions about the types of mobility devices that are best for their patients, which could ultimately lead to inappropriate Medicare payments.

**EXCESSIVE PRICING FOR POWER WHEELCHAIRS**

The second report that I am releasing today assesses Medicare's reimbursement levels for K0011 power wheelchairs. We have consistently found over the years that many items of medical equipment have been reimbursed excessively. This has in large part resulted because Medicare fee schedules for medical equipment, enacted in 1987, are based on historical charges to Medicare or retail prices available in the marketplace.

With the rapid growth in utilization and expenditures of the power wheelchair benefit, it is essential that the Medicare program pay for power wheelchairs at levels that are consistent with prices in the marketplace. We found that Medicare and its beneficiaries pay more than consumers or suppliers for K0011 power wheelchairs. A wide variety of power wheelchair models are reimbursed under the K0011 procedure code; however, Medicare does not collect information on the specific model of power wheelchair actually provided to beneficiaries. As part of our review, we identified Medicare-covered K0011 power wheelchairs from the Statistical Analysis Durable Medical Equipment Regional Carrier's product classification list. We also identified K0011 power wheelchair models that were provided to Medicare beneficiaries in 2001. We then obtained prices for these wheelchairs from three sources: the websites of power wheelchair suppliers, two national

wholesalers, and suppliers who negotiated directly with manufacturers and distributors of K0011 power wheelchairs.

We found that the median purchase prices for both consumers and suppliers of K0011 power wheelchairs were lower than the Medicare reimbursement amount. The prices we obtained for K0011 power wheelchair models varied widely, from a low of $999 to a high of $16,995. Ninety-four percent of the prices we reviewed were below the Medicare reimbursement amount.

Compared to the median Medicare reimbursement amount of $5,297, consumers were able to purchase K0011 power wheelchairs for a median price of $3,863, suppliers were able to purchase K0011 power wheelchairs from two wholesalers for a median price of $2,363, and suppliers who negotiated directly with distributors and manufacturers were able to obtain K0011 power wheelchairs for a median price of $1,550.

For the models of K0011 power wheelchairs actually supplied to Medicare beneficiaries, we found that the median prices to consumers and suppliers were below the Medicare reimbursement amount of $5,297. The median prices for these power wheelchairs were very close to the median prices obtained for all the power wheelchairs, with the prices ranging from $1,699 to $3,888.

We believe that the program and its beneficiaries could have realized substantial savings if the Medicare reimbursement amount for K0011 power wheelchairs more closely resembled the costs to consumers and suppliers. If Medicare set the K0011 reimbursement amount at the median prices available to consumers, the Medicare program and its beneficiaries would have saved over $224 million in 2002. If the Medicare program based its reimbursement amount on the median price negotiated by suppliers with manufacturers and distributors, the program could have saved $586 million in 2002.

We did not collect data regarding supplier administrative costs related to furnishing K0011 power wheelchairs to Medicare beneficiaries. Therefore, the median prices available to suppliers do not include these associated supplier costs. These estimates of potential program savings would be lower if median prices had included suppliers' administrative costs. On the other hand, we would assume that the prices collected from websites of suppliers include profit margins and any costs related to billing other insurers. We have no evidence to suggest that the costs associated with billing the Medicare program are significantly different from the costs of billing other insurers.

I would like to note that MMA reduced the payment amount for certain items of durable medical equipments, including power wheelchairs. As a result of MMA, the price for K0011 power wheelchairs is reduced to $5,097.

**CORRECTIVE ACTIONS**

Obviously, it is more desirable to prevent fraud and abuse from occurring than it is to try and recoup program losses after they have occurred. To that end, we have worked closely with program officials over the years to institute many reforms in the area of medical equipment, including consolidating claims processing into four DMERCs, enhancing enrollment standards, enacting standards that suppliers must meet in order to bill Medicare, and conducting site visits for suppliers.

Given the continuing levels of unacceptable abuses in this area, both for medical equipment in general and power wheelchairs specifically, it is critical that additional systems improvements and preventive practices be adopted. The two reports I am issuing today make many recommendations for program improvements. We believe that the recommendations in these reports warrant consideration. Some of these recommendations include:

- Evaluate the medical conditions and functional abilities that are associated with each of the different types of mobility aids and describe these conditions/abilities in the coverage policies;

- Educate ordering providers about Medicare's coverage criteria for different types of medical equipment, including power wheelchairs, manual wheelchairs, and scooters;

- Educate Medicare beneficiaries about coverage criteria for medical equipment and supplies, including wheelchairs and scooters, as beneficiaries themselves play a key role in ensuring that Medicare does not pay for medically unecessary or unused items;

- Create a new coding system for K0011 power wheelchairs that accounts for the variety in models and prices for power wheelchairs;

- Use the pricing information obtained as part of our reviews to determine whether payments should be reduced; and

- Require DMERCs to conduct frequent reviews of the K0011 procedure code to ensure appropriate payments. This includes ensuring that suppliers have complete and thorough documentation.

**RECENT EFFORTS TO CONTROL ABUSE**

In September 2003, CMS and the OIG issued a joint press release to announce new efforts to stem problems with the power wheelchair benefit. In order to address significant increases in allowances for power wheelchairs and indications of improper billing activity, CMS has launched a campaign to curb abuse of the Medicare program by unscrupulous suppliers of mobility products. In fact, as part of this campaign, CMS has

already begun implementing some of the OIG recommendations that I have mentioned here today.

For example, initiatives in CMS's campaign include: aggressively scrutinizing new applications for supplier numbers; publishing regulations that will enhance CMS's ability to screen new supplier applications; and collaborating with law enforcement agencies to process fraud cases and ensure application of sanctions, and civil or criminal prosecutions. As part of its campaign, CMS may also revise coverage policy for power wheelchairs and scooters to ensure that national policy accurately defines the conditions under which Medicare will cover mobility products. They will adopt a consistent approach to medical review; clarify physicians' responsibilities as prescribers of mobility devices; and educate beneficiaries about Medicare coverage guidelines. In addition, CMS plans to develop inherent reasonableness review guidelines and place power wheelchairs first in line for analysis for potential inherent reasonableness adjustments. This way, Medicare can be assured that it is paying appropriately for power wheelchairs.

**CONCLUSION**

Mr. Chairman, as I previously stated, the abuses associated with power wheelchairs truly are troubling. These inappropriate payments waste taxpayer dollars that could otherwise fund appropriate equipment for needy Medicare beneficiaries.

Power wheelchairs can greatly improve the quality of life for an individual who suffers from limited mobility. While it is extremely important to preserve this critical benefit and ensure that those who truly need power wheelchairs are able to obtain them, there are indications that the power wheelchair benefit has been a target for abuse by unscrupulous providers; ultimately, these schemes can victimize our beneficiaries. Wheelchair abuses are the latest in a long line in the medical equipment area that the OIG has taken concerted efforts to address. We are pleased that our continued work in this area is contributing to heightened awareness related to reimbursement for medical equipment and supplies.

We applaud the efforts of CMS and Congress to curb power wheelchairs fraud, waste, and abuse while simultaneously preserving the benefit for those recipients who truly need power wheelchairs. We also appreciate your own efforts on both fronts, Mr. Chairman. We all must take further steps to eliminate abuses, while continuing to provide a benefit that can greatly enhance the quality of life of our beneficiaries.

## APPENDIX A

## RECENT WHEELCHAIR INVESTIGATIONS

- In Florida, a man was formally charged with conspiring to defraud Medicare in connection with approximately $5 million of fraudulent claims for the cost of power wheelchairs and accessories that were allegedly supplied by two DME companies. Under the direction of the companies' proprietors, employees of these companies conducted staged deliveries of motorized wheelchairs to Medicare beneficiaries. At these staged deliveries, patients were given several documents to sign, including delivery confirmation tickets. The suspects would forward the documents along with fraudulent certificates of medical necessity to a billing company, which submitted the claims to Medicare for the cost of the motorized wheelchairs and accessories. On August 29, 2003, the man was sentenced to 24 months imprisonment and ordered to pay $406,000 in restitution for conspiracy to defraud and money laundering.

- Another Florida DME company owner conducted a scheme to continue billing Federal health care programs while excluded. In 1997, he was convicted of Medicaid fraud and sentenced to a term of community control with intermittent confinement and work release. While on work release, he continued working as a sales representative for a DME company. He continued his fraudulent scheme of billing Medicare and Medicaid for high-priced, new power wheelchairs when he actually provided used wheelchairs and scooters; he also billed Medicare for unnecessary repairs of wheelchairs. In addition, he opened three DME companies using the names of straw nominee owners to circumvent his exclusion from the Medicare and Medicaid programs. Beginning in 1999 and continuing through 2002, he received over $1 million from Medicare by submitting claims for power wheelchairs that were not provided, were used, or were exchanged for scooters. He also billed Medicare for unnecessary repairs of the equipment he previously provided. On November 25, 2003, he was sentenced to 37 months in prison.

- A Michigan DME company owner persuaded elderly patients to purchase motorized wheelchairs they did not need. He was sentenced on August 21, 2003, to 63 months incarceration and ordered to pay $1 million in restitution for defrauding Medicare, Medicaid, and a private insurer. In addition, he forfeited $1 million in assets obtained through the fraud.

- In Georgia, a DME company owner and his business partner submitted numerous false claims to Medicare for motorized wheelchairs that were never provided to beneficiaries from 1997 through 2002. The owner and his partner were sentenced on May 20, 2003, for their role in this scheme to defraud Medicare. The owner was sentenced to 18 months incarceration and ordered to pay $504,000 in joint restitution with his business partner; and the business partner was sentenced on May 1, 2003, to 30 months incarceration.

- In California, Medicare reimbursed a DME company owner for power wheelchairs and other medical equipment that were never provided to beneficiaries. He was sentenced on August 18, 2003, to 33 months confinement and ordered to pay $249,000 for health care fraud.

- In Pennsylvania, an OIG investigation revealed that, through a marketing program, Pride Mobility Products Corporation, a manufacturer of power wheelchairs, scooters, and lift chairs, solicited and received monthly payments from suppliers in return for referring sales leads to those suppliers. On October 22, 2002, the company agreed to pay $80,000 to resolve its liability for violations of the kickback provision of the Civil Monetary Penalties Law. In addition to the payment under the settlement agreement, the company was also required to adopt and implement certain compliance measures.

- In North Carolina, from January 1999 through April 2000, the owner of a DME company billed Medicare for power motorized wheelchairs when he actually provided beneficiaries with less expensive scooters. The company owner was sentenced on April 25, 2002 to 13 months in prison and ordered to pay $200,000 in restitution for mail fraud.

- A Texas DME company was involved in a scheme that provided motorized scooters and wheelchairs to Medicare beneficiaries, but billed Medicare and private insurance companies for equipment that was either not medically necessary or was more expensive than the equipment actually provided. The company was ordered to pay a $10,000 fine on February 21, 2002, for mail fraud and wire fraud. The company's owner was sentenced on February 22, 2002, to 18 months imprisonment and ordered to pay $300,000 in restitution for mail fraud. A salesperson was ordered on February 28, 2002, to pay $85,000 in restitution for wire fraud.


**TESTIMONY OF**

**KAY COX**
**PRESIDENT AND CHIEF EXECUTIVE OFFICER**
**AMERICAN ASSOCIATION FOR HOMECARE**

**BEFORE THE**
**COMMITTEE ON FINANCE**
**U.S. SENATE**

**FRAUD AND ABUSE IN THE**
**POWER WHEELCHAIR PROGRAM**

**APRIL 28, 2004**


Written Testimony of Kay Cox
American Association for Homecare
April 28, 2004

Chairman Grassley, Ranking Member Baucus, and Members of the Committee, thank you for the opportunity for the American Association for Homecare (AAHomecare) to assist the Committee's important review of the CMS Power Wheelchair Program.

AAHomecare is the only national association that represents every line of service within the homecare community. AAHomecare represents approximately 800 member companies employing thousands in all 50 states, including providers of durable medical equipment (DME), home health, infusion and respiratory care services and rehab and assistive technologies, as well as manufacturers and state associations.

AAHomecare joins this Committee in refusing to tolerate the stealing of taxpayers' hard-earned dollars set aside for the care of Medicare beneficiaries. We endorse zero tolerance for Medicare fraud and abuse involving power wheelchairs. AAHomecare will continue to assist CMS and the Federal law enforcement agencies in an effort to ensure the integrity of the Medicare program. For example, we have and will continue to suggest ways to improve coding of power wheelchairs in an effort to ensure greater precision in the billing and payment for medically necessary items.

As the investigations and related efforts in the power wheelchair area proceed, we respectfully caution about drawing overgeneralizations of our industry. The great majority of durable medical equipment (DME) providers and manufacturers in your states and hometowns are run by hard working American men and women interested in providing products that treat and improve medical conditions for patients at fair prices. These honest DME providers and manufacturers understand the importance of forming transparent, long-term relationships with the Medicare program. Those providers who




are not focused on the long-term appropriate needs of their patient community harm the program, and more importantly the patients.

This is why AAHomecare and its Rehab and Assistive Technology Council have adopted and promulgated a Code of Ethics, and have approved a Guide of Conduct for our membership. In addition, there are national credentialing bodies for professionals who serve individuals requiring rehab and assistive technology, including power wheelchairs.

We would like to present the following suggestions for addressing the fraud and abuse problems this Committee is focusing on with the power wheelchair benefit.

First, the guiding principle should be to provide each Medicare beneficiary with medical equipment technology that is both medically necessary and appropriate to give the patient a fuller, more satisfying and healthier life. Where a beneficiary has a genuine medical need for a power wheelchair, as judged by the patient's attending physician, the right wheelchair should be provided in accordance with that need. Not only will the Medicare patient benefit from increased independence, these individuals have better health outcomes when compared to individuals with similar medical conditions who are confined to their bed.

Second, Medicare coverage, coding, reimbursement and documentation policies for power wheelchairs, as well as standards for quality, should be improved.

- Coverage and coding policies must accurately capture the evolving and improving varieties of power wheelchair technologies and medically necessary accessories. For example, power wheelchairs with significantly different features and product cost should not be lumped together in

outdated Healthcare Common Procedure Coding System (HCPCS) codes that reflect older technology. AAHomecare has worked with CMS, and its contractors, the four Durable Medical Equipment Regional Carriers (DMERCs) and the Statistical Analysis DMERC (SADMERC) to improve coding for power wheelchair products. More specific product coding will provide prescribing physicians with better information, and will also improve Medicare billing and payment practices.

- Reimbursement should appropriately reflect medical equipment and overhead costs, including the cost of patient assessment and education, delivery and maintenance, and a reasonable return for the provider.
- Documentation. AAHomecare has previously submitted detailed recommendations to CMS to improve the use of medical necessity documentation in order to give providers clear guidelines on the criteria necessary to support a power wheelchair Medicare claim.
- Quality Standards. From the outset, AAHomecare's DME providers and manufacturers embraced the new MMA federal quality standards and accreditation requirements for DME. AAHomecare will work with CMS to ensure that any new standards complement quality control measures already voluntarily adopted by our industry.

Third, CMS and law enforcement agencies should bear in mind the critical distinction between merely negligent billing errors or omissions, on the one hand, and the intentional or "knowing" submission of false claims on the other. I think we can all agree that Medicare is an extraordinarily complex benefit program. Where errors have




been made in billing, coding, or documentation for furnishing a particular power wheelchair, the appropriate overpayment (if any) should be collected by the program consistent with the Medicare program's legal authorities. However, criminal sanctions and civil penalties are not appropriate for honest mistakes. Well-intentioned providers work hard to comply with Medicare requirements while faithfully serving the needs of the patients in their communities. They should neither be unfairly penalized nor subject to overgeneralizations based on the intentional misconduct of abusive operators.

On the other hand, we say, "Go get them," where law enforcement agencies obtain reliable evidence of the "knowing" submission of false claims, as defined in the False Claims Act and the Civil Monetary Penalty statute, or knowing and willful violations of the Anti-Kickback Statute. AAHomecare and all honest providers in this industry do not defend or tolerate this type of conduct.

Mr. Chairman, AAHomecare and our members are on the frontlines of serving Medicare beneficiaries each and every day - in your state and across the Nation. We vigorously advocate ethical and honest conduct in these endeavors, as well as clear, updated, and fair regulation. We will continue to serve as an experienced and knowledgeable resource for HHS and all others in this effort, including this Committee. Thank you.

**U.S. Department of Justice**

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*Southern District of Florida*

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April 27, 2004

The Honorable Bob Graham
United States Senate
524 Hart Senate Office Building
Washington, DC 20510

Dear Senator Graham,

Thank you for the opportunity to update you regarding our achievements in pursuit of criminal and civil violations against the Medicare Trust Fund. Together with our investigative agencies, both federal and state, we continue to stay unwavering in our dedication to halt the fraudulent activities through tenacious investigatory practices and responsive legal proceedings. Since the opening of the Health Care Fraud Center, we have secured 180 criminal convictions with over $139,000,000 accessed in restitutions, fines and forfeitures for the Trust Fund. In addition, civil proceedings have resulted in restitutions in the amount of $120,000,000.

We strive to work in a collaborative effort with the lead investigative agencies, the FBI and HHS-OIG. But in particular, the Southern District of Florida has forged very close working relationships with the State of Florida Attorney General's office, as well as the Regional Director for Centers for Medicare and Medicaid. This close knit team has used their knowledge and expertise to create proactive, strategic methods to prevent future fraud against the Trust Account. We are indeed very proud of our statistical accomplishments, but more importantly, our continued dedication to preventing future fraud.

Very truly yours,

MARCOS DANIEL JIMENEZ
UNITED STATES ATTORNEY

by: Doris J. Giles
Program Manager, Health Care Fraud

U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

Prepared Remarks of U.S. Sen. Chuck Grassley of Iowa
Chairman, Senate Committee on Finance
Hearing: "Taking Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program

Let me begin by extending a special thanks to all the witnesses for their participation in today's important hearing. A special thank you to Rebecca Lewandowski, our first witness.

The purpose of today's hearing is to examine a number of the fraudulent schemes and costly and abusive practices that are taking place in the sale of motorized wheelchairs to Medicare and Medicaid recipients. However, merely identifying problems is not enough. I want today's hearing to also address fixing those problems. Accordingly, I am asking each witness today to offer solutions based on their own experiences.

Therefore, I want to ask Mr. Kuhn, who is here today representing the Centers for Medicare and Medicaid Services, to remain at the hearing and listen to each of the witness's testimony and recommendations. I intend to follow up with Dr. McClellan at CMS to get his action plan, including any other needed actions.

I want to make it clear from the start that Medicare and Medicaid fulfill vital responsibilities for our seniors and many others. It is critical that the CMS meet the interests and needs of all these individuals in an effective, efficient, economical, and competent manner At the same time — it is imperative that the interests and expectations of the taxpayers be met, as well.

Since the inception of the Medicare and Medicaid programs, the government has reimbursed qualified beneficiaries and recipients for the medical equipment they need to function in society. Overall, however, it's fair to say that the system has experienced some serious problems with fraud and abuse over the years.

Now today, we are here once again, attempting to address yet another serious problem area for CMS — fraud, waste and abuse involving its reimbursements for power wheelchairs. We have a power wheelchair–the K11 right here in the hearing room. The K11 is the main type of chair purchased by Medicare and we will hear that term come up a lot today.

Because of the immense size and cost of the Medicare and Medicaid programs, it seems that no fraud in these programs is ever small: rather, it tends to total in the hundreds of millions

of dollars — or even the billions — and that's with a B.

Today, the General Accounting Office and the Office of Inspector General at the Department of Health and Human Services are here to report on many serious problems they have documented. In fact, the OIG is releasing two reports today.

One of these reports looked at those who are receiving the most commonly provided power wheelchair, the K-11, For this report, the OIG examined a statistically-valid sample of those who had received a K-11, and found that almost one-third–you heard it right–one third- did not meet the requirements for any type of wheelchair.

In fact, the OIG found that only 13% of those it surveyed actually met the coverage requirement for a K-11. That, I submit, is not a very good batting average — in any league. The OIG also conservatively calculated that for just calendar year 2001 alone, the overpayments for K-11 power wheelchairs totaled an estimated $178 million, and this was when the expenditures for power wheelchairs were less than half what they total today.

Another OIG report being released today, looks at the prices that Medicare pays for the K-11, versus the prices that others pay. The conclusion, despite Medicare's huge size and buying power, it actually pays more for the K-11s than do other buyers. Please take a brief look at the chart we have here. Do you see a problem here??

Imagine, if the Medicare reimbursement amount was set at the prices available to consumers and suppliers, then Medicare and its beneficiaries could have saved over $224 million in one year. And if Medicare based its reimbursement amount on the median price offered by wholesalers or the median price that suppliers negotiated with manufacturers and distributors, the program could have saved between $459 million and $586 million — just in 2002.

None of this makes a whole lot of sense to this senator, and I don't think it will make a whole lot of sense to the taxpayers from Iowa or the other 49 states who have just finished sending much of their hard-earned dollars to Washington.

Coupling the OIGs findings on price and eligibility, and unfortunate to say, there are also lots of schemes out there that are ripping off Medicare when it comes to power wheelchairs. Let me turn you attention to a one minute DVD that we are going to play for you.

Now let me tell you what you were looking at. You were looking at a group of people who were defrauding the Medicare program. The Office of the Inspector General as part of a sting operation, set up a pole camera, called what was sham storefront DME supplier and told them that the Center for Medicare and Medicaid Services was going to conduct an on-site visit. Because it was a sham operation, they needed to bring in supplies likes desks, chairs and DME supplies to pass the on-site review. That's what you just saw.

Today, we have one witness who has agreed to testify and to provide us with a real insiders account of how power wheelchair fraud works. The DVD that you just saw is one of the

sham DME's in which she was involved. She has agreed to talk to us candidly about her personal experience in a scam that bilked Medicare for about $25M.

Now, I would be remiss if I did not say that most suppliers and most manufacturers are putting in an honest days work and submitting accurate bills to the federal government for payment. They are playing by the rules and we welcome their assistance in combating fraud.

The GAO, as well, has some startling findings to report today. Although CMS has noted that there was a four-year growth rate of about 450% in expenditures for power wheelchairs, only recently, has CMS finally gotten around to asking "Why?" and then begun to attempt to stop it. I find that very troubling — especially since GAO reports that CMS was advised about the problem some 6 or 7 years ago. Fortunately, the Center for Medicare and Medicaid Services recently initiated Operation Wheeler Dealer in an effort to attack the problem of wheelchair fraud; for that I am grateful; but rest assured we won't be waiting another 6 or 7 years for the results of that initiative.

GAO also has also examined CMS's 10-point initiative unveiled last September to address power wheelchair fraud. I am anxious to hear what GAO has to say about that proposal and I am interested in CMS responses to the findings that will be presented by both the GAO and the OIG.

Finally, we will have some thoughtful comments from some skilled professionals and representatives of the disability community and the DME industry.

**TESTIMONY OF**
**HERB KUHN**
**DIRECTOR, CENTER FOR MEDICARE MANAGEMENT**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**ON**
**POWER OPERATED WHEELCHAIRS**
**BEFORE THE**
**SENATE FINANCE COMMITTEE**

**APRIL 28, 2004**

Chairman Grassley, Senator Baucus, thank you for inviting me to discuss Medicare's coverage and payment policies regarding motorized wheelchairs and power operated vehicles (POV)/scooters. I want to thank you for your leadership in making sure that fraud, waste, and abuse are addressed in Centers for Medicare & Medicaid Services' (CMS') programs. As you know, working together using the additional authorities you have given us, we have reduced fraud significantly across the Medicare program. For example, since 1996 when CMS first began measuring Medicare's payment error rate, the rate has decreased by more than half from 13.8 percent to 5.8 percent. While we have made much progress, we must remain vigilant to ensure that Medicare's beneficiaries continue to receive the care and coverage they need and that we fulfill our fiduciary responsibilities to the American taxpayer. The wheelchair benefit is one such area where the Agency has worked to develop a comprehensive program to effectively manage spending while not affecting access to this very important service. Achieving these two goals requires CMS to remain vigilant both on behalf of the beneficiary and on behalf of the taxpayer, a challenge in the best of circumstances.

Over the years technical progress in power mobility devices has led to more options that provide better assistance to beneficiaries with disabilities. At the same time this growth in options has resulted in significant increases in prices and thus, growth in expenditures. CMS has undertaken a number of initiatives in response to the problems that were identified with significant growth in expenditures for motorized wheelchairs. Although these initiatives have helped, CMS has determined there was and continues to be a need for more comprehensive actions to fully stem the tide of abuse and ensure that beneficiaries who truly need these items have access to them. Building on our past

efforts and last fall's Operation Wheeler Dealer (OWD), we are now undertaking a broad three-pronged initiative to address coverage, payment, and quality of motorized wheelchair suppliers. With input from key stakeholders, CMS will provide guidance on implementing coverage policy to ensure appropriate coverage of power wheelchairs through a consensus-driven, evidence-based process. In addition, to better serve our current and future beneficiaries, we will ensure that payment is appropriate through mandated fee schedule adjustments, coding updates, and competitive bidding. Furthermore, CMS will ensure that beneficiaries get high-quality mobility services by revising supplier standards, implementing an accreditation process, and continuing to scrutinize applications from potential suppliers to make sure they are qualified.

Mr. Chairman, although we have faced many challenges, I assure you our efforts to obtain high value and prevent fraud will continue and be augmented further by these additional bold steps to protect the Medicare Trust Fund while ensuring beneficiary access. I would like to describe for you the challenge before this Agency, the past and current initiatives to address it, and our plan of action for the future.

**The Challenge**

Medicare covers power wheelchairs under limited circumstances and, as the quality of mobility devices continues to improve, it is more important than ever that those beneficiaries who qualify for coverage continue to have access to the devices. At the same time, due to the high payment rate for power wheelchairs (more than $5000 not including the cost of accessories under our payment rules), they present a lucrative opportunity for those who would defraud Medicare and its beneficiaries. Total allowed charges for power wheelchairs in 2003 will be approximately $1.2 billion when all remaining claims for items furnished in 2003 are received and processed up from $289 million in 1999. This is an increase of more than 300 percent over the past five years. This growth greatly outpaced all other economic indicators including growth in Medicare Part A of 17 percent, Part B of 54 percent, and overall Medicare program growth of 31 percent over this same period.

**Prior and Current Initiatives**

CMS uses a broad set of approaches to respond to the challenges of overuse, abuse, and fraud for any benefit in Medicare while preserving beneficiary access to needed services. Such tools were applied to combat fraud and abuse related to power operated wheelchairs. CMS has worked with the Durable Medical Equipment Regional Carriers (DMERCs) (who process wheelchair claims on behalf of CMS), providers, and law enforcement partners to accomplish our objectives. Following are highlights of a number of such initiatives.

*1998: CMS Issues Fraud Alert*

The unusual spending growth in the power wheelchair benefit did not begin in 1999. In fact, the power wheelchair benefit has grown faster than spending on other items every year since 1994. Based on reviews conducted by the DMERCs, CMS began to notice inappropriate and potentially fraudulent use of the power wheelchair benefit. In response, CMS issued a fraud alert in October 1998 to all the DMERCs and law enforcement officials to notify them of problems that were being detected in claims data. This fraud alert explained techniques that were being used to obtain inappropriate payments for power wheelchairs and scooters and provided guidance on how to detect potential fraud and abuse of the benefit.

*1998 - 1999: Inherent Reasonableness under BBA and BBRA Authority*

Inherent Reasonableness (IR) is the authority provided to CMS to correct unreasonable Medicare payment amounts for specific items and services under Part B, including Durable Medical Equipment (DME). CMS utilized the authority in the Balanced Budget Act of 1997 to develop and issue an interim final rule (IFR) invoking IR for several DME items. However, in 1999, before using this authority to address power wheelchairs, the Balanced Budget Reconciliation Act (BBRA) revoked use of IR until four conditions were met: (1) the General Accounting Office (GAO) released its report on the IFR and our actions to utilize this authority; (2) CMS issued a notice of final rulemaking responding to the GAO's report and comments received on the IFR; (3) CMS reevaluated

its criteria for identifying unreasonable payment amounts in the final rule; and (4) CMS took steps to ensure use of valid and reliable data to determine IR.

CMS issued a new IFR December 13, 2002, that addressed the additional BBRA requirements and accepted the GAO recommendations related to IR. CMS is in the process of developing the general methodology to collect data necessary for making IR adjustments. Using the IR authority, CMS can lower its payment amounts for items if it can determine that the current payment amounts are grossly excessive (i.e., at least 15 percent greater than the amount determined to be realistic and equitable using valid and reliable data). We are currently working to obtain pricing information and are developing guidelines to implement the IR authority so that this option can be considered when addressing Medicare payment for power wheelchairs.

*1998 - Present: DMERC Claims Reviews Increase and Are Stalled by Objections to Administrative Requirements*

In the late 1990s, the DMERCs began to intensify their scrutiny of claims for power wheelchairs. The DMERCs tried many different techniques to ensure that claims met CMS coverage requirements. For example, one region required physical therapy notes or evaluations for all claims. Others began beneficiary and provider surveys to ensure compliance. Unfortunately, the power wheelchair industry objected to the increased scrutiny due to excessive administrative requirements, thus stalling actions on an industry-wide basis. However, CMS was able to continue focused reviews on particular problem providers, and continued to do so.

*2001-2002: CMS Supports Law Enforcement Operation in Texas*

CMS has always worked closely with and actively supported law enforcement investigations nationwide. Based on the number of referrals from the DMERCs made regarding potential fraud, law enforcement officials focused their investigations on the Texas area. In fact, a comparison of the number of DMERC referrals in all of 1999 to those in just the first quarter in 2004 shows an increase of 54 percent nationally, 360 percent in Texas, and 500 percent in Harris County, Texas.

*2002-2004: CMS Targets Fraud in Harris County, Texas*

In Harris County, Texas, Medicare paid for more than 31,000 power wheelchairs in 2002, compared to just more than 3,000 power wheelchairs in 2001, an almost tenfold increase. Even with this significant increase, however, it is difficult to identify a pattern of abuse at the moment it is occurring due to lags among billing, claims submission, claims payment, and aggregation of data. Furthermore, Medicare's four DMERCs process over 10 million claims each year, which adds to the challenges. Despite these challenges, as soon as CMS became aware of the magnitude of the fraud, CMS took swift action to uncover and remedy the various types of fraud.

The targeted efforts in Harris County have resulted in significant success. In May 2003, the billed amount for the main power wheelchair code by suppliers located in Harris County was $59.8 million. By August 2003, this figure dropped to $33.3 million and to $4.9 million by December 2003. We estimate that these, and other efforts directed specifically at Harris County, have prevented $140 million in unwarranted payments. In addition, as shown in Figure 1, the percentage of claims submitted and allowed in Harris County compared to national claims has returned to 2000 levels from a high of approximately 23 percent of national claims submitted and 17 percent of claims allowed in 2003. In the first quarter of 2004, only about 4.5 percent of claims originated in Harris County and about 0.1 percent of the national claims were paid to Harris County.

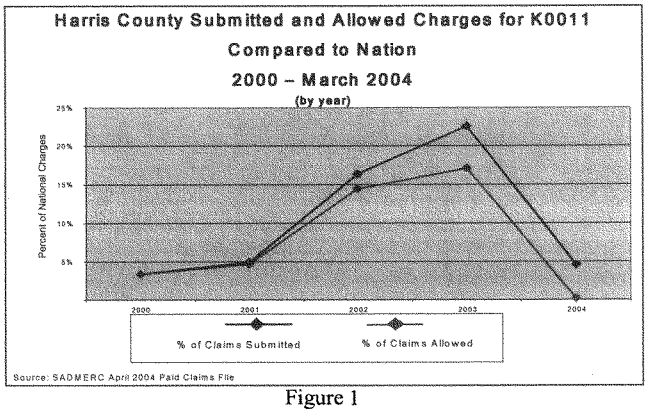


Figure 1

In addition, to prevent further fraud and abuse in Harris County, CMS' Dallas Regional Office ordered the Region C DMERC to take the unprecedented action of reviewing 100% of claims for power wheelchairs from Harris County. A special task force also was created in the Dallas office to individually approve all payments for motorized wheelchairs from Harris County. Furthermore, CMS required all power wheelchair suppliers in Harris County to attend mandatory training on wheelchair coverage and medical review policies. These initiatives continue today.

*2003: CMS Launches Operation Wheeler Dealer (OWD)*

CMS launched OWD to more carefully scrutinize wheelchair claims and to supress suppliers who appeared to be engaging in fraudulent or abusive marketing activities. In March 2003, CMS convened a task force to develop a more formal targeted course of action for the Agency at the national level. In September 2003, CMS launched OWD - a 10-point action plan designed to assure that the DMERCs were able to correctly process and pay claims. The response to the initiative has been positive. OWD has ensured access to wheelchairs for beneficiaries who needed them while substantially curbing abuse of the Medicare program by unscrupulous providers of power wheelchairs and other power mobility products. This plan addresses five main program areas that contributed to this growth in spending: fraud, supplier enrollment, application of Medicare coverage policy, payment, and education.

For example, CMS is aggressively reviewing applications from companies seeking to provide power wheelchairs to ensure they meet reputable business standards of operation. In the coming months, CMS will be creating new quality standards for suppliers to augment the current business standards to which all suppliers must adhere. These quality standards will further assure that CMS only enrolls suppliers who can be true long-term business partners. Using the existing coverage policy, the DMERCs targeted their reviews of claims by focusing on those services or providers that posed the greatest risk of loss to the program. The DMERCs will continue to deny payment for claims that do not meet CMS' coverage criteria. CMS and the DMERCs also are working together to

develop educational materials for physicians and beneficiaries that explain when power wheelchairs are appropriate. DMERCs also provide educational material to suppliers, including several articles explaining OWD and existing coverage policy. These actions are consistent with OIG recommendations.

*2004: OWD Results to Date*

In addition to the successes in Harris County, Texas, OWD has proven successful on a nationwide basis. Working collaboratively with the Department of Justice (DOJ) and the OIG, Federal officials have recovered $84 million in fraudulent claims for power mobility products nationwide since 2003. DMERCs have referred about 155 potential fraud cases (representing 265 suppliers) involving power wheelchairs to law enforcement since September 2003. About 10 percent of these cases have been closed already, indicating a very aggressive approach by law enforcement.

Law enforcement's expedience in addressing these cases demonstrates not only their commitment to working with CMS, but also the scope of the fraud that was occurring. For example, a doctor in Dallas recently pleaded guilty to health care fraud after defrauding Medicare out of almost $5.9 million for motorized wheelchairs. This particular doctor admitted to writing prescriptions for wheelchairs for beneficiaries who did not need them in exchange for kickbacks from suppliers.

In addition, DMERCs have opened an additional 77 investigations to determine whether these cases should be referred to law enforcement. An additional 196 cases are pending DMERC review.

Since the task force to develop OWD convened in March 2003, utilization and allowed charges for power wheelchairs declined from a monthly high of over $113 million in April, to about $69 million in December 2003, as shown in Figure 2. However, of the claims submitted, the number approved and paid rose from 60 percent to 80 percent, indicating that the accuracy and validity of claims have improved.

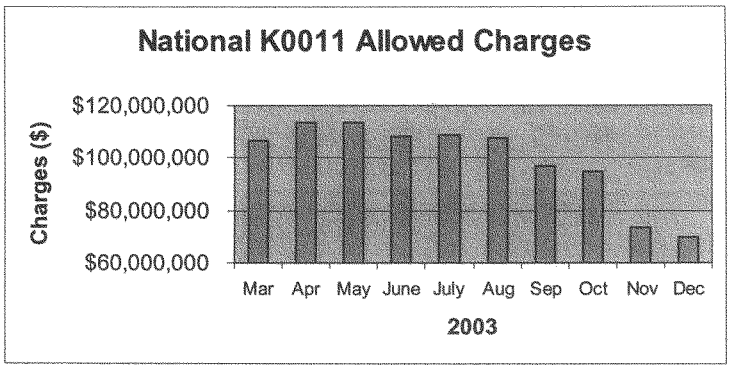


Figure 2

**Next Steps**

CMS plans to build on the success of OWD by implementing a three-pronged approach to address timely and appropriate coverage, payment, and quality of suppliers of power wheelchairs. These steps also encompass specific recommendations from the OIG regarding what CMS can do to address pricing and payment issues, specifically reviewing coding for power wheelchairs and educating providers and beneficiaries.

*Appropriate Coverage*

CMS is working on a proposed regulation to be issued later this year that will to address concerns related to power wheelchair coverage. The regulation will implement the provisions of theMedicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) with regard to power wheelchairs and scooters.

In addition to the regulation, CMS is examining steps to supplement our previous coverage guidance regarding "bed- or chair-confined" from a clinical and functional perspective. The goal is to focus on a set of clinical and functional characteristics that are evidenced-based and will better predict who would benefit from a power wheelchair or scooter. The Chief Medical Officer for CMS has already convened a group of clinicians from across HHS and other agencies to describe the conditions that are associated with the current coverage definition and to develop guidance, including opportunities for

public comment, for the DMERCs in making local coverage decisions. The group will start its work in May 2004 and intends to complete its work by year-end.

*Appropriate Payment*

Most power wheelchairs are billed using one Health Common Procedure Coding System (HCPCS) code for the base equipment (K0011) and additional codes for additional options or accessories. The technology, range of products, and market for power wheelchairs has changed substantially since the current HCPCS codes for power wheelchairs were added in late 1993. The fee schedule amounts for code K0011 are based on manufacturer suggested retail prices for 11 brands of wheelchairs made by 3 manufacturers in the early 1990s. Pricing information from OIG reports and other data gathered by CMS indicate that the current fee schedule ceiling for code K0011 of $5,296.50 is excessive and is an important contributing factor behind the startling growth in expenditures for this code. Our goal is to assure that Medicare pays appropriately for motorized wheelchairs, and ultimately, to have Medicare payments reflect market driven prices in a competitive bidding environment. We are pursuing this goal in three phases.

First, we are implementing the authority provided by Congress under the MMA to freeze the DME fee schedule amounts at 2003 levels for 5 years (2004 through 2008). This freeze was implemented through program instructions issued effective January 2004. Effective January 1, 2005, the MMA also requires CMS to reduce the fee schedule ceiling for base wheelchair equipment (K0011) by 3.28 percent from $5,296.50 to $5,122.74, a percentage reduction based on the difference between Medicare payments and the median payment made for these items under the Federal Employee Health Plans.

In addition to the changes under the MMA, CMS will work with a panel to make changes to the HCPCS coding for power wheelchairs that will establish a code set that better describes the power wheelchairs currently on the market and thus will assure that wheelchair payments are accurate. The industry and the OIG have recommended an expansion in the HCPCS codes for power wheelchairs. The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is developing a preliminary

recommendation for coding categories for the various combinations of power wheelchair bases and accessories. Once our proposal is developed and undergoes careful review by CMS policy and clinical staffs, we will consult with experts in other Federal agencies (such as the Veterans Administration), and solicit public comment. While it is not possible to predict with certainty the impact of these coding changes on price, we expect Medicare would pay less for basic power wheelchairs, less than or equal to what we pay for mid-level wheelchairs, and more for expensive products needed by specific patient populations. The net effect will likely be lower overall payments for wheelchairs, and more importantly, payments that are much more closely tied to the actual costs of these types of wheelchairs.

As required by MMA, CMS also is developing plans to implement its new authority to establish a competitive bidding process for DME. Competitive bidding will become a permanent part of Medicare with a phased-in process from 2007 through 2010. CMS intends to apply competitive bidding based on the revised mobility device codes just described.

The Secretary has the authority to designate which products to phase into competitive bidding based on the highest cost items, highest volumes, or items with the largest savings potential. Phase in of power wheelchairs will begin in 2007. Pursuant to the MMA, bidding will take place in at least 81 Metropolitan Statistical Areas (MSAs) across the country by 2010. Effective January 1, 2009, the payment information from competitive acquisition areas can be used to adjust the payment amounts for those items in other areas.

Full implementation of the competitive bidding program after 2009 will assure that the program is paying market-driven prices for power wheelchairs. In addition, more precise descriptions of the types of wheelchairs in the proposed new codes (described above) will lay the foundation for competitive bidding by establishing a code set that adequately describes the range of power wheelchairs currently on the market. Furthermore, the contractor reform provisions under MMA will bring about performance-based

contracting and other reforms that will enhance the quality and efficiency of contracts resulting from competitive bidding.

*Quality Standards*

Another goal of CMS is to ensure that there are appropriate quality controls for suppliers. We will revise the supplier standards for enrolling in Medicare to include quality measures as required by the MMA, building on existing standards in the industry. In the coming months, CMS will begin the steps to implement new supplier standards building on existing industry standards. CMS will also develop a proposal for an accreditation program, as part of the implementation of competitive bidding, to further ensure that power wheelchair suppliers meet industry and community standards for power wheelchair utilization. Lastly, CMS, through our contractor the National Supplier Clearinghouse, will continue its work to ensure thorough review of all applications for enrollment so that only qualified suppliers are allowed to bill the Medicare program.

**Conclusion**

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you again for inviting me to testify today about the issues involving Medicare's payment and coverage of motorized wheelchairs and scooters. While we remain vigilant in our efforts to eliminate fraud, we must keep in mind that many beneficiaries need and deserve this critical benefit and could be denied access. We have made substantial progress in identifying and eliminating fraudulent practices, while at the same time protecting beneficiary access to needed equipment. Taking steps to recover millions in fraudulent claims, CMS has outlined a broad reform agenda to further improve our systems. This agenda is consistent with the recommendations set forth by GAO and OIG.

Specifically the OIG recommended that CMS:

- Require DMERCs to address several areas within the coverage policy;
- Require DMERCs to conduct frequent reviews of the K0011 code;
- Create a new coding system to account for new models and prices; and
- Educate providers and beneficiaries about Medicare's coverage criteria.

As noted in the aforementioned testimony, CMS is already addressing several of these recommendations, for example:

- CMS is developing a regulation implementing MMA that would expand the categories of practitioners who can order POVs and would establish a requirement that the treating practitioner conduct a face-to-face examination for the beneficiary before writing a prescription for a POV.
- In addition, CMS will provide guidance on implementing coverage policy to ensure appropriate coverage of power wheelchairs through a consensus-driven evidence-based process.
- CMS also is examining changes to the HCPCS coding for power wheelchairs that will be developed based on recommendations by HHS and other Federal agencies' clinical experts along with input from the public.
- CMS currently is rolling out educational campaigns designed to provide physicians and beneficiaries with the necessary information about our coverage policies.

CMS' three-pronged initiative sets a very aggressive agenda and I believe this approach will improve access to high-quality power mobility devices for beneficiaries and ensure appropriate coverage through the regulatory process and guidance for DMERCs; will save money by providing appropriate payment for motorized wheelchairs through MMA, coding changes, and competitive bidding; and allow only qualified suppliers to bill the Medicare program through revised standards, accreditation, and thorough supplier application reviews.

Thank you again, and I look forward to answering any questions you might have.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 303-D
200 Independence Avenue, SW
Washington, DC 20201


**Public Affairs Office**

# MEDICARE NEWS

FOR IMMEDIATE RELEASE
April 28, 2004

Contact: CMS Press Office
(202) 690-6145

## MEDICARE ANNOUNCES NEW INITIATIVES ON POWER WHEELCHAIR COVERAGE AND PAYMENT POLICY

Centers for Medicare & Medicaid Services Administrator Mark D. McClellan, M.D., Ph.D. today announced a series of further steps on Medicare coverage and payment policies that apply to power wheelchairs and power scooters building on recent successes in reducing Medicare abuse. CMS is implementing a three-pronged approach focused on coverage, payment and quality of suppliers of power wheelchairs.

"Medicare spending for power wheelchairs and power scooters has skyrocketed in recent years to more than $1.2 billion a year, yet some beneficiaries who really need these mobility devices are not getting high-quality and timely assistance," said Dr. McClellan.

"CMS has cracked down on fraud and abuse in the wheelchair market, including the launch of Operator Wheeler Dealer last fall in collaboration with the HHS Office of the Inspector General," said Dr. McClellan. Now we are moving to the next stage in strengthening our policies for power mobility devices."

The first prong of the plan is to develop guidance on the current coverage of power wheelchairs. Beginning next month, CMS's chief medical officer will bring together clinicians from across HHS and other government agencies to refine and describe the conditions that are associated with the current coverage definition and to develop draft guidance for determining whether a patient meets the definition of "bed or chair confined." The goal is to focus on a set of clinical and functional characteristics that are evidenced-based and will better predict who would benefit from a power wheelchair or scooter. The public will be given an opportunity to comment before the guidance is finalized.

To further ensure that beneficiaries who get mobility devices receive a high-quality and timely evaluation, appropriate device choice and clear guidance in using the device, CMS will also address requirements for ordering mobility equipment through a proposed regulation. The regulation will, in part, implement provisions of the 2003 Medicare Modernization Act.

The second area in which CMS is taking action is in billing and payment for power wheelchairs and scooters. CMS' goal is to assure that Medicare pays appropriately for motorized wheelchairs, and

that beneficiaries have access to them when needed. The technology, range of products, and market for power wheelchairs have changed substantially since the current HCPCS codes for power wheelchairs were added in late 1993. Currently, most power wheelchairs are billed under a single code (K0011), for which Medicare has set a single ceiling amount of $5,296.50, even though different models of these wheelchairs have substantially different market prices. CMS is working with a national coding panel to develop a new set of codes that better describe the wheelchairs currently on the market. Accurate individual payment ceilings would then be developed for each of the new codes.

Further, CMS plans to implement competitive bidding for a number of items of durable medical equipment, as authorized by last year's Medicare modernization law. CMS expects to include power mobility devices in the competitive bidding program.

The third prong of the new plan is to ensure that there are strong quality controls for suppliers to assure that beneficiaries will receive high-quality power mobility services. CMS will revise the supplier standards for enrolling in Medicare to include quality measures as required by the MMA, building on existing standards by the industry. CMS intends to finalize new standards in the fall of next year. In addition, CMS will develop a proposal for an accreditation program, as part of the implementation of competitive bidding, to further ensure that power wheelchair suppliers meet industry and community standards for power wheelchair utilization. Lastly, CMS, through its contractor, the National Supplier Clearinghouse, will continue its work to ensure thorough review of all applications for enrollment so that only qualified suppliers are allowed to bill the Medicare program.

These new initiatives build on prior CMS efforts to combat improper payments for power wheelchairs. For example, Operation Wheeler Dealer involved aggressively scrutinizing all new applications for Durable Medical Equipment supplier numbers. Operation Wheeler Dealer also included special program integrity efforts in conjunction with federal law enforcement officials on Harris County, Texas, where a high incidence of fraud had been detected. All power wheelchair claims from Harris County were individually reviewed and approved by our regional office, and suppliers were required to attend training on Medicare wheelchair coverage policies. As a result, claims for the main power wheelchair code billed by suppliers in Harris County dropped from $59.8 million in May 2003, to $33.3 million in August 2003, to $4.9 million in December 2003. These initiatives continue today.

In addition to the successes in Harris County, Operation Wheeler Dealer has proven worthwhile on a nationwide basis. Working collaboratively with the Justice Department and the Office of Inspector General, since 2003 federal officials have recovered $84 million in fraudulent claims for power mobility products nationwide. The contractors that process power wheelchair claims have referred about 155 potential fraud cases (representing 265 suppliers) involving power wheelchairs to law enforcement since September 2003. About 10 percent of these cases have been closed already, indicating a very aggressive approach by law enforcement.

"In launching Operation Wheeler Dealer, CMS and the OIG took action to stop Medicare fraud, and those actions are having an impact," said Dr. McClellan. "With this new initiative, and with input and feedback from suppliers and beneficiaries, we are going to do even more to make sure that Medicare funds are spent on patients who need them, and that beneficiaries with disabilities are getting the high-quality, modern services they deserve."

# # #

**Senate Committee on Finance**
**Hearing on "Taking Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program"**
**April 28, 2004**

This is the answer for the record to be inserted into the transcript from the hearing.

**SENATOR GRAHAM— What I would like to do, frankly, is go before the appropriators and urge them to provide funding to establish other similar medical fraud units in high intensity areas, and I would like a memo as to your recommendations as to whether that is a good idea, and if so, how you would recommend going about phasing it in more broadly, and what would be its cost. Based on the Harris County/South Florida example, what are its likely savings in the reductions of, and deterrence of, medical fraud?**

**INSERT:** Page 63, line 25

**MR. KUHN:** Senator Graham, the South Florida Fraud Control center has the potential to serve as a guide for Federal efforts to detect and eliminate fraud and abuse of the Medicare program. We are determining how a system like the one in Florida could be used on a national level. As part of this effort, we are evaluating how to enhance our existing resources in order to identify fraud, waste and abuse proactively, instead of reacting to it after the fact. We have a satellite office in Miami that works solely on identifying and deterring fraud. I'm pleased to say that this office has enjoyed many successes. We are now determining if similar offices would be useful in other areas of the country.

# Testimony before the Senate Committee on Finance

## Rebecca Lewandowski

## April 28, 2004

Good Morning, Senators

My name is Rebecca Lewandowski. What brings me before you today is my involvement in a massive California based Medicare fraud ring. Several co-defendants and I are currently waiting sentencing on multiple federal charges in Phoenix, Arizona.

Please allow me to give you some history how I became involved with my co-conspirators and their company. My younger brother befriended two young men who already had two Durable Medical Equipment (DME) companies established in Nevada and California. As their friendship grew, so did their desire to expand by recruiting new people to assist in opening additional DME companies in partnership with the two brothers. With promises of wealth and a better life, he was enticed into applying for a DME provider number, and ultimately billed Medicare for over two million dollars.

During the Spring of 1998, I was introduced to the Edem brothers, who were looking for clerical assistance in their Long Beach, California office. At that time, I was unemployed and was thrilled with the opportunity to work for them. My duties for the Edem brothers began with completing certificates of medical necessity, delivery tickets, and various insurance related documents. They said physicians gave them power of attorney to sign on behalf of the doctors, and my responsibilities then escalated to forging physicians' and patients' signatures on thousands of documents for several DME companies, all of which were maintained from our Long Beach location. I was given the title of Office Manager, and was made the direct contact for our two billers. Through my association with our billers, and with the assistance of Medicare provided manuals and booklets, I was eventually coordinating

billing for approximately twenty companies. The Edems instructed me to bill a specific amount each month, and I achieved the goal. In total, our operation defrauded the Medicare program for twenty-five million dollars.

Within six months of my first day of employment, at twenty-four years old, with no medical experience, and totally ignorant how to operate a legitimate DME operation, I was the sole proprietor of Mercury Medical Supply in Klamath Falls, Oregon. The process by which I obtained a DME provider number was fairly simple. I referred to my brother's already approved application as a guide, and simply copied the information onto my application. The Edems provided three thousand dollars to rent an office space and to finance other related expenses. In order to approve an application, CMS requires a site surveyor to conduct a surprise

inspection of each business location. The site surveyor asks several test questions relating to the DME company. On the day of inspection for my storefront, the surveyor telephoned me for an appointment. That call gave me ample opportunity to prepare for my surprise visit. After completing the test questions, the surveyor gave me a copy of the list of questions. That mistake set a precedent for every other site inspection that followed. During a two-year period, my storefront billed Medicare one million one hundred fifty-eight thousand dollars. Eighty-four percent of that money was paid to the Edems, six percent to the biller, and ten percent to me.

The process of creating sham storefronts repeated with new people posing as DME suppliers and obtaining new Medicare provider numbers. The Long Beach operation was responsible for over twenty new

companies in California, Oregon, Nevada, Arizona, Utah and Missouri. In December 2001, federal agents raided the Long Beach office and several homes, and discovered six supplier applications for new DMEs in the State of Washington.

Key individuals within our organization that made the operation function properly included marketing persons, billers, physicians, nurses, office support staff, delivery drivers, and Medicare beneficiaries. The goal of each role was to benefit all of our DME companies working as a single unit.

The marketing persons were from a specific ethnic background, and most were related by blood or through marriage. Their mission was to visit similar ethnic communities to solicit information from Medicare beneficiaries. Often modestly-priced supplies, such as Ensure or walkers, and less often, cash, were offered in

exchange for beneficiary information and for their silence. Marketing persons exploited the language barrier to manipulate and to deceive non-English speaking beneficiaries into giving them identification cards and Medicare numbers, and were paid between $800 and $1,500 for each name and Medicare number.

We provided each beneficiary a toll-free number for any questions or complaints regarding a Medicare statement. All incoming calls from beneficiaries from every location rang directly into our Long Beach office. Our goal was to satisfy the beneficiary, and avoid any complaints of fraudulent activity reaching Medicare.

Some of the mistakes and poor decisions that were made within our organization were of such significance that we should have been exposed much sooner than we were. All our "patients" were of similar ethnic background and resided in California. The same

doctors were used repeatedly for all the companies. All paperwork for every company was completed by the same staff, and had striking similarities. Less than five percent of our "patients" ever visited a doctor or a clinic.

At the height of our operation, we billed Medicare for approximately 100 power wheelchairs each month, but delivered only a tiny fraction of that number. I received a letter from a fraud analyst representing Medicare that stated a patient complained about not having received the power wheelchair for which we billed Medicare. Offering no explanation, I mailed a refund check to Medicare, and billed another fifty thousand dollars the following month. In many instances, a simple telephone call to either a doctor or a patient could have prevented some of this fraudulent activity.

My experience with the whole process of how these sham storefronts operated has given me several ideas how to improve the system that we easily manipulated. Screening new provider applicants for previous violations and/or convictions could eliminate repeat offenders. More thorough investigations should be performed when a beneficiary complains of having been the victim of fraud. The site surveyor inspections should always be a surprise, and should occur more frequently. Random calls to doctors and patients will help to identify illegitimate claims. New DME companies should be restricted to submitting paper claims only, as opposed to electronic submissions. This allows Medicare a closer inspection of a patient's file, which could alert them to suspicious paperwork. Lastly, literature written in several languages could assist educate minorities about fraud and abuse.

If telling my story sheds more light on this rampant problem and assists you in plugging some holes in the Medicare system, my time has been well spent.

Thank you.

# COMMUNICATIONS

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STATEMENT OF THE AMERICAN ASSOCIATION FOR HOMECARE (AAHOMECARE)

May 28, 2004

The Honorable Charles E.Grassley
Senate Finance Committee
219 Dirksen Building
Washington, D. C. 20510

Dear Chairman Grassley:

On behalf of the members of the American Association for Homecare (AAHomecare), I wish to reiterate our appreciation for the opportunity to testify before the Committee on Finance on fraud and abuse in the Centers for Medicare and Medicaid Services (CMS) power wheelchair program. AAHomecare has zero tolerance for Medicare fraud and abuse involving power wheelchairs. Our organization has a voluntary Code of Ethics and we have approved a Guide for Conduct for our membership. AAHomecare is committed to promoting compliance with Medicare program rules and we do so by sponsoring education programs. AAHomecare will continue to assist CMS and the Federal Law enforcement agencies in an effort to ensure the integrity of the Medicare program. In the past, for example, we have made recommendations to CMS on coding and documentation for power wheelchairs. Our recommendations will promote greater precision in the billing and payment for power wheelchairs.

**The CMS Three Pronged Initiative**

We are encouraged to see that CMS has announced it will undertake a review of the coding and coverage criteria for power wheelchairs. We believe that appropriate coding and coverage policies will provide prescribing physicians with better information and will improve Medicare billing and payment policies. We urge CMS to carefully consider the detailed recommendations for power wheelchair codes that the industry has already submitted. We also recommend that CMS include the views of non-government clinicians who are involved prescribing motorized wheelchairs as it develops coverage guidelines. Likewise, it is important to include input from clinicians who evaluate and fit beneficiaries for power wheelchairs. CMS must include the clinical community early in

the development of coverage guidelines to ensure that the needs of individuals who require power wheelchairs are appropriately considered.

CMS has also announced that it will promulgate new supplier standards to address the fly-by-night operators that enter the Medicare program to steal tax payer money. AAHomecare has a record of supporting better supplier standards under the Medicare program. We embraced the inclusion of a provision in the Medicare Modernization Act of 2003 (MMA) that requires CMS to implement quality standards and mandatory accreditation for suppliers as a condition for billing the Medicare program. AAHomecare and its members will work with CMS and the homecare community to ensure that CMS promulgates meaningful supplier quality standards that are consistent with the voluntary standards that providers already follow.

**The Inspector General's Reports on Power Wheelchairs**

The Office of Inspector General (OIG) for the Department of Health and Human Services has issued two reports on Medicare's power wheelchair benefit. One report reviewed Medicare reimbursement for power wheelchairs with prices paid by consumers for power wheelchairs and those paid by supplier's purchasing power wheelchairs from wholesalers or manufacturers. [1] The other report reviewed Medicare payments for power wheelchairs in light of Medicare coverage criteria and documentation requirements. [2]

Pricing for Power Wheelchairs

We question the OIG's analysis for determining prices for power wheelchairs. The analysis relies on products on the SADMERC product classification list. The products listed as K0011 on the SADMERC classification are not equal in terms of medical necessity features, product capability or quality. Consequently it is not possible to draw useful conclusions about pricing for power wheelchairs under the K0011 code based on the OIG's analysis. Further, the OIG's report notes that the suppliers offering power wheelchairs to the public via internet websites may not in fact furnish products to Medicare beneficiaries, may offer different products, and may have different cost structures than suppliers that service Medicare beneficiaries. These mark important differences that call into question the OIG's comparisons. It is worth repeating that a new coding structure will improve billing and payment policies for power wheelchairs.

Finally, and most importantly, the report states clearly that the OIG did not collect data on supplier administrative costs for furnishing the power wheelchairs. Suppliers that service Medicare beneficiaries incur significant costs beyond product acquisition. These include costs associated with direct patient care and costs for administrative and support services necessary for quality assurance and regulatory compliance. Moreover, Medicare program rules increase supplier operating costs by imposing cumbersome documentation and billing requirements that other payers do not require. Comparisons between the

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1 A Comparison of Prices for Power Wheelchairs in the Medicare Program, OIG Report OEI-03-03-00460, April 2004.

[2] Medicare Payments for Power Wheelchairs, OIG Report OEI-03-02-00600, April 2004.

Medicare program and other government payers are not appropriate unless these differences are considered and accounted for.

Medicare Payments for Power Wheelchairs

In its analysis of improper Medicare payments for K0011 Wheelchairs by Medicare, the OIG concluded that the Medicare program spent $178 million in 2001 on K0011 power wheelchairs for Medicare beneficiaries that did not meet Medicare's coverage criteria. This study focused primarily on documentation under Medicare's stringent coverage policy for power wheelchairs. In the past, AAHomecare has made specific recommendations to CMS on documentation for power wheelchairs. Suppliers need adequate guidance from CMS and the durable medical equipment regional carriers (DMERCs) on the type of documentation they will require when reviewing power wheelchair claims in an audit.

As we stated above, we support CMS' efforts to review its coverage policy and encourage CMS to include a broad mix of clinicians as it moves forward with this initiative. A coverage policy that recognizes the needs of beneficiaries and the available technology will address the concerns that the OIG raises in this report. The OIG also made a number of recommendations we have been on the record for supporting. For example, the OIG recommends that:

- CMS create a new coding system for K0011 power wheelchairs that account for the variety in models and prices for power wheelchairs.
- CMS clarify the coverage criteria for power wheelchairs.
- CMS enhance provider and beneficiary education about power wheelchairs.

We believe that the best outcome can be achieved when CMS, clinicians, the supplier community and the patients they serve work together in partnership, and we are committed to assisting CMS as it moves forward with these recommendations Senator, Grassley, I reiterate our appreciation for the opportunity to testify before the Committee. Please feel free to contact me if we can be of assistance in any fashion.

Sincerely,

Kay Cox
President & CEO


American Physical Therapy Association

# Statement for the Record

## Senate Finance Committee Hearing
## "Taking the Taxpayers for a Ride:
## Fraud and Abuse in the Power Wheelchair Program"

Hearing date: April 28, 2004
Submission date: May 12, 2004

Submitted by the American Physical Therapy Association
1111 N. Fairfax Street
Alexandria, Virginia 22314
(703) 706-8533

This statement is submitted on behalf of the American Physical Therapy Association (APTA), which represents the interests of more than 64,000 physical therapists, physical therapist assistants, and students of physical therapy. We would like to thank Chairman Grassley for holding the April 28, 2004, hearing to examine issues related to Medicare payment policies for power wheelchairs.

Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations. Therapists provide patient care in a variety of settings including hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, or sub-acute facilities; patients' homes; education or research centers; schools; hospices; industrial workplaces or other occupational environments; fitness centers; and sports training facilities.

Physical therapists work very closely with Medicare beneficiaries and their physicians to determine how to best meet their individual mobility needs. Physical therapy is the profession devoted to restoration, maintenance, and promotion of optimal physical function and movement. Functional mobility takes on many different forms, and physical therapists are often challenged to analyze and think of functional mobility in non-traditional ways. Ambulation, while perhaps the most accepted example, is only one illustration of functional mobility. Physical therapists are experts in maximizing the independence of ambulatory and non-ambulatory persons through a variety of means. The desired level of mobility is achieved through the recommendation and use of assistive devices that are appropriate for that individual. In certain cases the best way to accomplish the goal of independent, functional mobility is through the use of power mobility products.

Although it can be a miracle for those patients who require it, the use of power mobility products has unfortunately been rife with fraud and abuse over the last several years. The Centers for Medicare and Medicaid Services (CMS) is now attempting to tighten the eligibility requirements for these devices to reduce or prevent inappropriate Medicare spending in this area. However, there is a risk that those patients who legitimately need these types of devices may suffer the consequences of years of insufficient enforcement to correct problems that were identified as early as 1997. It is imperative that as CMS further defines and narrows the standards for eligibility, beneficiaries that justifiably require these assistive devices are able to maintain access to them.

Currently no medical background is necessary for an applicant to obtain a Durable Medical Equipment (DMEPOS) supplier number from CMS. There are no qualification guidelines apart from the 21 supplier standards – none of which require specialized education. These 21 standards begin to address some areas that could be exploited for fraudulent activity, but they do not go far enough. There is no mention of the qualifications of individuals employed by the supplier or the person doing the assessments of eligibility and need. Regulation of dealers is minimal compared to the standard that providers experience in the Medicare program. Often, the supplier is even notified as to when to expect the "surprise" inspection. Little follow-up is performed to ensure that a beneficiary actually received the product for which Medicare was billed. Unfortunately, there also are incentives built into the system that may encourage providers to recommend a product that is excessive when compared to what is really needed by the patient. APTA believes that CMS should further investigate recommendations by the Inspector General and the General Accounting Office to examine the current system for obtaining a DMEPOS supplier number.

Certificates of medical necessity (CMN) are an inadequate means of attesting to a beneficiary's need for a power mobility device. The CMNs do not inquire into a patient's living situation, environment, family support, and there is no section for a patient assessment. As a result, it is quite easy at this point for the answers from an approved CMN to simply be copied to another and be submitted for payment. The system can be cheated easily with minimal effort on the part of the suppliers submitting the claim. At this time a letter of necessity is not required, but even when submitted it is rarely referred to by the payer (CMS). At a minimum, CMS should require and review a letter of medical necessity written by a qualified professional, including physical therapists, that justifies the need for the power wheelchair prior to authorizing the payment for the device. In addition, the certificates of medical necessity should contain additional fields of pertinent patient information and should be completed only by qualified, educated, professionals.

A licensed, qualified professional should be held responsible for the recommendation of a device. When a qualified professional performs a screening for a power device and determines that a patient has the disability and either has no expectation of ambulation or is inefficient with ambulation or manual wheelchair propulsion, a motorized wheelchair should be provided. Inefficient ambulation or manual wheelchair propulsion includes the inability to move safely at a reasonable rate of speed and/or the lack of endurance to move functional distances, and should qualify individuals for power mobility devices.
However, devices of this nature are extremely expensive and the APTA would support a process of peer- reviewed pre-authorization for such a device, including the requirement of a letter of medical necessity. The pre-authorizing review request and decision should be made based on clinical evaluation and performance.

Physical therapists use their knowledge of anatomy, biomechanics, and posture to make decisions about a proper assistive device. Physical therapists practice with a comprehensive approach to patient evaluation that includes physical, safety, family, and environmental assessments. They determine what types of postural support a person needs, based on the person's neuromotor and musculoskeletal impairments. They also determine the appropriate control system for power devices by: 1) identifying potential movement patterns that can be reliably and voluntarily controlled; 2) identifying the part of the body that will potentially operate the control mechanism; 3) determining the type of control mechanism that best interfaces with the movement pattern; 4) trying potential options and evaluating a person's ability to activate, control direction, and release the wheelchair control mechanism; and 5) determining how to mount the control mechanism.

One factor CMS must take into consideration when establishing eligibility criteria for power mobility devices is the fluctuation of symptoms and functional abilities of some beneficiaries that need these devices. The clinical judgment of a qualified professional is essential when discussing this patient population. Physical therapists are uniquely qualified by their training to evaluate and make recommendations for the complex, unpredictable patient. The classic example of a patient with variable deficits is a person diagnosed with multiple sclerosis. Classically, persons with this disease present with variable deficits dependent upon many factors including fatigue level, weather, time of day, and whether or not she is experiencing a clinical exacerbation. Patients with this disease are significantly affected by fatigue and symptoms tend to worsen the more tired a patient becomes. A beneficiary may wake in the morning and feel well enough to walk to the bathroom, shower, dress, and make a small meal independently and

safely. However, the same person may not be able to walk back to her bedroom in the evening without falling because of loss of balance. The beneficiary may be able to walk the length of her home independently and safely one day, while the next day have strength, endurance and balance deficits that make ambulation impossible. The manual wheelchair would not be a viable option for this patient because of the exertion required for manual propulsion. This level of activity would cause extreme fatigue, thus worsening the patient's symptoms, further debilitating her.

The accepted clinical practice of providing a wheelchair is initiated by the referral from the medical doctor to a qualified professional, such as a physical therapist, for specific recommendations regarding the most appropriate device. Typically, the physician's face-to-face visit with the patient results in a referral to another qualified professional, such as a physical therapist, with expertise in assistive technology assessment for recommendations on mobility needs. The physical therapist then conducts a thorough examination of the patient, consults with the physician, and jointly the determination of the most appropriate device is made. This is a collaborative process between health care professionals, and physical therapists are often the ones with the knowledge of coverage requirements and are able to make the most appropriate recommendations within the structure of the coverage guidelines.

It is the position of the APTA that any policy developed CMS regarding coverage and eligibility requirements for power mobility must include physical therapists as an essential member of the patient assessment team. It is our hope that any policy will follow current clinical practice and recognize the role of the therapy provider in advising the medical doctor and beneficiary regarding the proper device.

Thank you for the opportunity to submit this statement and your consideration of our suggestions. If we can be of any assistance to the Finance Committee as its inquiry progresses regarding the provision of power mobility products in the Medicare system, please contact me at 703-706-3160.

Dave Mason
Vice President Government Affairs
American Physical Therapy Association

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May 5, 2004

Senate Committee on Finance
Attn: Editorial and Document Section
Rm. SD-203
Dirksen Senate Office Bldg
Washington, DC 20510-6200

**Statement for the Record: Hearing: Wednesday-April 28, 2004 @10AM**
**"Taking Taxpayers For A Ride: Fraud and Abuse In The Power Wheelchair Program**

We respectfully submit the following statement relative to the above hearing and ask that it be added to the public record. Previously, we have sent this same information to the attention of Chairman Charles Grassley.

It is our intent that the Centers for Medicare and Medicaid Services (CMS) are made equally aware of the advantage that POV/Scooters have over power chairs for many people with walking limitations. Amigo Mobility International seeks to bring awareness of an effective, lower cost mobility alternative to immediately begin reducing Medicare claim costs.

If there is need for any clarification or further questions to be addressed, we are pleased to assist as needed.

Thank you for the opportunity to include our statement on this most important matter directly affecting the healthcare industry and the ongoing solvency of Medicare.

Sincerely,

Allan R. Thieme
President
Enc.

April 27, 2004



Senator Charles Grassley
Chairman of the Committee on Finance
135 Hart Senate Bldg.
Washington, DC 20510-1501

Dear Senator Grassley,

In an effort to combat widespread fraud in the power wheelchair industry, the Centers for Medicare and Medicaid Services (CMS) are attempting to "clarify" coverage criteria for power wheelchairs. It is our hope that CMS is equally aware of the advantage that POV/Scooters have over power chairs for many people with walking limitations.

Currently, individuals with walking limitations seeking Medicare reimbursement are most often directed to Power Chairs as the primary mobility solution. However, the design and function of POV/Scooters are clearly different than those of a Power Wheelchair.

As outlined in Attachment A, POV/Scooters provide numerous advantages over Power Chairs, including:

- Psychological Advantages
- Full Body Therapeutic Advantages
- User Friendly Advantages
- Safety Advantages
- Pricing Advantages (multi-million dollar savings annually)

Given all the proven physical, psychological and financial benefits of a POV/Scooter over a Power Wheelchair, a critical question remains. Why is Medicare reluctant to level the playing field and encourage a lower cost mobility alternative as a better mobility solution to individuals with mobility limitations? It would appear logical that the *lowest cost* mobility solution would be the *first choice* as reimbursed medical equipment. Ironically, our current system is exactly reversed.

Consider the following example that was brought to our attention. A man in the Midwest was sent home from a rehab center with a power wheelchair (Medicare financed). His need for a power-driven mobility vehicle was legitimate, but he was given no choice between a power wheelchair and a POV/scooter and no visit was made to his home to see how he could manage. He and his wife found the power wheelchair too big and awkward to use effectively around the house and too heavy to load into their vehicle. During the time he was struggling to use the power chair, the couple invested in an SUV and a lift mechanism to try to make the chair portable beyond their home. But even that didn't

work. They finally purchased their own scooter, and the power wheelchair is sitting in the garage unused.

According to an article in the April 2004 issue of New Mobility (Attachment B), a Coalition has been formed to fight the CMS clarification: Restore Access to Mobility Partnership (RAMP) including the Scooter Store, Pride Mobility, the American Association for Homecare, Invacare Corp., The MED Group, Mobility Products Unlimited, and Sunrise/Quickie Medical. Their biggest issue appears to be the need to clarify and relax the "strictly nonambulatory" limitation. They feel this stipulation is "a result of an overaggressive CMS crackdown on fraudulent sales and billing scams that is dramatically hurting the DME industry and ultimately the end user."

However, this Coalition hasn't addressed the bigger issue of properly evaluating the needs and abilities of those with walking limitations.

How ironic that POV/Scooters have always offered more mobility and are less expensive than power wheelchairs, but have always been harder to get under Medicare. Amigo Mobility respectfully requests that individual needs along with home evaluations be determined and that lower cost alternatives, such as POV/Scooters, be given equal or priority consideration for providing the best solution based on those findings and Medicare costs.

Having a patient's specific needs and abilities evaluated would result in a win-win situation for the end user and Medicare. The end user would be given multiple mobility options, providing him/her with the best solution for his/her needs, inherently reducing fraudulent activity. And, offering an effective, lower cost mobility alternative would also immediately begin reducing Medicare claim costs.

It is our recommendation that Medicare regulations consider one of two directions: 1) they should be reversed, so that power wheelchairs, instead of scooters, would be prescribed only by a specialist in physiatry (rehabilitation medicine), orthopedics, neurology, or rheumatology, or (2) they should be made uniform for all mobility vehicles.

We sincerely appreciate your consideration and support of these recommendations.

Best regards,

Allan R. Thieme
President

**ATTACHMENT A**

# POV/Scooter Advantages

***Psychological Advantages***

- The small size of a POVs/Scooter allows the individual to be seen first, **downplaying the individual's limitations** and diminishing the appearance of a disability
- The easy maneuverability, transportability and full swivel seat allow the user to **actively participate** in activities and conversation
- These two advantages promote user **self-confidence and autonomy**, ultimately resulting in a reduced need for counseling, and thereby **saving insurance dollars**

***Full-Body Therapeutic Advantages***

- POVs/Scooters promote **full-body movement**
- Individuals use their hands, arms and upper torso when driving
- A full, 360-degree swivel seat…
    - Facilitates **lower body movement** from waist to toes
    - **Decreases the chance of pressure sores**
    - Promotes **easy transfer** of individuals
- Movement of this nature will **delay the rate of muscle deterioration**, and additional medical ailments requiring additional Medicare dollars for treatment

***User Friendly Advantages***

- Ergonomic handle design provides **better user control**
- Small size makes it **easier to maneuver** around the house, through narrow hallways, in bathrooms and kitchens, etc.
- Lift-All available for additional **easy transportation** flexibility

***Safety Advantages***

- Swivel seats and seat lock allow for **ease of transfer** and transportability
- **Programmable speed control** and **dynamic and regenerative braking** promotes user safety

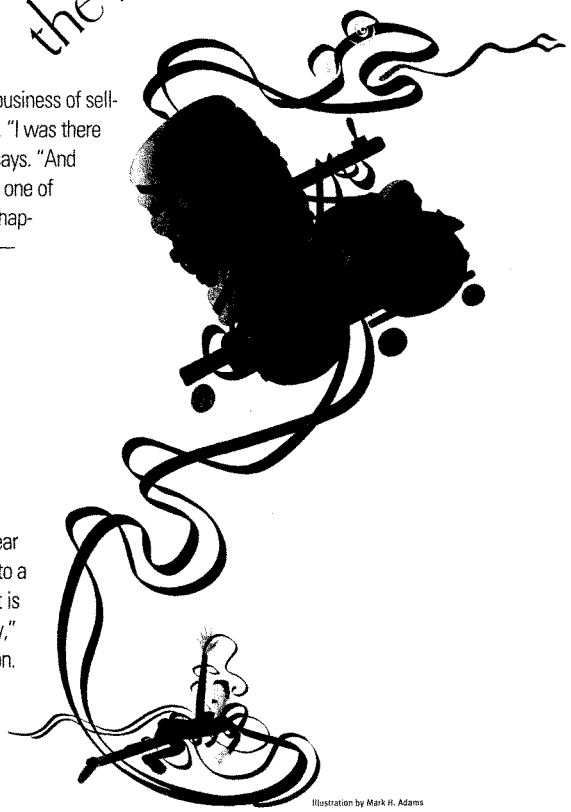
***Pricing Advantages***

*(Two stats taken from pages of Dara Corrigan's testimony before the Committee on Finance-April 28, 2004 – page 2 (number of K0011 units) and page 4 (percent of beneficiaries who may have met criteria for a less expensive mobility device.)*

- 274,000 K0011 Units In 2003
- Average Price = $4379
- 2004 MI allowable cost for POV/Scooter = $1922
- Difference = $2457
- Assuming 45% of the 274,000 individuals may have met criteria for less expensive POV/Scooters = **annual SAVINGS of $303 million in 2003!**

# the Big Squeeze

Ken Nelson has been in the business of selling wheelchairs since 1963. "I was there when Medicare started," he says. "And this new CMS clarification is one of the worst things that has ever happened." On Dec. 9, 2003, CMS—the Centers for Medicare and Medicaid Services—issued a policy clarification that limits coverage on power mobility devices to people who are strictly nonambulatory: "Power wheelchairs ... are covered only for patients who are nonambulatory. If a patient can only bear weight to transfer from a bed to a chair or wheelchair, the patient is considered nonambulatory," reads the clarification.



BY TIM GILMER

Illustration by Mark H. Adams

was designed to be driven standing." He says other companies designed the standing function on their power chairs as an afterthought.

One of Vertran's goals was to improve on the HiRider's stability issues. "I can go up and down inclines standing all day, and I don't worry about tipping," he says. "I would have to be doing something really stupid to tip over."

How Vertran builds in stability is no secret. "What we did," says Johnson, "is move the user and the center of gravity back, so that when you stand, the center of mass—you and the Vertran—is right down the center of the base. The heavier you are, the more stable this thing is."

Johnson says the design works optimally when you're vertical due to its drive design. "In a sense it's a midwheel-drive product. All I have to remember is that there are 20 inches behind me. It feels very natural and intuitive when you drive it standing."

## An Emotional High

Vertran, says Johnson, helps you become more culturally integrated. "When I'm at the bar I'm hanging out *at* the bar. That gives me an equal opportunity on the playing field." Switching back and forth from a manual chair to Vertran lets him study how people treat him. "People who are standing are more accepted than people who are sitting."

What he likes best is when people don't realize he's disabled. "They come up to me and say, 'Hey, man, that's cool! Can I try that?' And then I have to explain to them ... it's essentially my legs."

Johnson says people don't prejudge him anymore with his product. "'Maybe you can walk, maybe it's a toy,' they think. With the existence of Segways these days, different types of contraptions are becoming more common."

Johnson also notices a change in his personality when he's using his Vertran. "I have a lot more confidence when I'm standing, and it shows. I'm also more vocal and smiling."

Even though Vertran helps him stand, he doesn't deny his disability. "Don't get me wrong, I live in a wheelchair everyday, but when I hang out, I'm not like everyone else in a wheelchair, and it really puts me at a different level. I almost feel that society has let us down in a sense because I feel

*Continued on page 49*

Nelson, president of Wheelchair Works in Milwaukie, Ore., says Medicare beneficiaries who are unstable and at risk of falling are being denied power wheelchairs. "We're sitting on 30 to 40 orders for power chairs because we don't know what to do." According to Nelson, Medicare will not reimburse his company if the power wheelchairs are delivered. "If they can walk at all," he claims, "I have to say, 'I'm sorry, I can't sell you a chair.' It gets my blood pressure boiling."

Sources in the durable medical equipment industry say the strict clarification is the result of an overaggressive CMS crackdown on fraudulent sales and billing scams that caused an astronomical increase in Medicare payouts for power wheelchairs and scooters—mostly intended for use by elderly people—over the past two years. "We're being looked at with a jaundiced eye," says Nelson, a past board member of the National Registry of Rehabilitation and Technology Suppliers, "but we didn't do the fraud, and ultimately it hurts the end user."

Wheelchair Works is about a 10-minute drive from Portland's Care Medical, one of eight stores Care owns in Oregon and Washington. Becky Ruecker oversees the claims process as compliance officer. Unlike others in the industry, Ruecker doesn't see financial calamity on the horizon, at least not for Care Medical. "We have always held strictly to Medicare guidelines, and the 'clarification' is what we have been doing for years." Another reason Ruecker feels mostly unaffected is that Care sells very few scooters to elderly homebound people. Most of their power wheelchair business comes from rehab centers.

Still, Ruecker, who says she has seen Medicare's "knee-jerk reactions" before, recognizes that the durable medical equipment industry is being hit hard. She thinks further clarification of existing guidelines is necessary. "I'd like to see them explore the language of 'functionally ambulatory,'" she says, an issue she has tried to raise in correspondence with CIGNA, one of four national carriers (called DMERCs) who administrate Medicare claims processing. CIGNA is responsible for DMERC's Region D [see sidebar, page 29].

"What about the patient who can take a few steps but cannot function in the home without a wheelchair?" she inquired in a letter written to CIGNA about a year and a half ago. And what about those who may be able to walk a few feet but are at "high risk for falls" or a "patient [who] can walk five feet on parallel bars" but is very unstable, she asked in a subsequent letter. "Although these patients can technically take steps," she concluded, "they cannot functionally ambulate by any measure." She says her efforts to discuss the issue of functional ambulation were quashed by Region D's medical director, Dr. Robert D. Hoover Jr.

## The Real Losers

No doubt the DME industry is feeling the squeeze, but the real losers are the consumers. Certain elderly people—"wall walkers"—can be fairly characterized as accidents waiting to happen. When they are denied power wheelchairs, not only are their lives put at risk, but Medicare itself may be threatened as well: DME industry sources say dollars saved from denying wheelchairs under Part B of Medicare are easily used up in paying for costly surgeries and treatments funded under Medicare's Part A.

The elderly may not be the only group affected by the clarification. People whose active lifestyles depend upon being able to use power wheelchairs also fall under the Medicare program because of low income, inability to work or discriminatory hiring practices. Others are covered by Medicaid, which is influenced by Medicare policy. Many are partially ambulatory or are advised by their doctors to conserve their energy, such as those with multiple sclerosis—who have good and bad days—and polio survivors who experience fatigue and other complications due to post-polio sequelae. Denying power wheelchairs to these groups invites future medical complications. And people with incomplete spinal cord injuries who may be able to walk a few steps but have used manual chairs for decades are at risk of developing repetitive strain injuries in their upper limbs—meaning probable surgery—if denied power wheelchairs.

The list of those potentially affected draws from many more disability groups—people with cerebral palsy, amputation, muscular dystrophy and amyotrophic lateral sclerosis, to name a few. The threat of power wheelchair replacements being denied—even retroactively, due to stricter CMS enforcement—is also a possibility.

Many in the DME industry think the *clarification*, issued without public or industry input, is tantamount to a policy *change*, which usually only happens as part of a public process. Some claim that the CMS clarification amounts to denial of due process.

Charges of discrimination have been strongly implied. A recent letter sent by faculty members of the University of Pittsburgh's respected Department of Rehabilitation Science and Technology to Dr. Paul J. Hughes, medical director of DMERC's Region A, states: "Restricting coverage for a powered mobility device until a beneficiary is nonambulatory is inappropriate. There are no other medical or rehabilitation benefits under the Medicare program that have such coverage restrictions."

> **"We're sitting on 30 to 40 orders for power chairs because we don't know what to do. ... If a person can walk at all, I have to say, 'I'm sorry, I can't sell you a chair.'"**
>
> —Ken Nelson

The ITEM coalition—Independence Through Enhancement of Medicare and Medicaid—made up of various organizations representing aging and disability populations, sent a letter to Secretary Tommy Thompson of the Department of Health and Human Services on Jan. 23 asking him "to rescind the wheelchair policy clarification and, in the alternative, issue a proposed policy that seeks public comment." Over 70 organizations make up ITEM, including the American Association of

## Many think the clarification, issued without public or industry input, is tantamount to a policy change, which usually only happens as part of a public process. Some claim it amounts to denial of due process.

People with Disabilities, Christopher Reeve Paralysis Foundation, National Organization on Disability, National Spinal Cord Injury Association, National Center for Independent Living and Paralyzed Veterans of America.

ITEM's letter claims the CMS clarification represents a return to an "antiquated regulatory standard" of many years ago that requires that wheelchair users be "bed or chair confined." It is a Medicare policy that in recent years has been bypassed in favor of a more modern, practical application stating that a patient "require[s] and use[s] a wheelchair to move around in their residence." The intent of the CMS clarification—to curb fraud in the Medicare claims process—has instead, according to AAPD's Andy Imparato, "thrown the baby out with the bathwater."

Sharon Webb, vice president of sales for Reading Medical West—one of Webb Medical System's handful of retail locations in Pennsylvania—and her husband have owned their business for the past 25 years. She says the impact on their sales has not been as great as on others, but she has noticed a "Medicare backlash"—private insurance carriers requiring more documentation and a lengthier claims process—over the last six months. "We're working twice as hard," she says, "which means extra labor that drives up the cost. It's really not fair." She says her company is facing tougher times in trying to get private insurance carriers to cover equipment for people with neurological impairments. It's well known that insurance companies are not shy about finding ways to deny claims or downsize payments, and Webb feels they are using the fraud issue "as a justification for denying claims."

But she says those who are most obviously affected are seniors in assistive living centers who can walk a few steps using a walker in their small apartments but need a power wheelchair do go anywhere else, for instance a common dining or recreation area. It used to be that Medicare considered the entire facility as their home; now Medicare only considers their small individual living area as their home. By enforcing the new language of clarification, Medicare is denying power wheelchair claims for those who can walk even a few steps in their "homes."

Webb worries about others as well. "I have CP customers who can walk a few steps. What will happen to them?" She attributes much of the problem to certain companies who have "created an impulse item" that contributed to fraudulent sales of scooters and power wheelchairs. But she agrees that the CMS clarification has gone too far.

In a recent letter to Sen. Arlen Specter, R-Pa., Webb writes: "We are concerned that the area of total bed or chair confinement may eliminate those who have neurological or neuromuscular disorders who have bad days, but on some better days they are able to take a few steps."

Chuck Walters has owned Quality Care, in Lodi, N.J., for 20 years. In 2003 he supplied as many as 30 to 40 power wheelchairs to polio survivors being counseled by Richard Bruno, Ph.D, *NM* contributing editor, author and recognized expert in the diagnosis and treatment of PPS. "Almost every one of Dr. Bruno's patients was ambulatory," says Walters. Bruno's motto of "conserve to preserve" makes sense if you are a polio survivor and you want to continue living a productive life. Now Walters worries that Bruno's ambulatory patients may be denied power wheelchairs based on the new clarification. "It's too early to know just yet," he says. He's warily waiting for pending Medicare decisions on claims.

Walters also has concerns about people with amyotrophic lateral sclerosis. The process of evaluating need, receiving, delivering, and getting payment for a power wheelchair now takes so long that some with ALS may not have time to enjoy the freedom their wheelchairs make possible before they lose the ability to operate them. In the past, when ambu-

## Alphabet Soup

**AAPD:** American Association of People with Disabilities—"the largest national nonprofit cross-disability member organization in the United States, dedicated to ensuring economic self-sufficiency and political empowerment for the more than 56 million Americans with disabilities."

**CIGNA:** The private insurance company that administers DMERC Region D.

**Clarification:** An official explanation of existing Medicare policy that can potentially result in changes in enforcement of that policy. A *change* in Medicare policy usually takes place as part of a process that includes public hearings and comment, while a *clarification* need only be posted and made public.

**CMS:** Centers for Medicare and Medicaid Services—federal agency that administers the Medicare and Medicaid programs under the Department of Health and Human Services.

**DME:** Durable Medical Equipment—wheelchairs, walkers, hospital beds, etc.—ordered by a doctor and used in the home.

**DMERC:** Durable Medical Equipment Regional Carrier. A private insurance company (carrier) that contracts with Medicare (through CMS) to process claims for DME, prosthetics, orthotics and supplies. There are four DMERCs in the United States: Region A—10 Northeastern states, including New York; Region B—8 Northern-Central states plus the District of Columbia; Region C—13 Southern states, Colorado, Puerto Rico and the Virgin Islands; Region D—17 Western and Midwestern states and three U.S. territories.

**HME:** Home Medical Equipment. A broad category that includes many products sold by medical supply companies for use in the home.

**ITEM:** Independence Through Enhancement of Medicare and Medicaid. A coalition of over 70 members—disability organizations, aging organizations, consumer groups, labor organizations, voluntary health associations, and nonprofit provider associations. ITEM raises awareness and advocates for policies to improve access to assistive devices, technologies and other services for people of all ages with disabilities and chronic conditions.

**NRRTS:** National Registry of Rehabilitation Techology Suppliers. Certified members adhere to ethical and professional standards in providing and servicing wheeled mobility, seating and positioning.

**RAMP:** Restore Access to Mobility Partnership, a coalition of major manufacturers and suppliers of power wheelchairs that advocates for rescinding the CMS clarification.

lation was not a black-and-white issue that determined approval or denial, patients would receive power wheelchairs in time for them to be beneficial. Now Walters envisions starting the claims process much earlier, when the patient is still ambulatory, possibly even eliminating providing a manual chair first. But will the new clarification, which states that the patient must be nonambulatory, result in a denial?

## What Now?

Changes in Medicare practices eventually filter down to Medicaid and private insurance companies. Walters says Medicaid is starting to become "just as bad" as Medicare. It used to be that when Medicare denied payment, Medicaid would often pick up the tab. "That's a thing of the past," says Walters, "at least in New Jersey." In an effort to save money, something every budget-beleaguered state in the union is trying to do, New Jersey has embarked on a recycling program.

It works like this: Walters goes out and evaluates the consumer, calling out exactly what is needed in a power chair. Medicaid then takes the specs and mea-

## Advocating Within the System

Darren Jernigan, Dave Williams and Cara Bachenheimer are professional lobbyists, but they offer suggestions about how anyone who wants to support a disability cause—such as fighting the recent CMS clarification—can get involved in the process.

"Try to get some work in a related field," advises Bachenheimer, who is vice president in government relations for Invacare Corp. "Work for a state or federal legislator to get an inside view of how the system works." Lobbying appealed to her because it combined her interests in both advocacy and the political process.

Jernigan, director of government affairs for Permobil, suggests volunteering. Even top lobbying firms, he says, will accept free labor. That access allows volunteers to learn from the best. Choosing a few topics and studying the pros and cons of the issues can enable people to talk to leaders in the field. "The beautiful thing about lobbying is that it is free," says Jernigan, "and every time you speak, passionately and intelligently, attacking or defending a subject, you are lobbying."

Williams, a consultant in legislative and political strategy for Invacare, urges the formation of a coalition between equipment consumers and providers/manufacturers with the intent of collaborating to reverse negative trends. Besides the recent CMS clarification, he expressed concern about the new Medicare reform act, saying it will limit choice of provider and product as well as create changes in eligibility.

One provision in the bill, says Williams, a wheelchair user, institutes competitive bidding for certain manual and power wheelchairs. This provision is designed to reduce costs but will limit the items covered to the most basic items needed to function "within the four walls of the home." It is detrimental, he says, to people with disabilities, like himself, who need mobility to participate in the community.

At the heart of these issues are four major legislative/judicial tools—the Rehabilitation Act of 1973, MiCASSA (as yet unpassed), the Olmstead decision, and the ADA (learn about them by visiting www.aapd-dc.org), all of which can be used to champion independence and full societal participation for people with disabilities.

"The Americans with Disabilities Act is an issue that has had the most impact on my life," says Jernigan, also a wheelchair user. "It would be the one issue that I would lobby for, at any cost, to protect."

*—Bethany Broadwell*

surements and passes them on to the one company in the state that collects and refurbishes used wheelchairs. Then, according to Walters, "they pull one out of the closet" and ship it to him. He installs a seating system, delivers the chair, makes sure it fits and the recipient knows how to operate it. For his services, he receives no reimbursement; only the seating system itself is paid for. The wheelchair recycling company, on the other hand, gets paid in full for supplying the refurbished chair. "They're using us as a free service. It's insane, and very unfair," says Walters. "It could put us all out of business."

Shelley Green's company, American Wheelchairs, is also struggling financially. Her only protection, she says, is having to tell consumers they must pay before the equip-

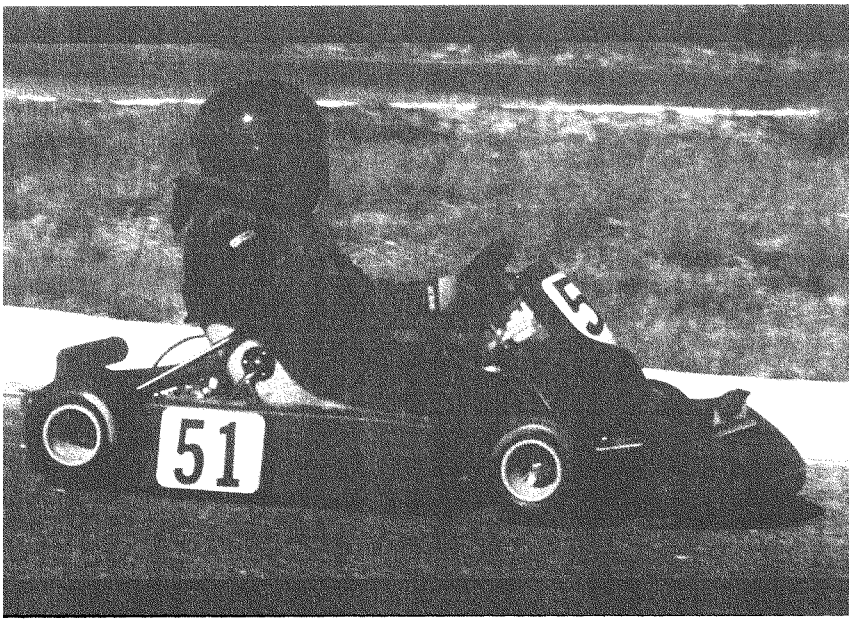
ment is delivered. "They [Medicare] just don't want to pay for power wheelchairs anymore," she says. "And it's because of the jerks who took advantage before and did the fraud." It is Green's misfortune to be doing business in Florida, within DMERC Region C, which encompasses many of the southern states, including Texas, where the most notorious fraud cases have been prosecuted.

Each region, even though governed by the same Medicare policies, tends to interpret and enforce policies in their unique way. Region C has a reputation for having been lax—by CMS standards—in the past. In Texas, sales of motorized wheelchairs in Harris County alone soared from 3,100 in 2001 to 31,000 in 2002. *HME News* editor Jim Sullivan points out that most of this occurred as a result of a single fraudulent operation that took place in Houston's Nigerian community. Another more recent case in the Dallas area seems to have been run in a similar way. Fraud has also been detected in Miami. In these three locations alone, fraudulent claims exceeded $70 million.

Nationally, according to CMS, total Medicare payments for motorized wheelchairs were $289 in 1999, $538 million in 2001, and $845 million in 2002. Payments for 2003, many still under investigation, may top $1 billion. The dramatic rise in sales is not solely due to fraud, according to the DME industry. The ITEM Coalition specifically notes "an expansion in public awareness of the medical necessity and accessibility of power wheelchairs by benefi-

*Continued on page 49*

# Alan Ludovici's DRIVING




BY BOB VOGEL

## Vertran *Continued from page 25*

that Vertran should be the norm."

Johnson believes in a cure for SCI, so why spend all this time and money developing Vertran? "In all reality I believe a cure will happen, probably not in my lifetime, but if it does, it's going to be an evolutionary process where you're going to have to learn to stand again. Vertran," he says, "will be a part of that." He sees regular, seated wheelchairs eventually being phased out.

In the latest *Star Wars* movie, Anakin Skywalker returns home to find his mom has married a man who uses a hovercraft wheelchair. "Funny thing," says Johnson, "despite the futuristic concept of the wheelchair, he was still seated. That just shows a change of mindset needs to happen." fm

### Resources

**Other Powered Standing Products**

- Independence Providers, 800/782-6324; www.lifestandusa.com.
- Independence Technology (iBOT), 866/813-0761; www.independencenow.com.
- Levo, 888/538-6872; www.levousa.com.
- Permobil, 800/736-0925; www.permobil.com.
- Redman, 800/727-6684; www.redmanpowerchair.com.
- Stand Aid of Iowa, 800/831-8580; www.stand-aid.com.
- The Standing Wheelchair Company, 800/782-6346; www.thestandingcompany.com.

## Big Squeeze *Continued from page 31*

ciaries during this time period" [due in part to aggressive marketing strategies]. Also key is enactment of the Ticket to Work law, which "extends Medicare coverage to SSDI beneficiaries when, in contrast to the in-the-home requirement, they leave their homes and return to work." Lax enforcement of Medicare policy may also have played a role.

Whatever the cause or causes, power wheelchair sales have dropped off dramatically since the CMS clarification. The biggest loser financially has been the Scooter Store, based in New Braunfels, Texas. In February they had to lay off 230 employees nationwide. Along with other industry mainstays, they have created a coalition to fight the clarification: Restore Access to Mobility Partnership (RAMP) also includes Pride Mobility, the American Association for Homecare, Invacare Corp., The MED Group, Mobility Products Unlimited, and Sunrise/Quickie Medical.

Darren Jernigan, director of governmental affairs for Permobil—another industry giant—thinks the industry's public relations approach in fighting the clarification is good, but may not be enough. He makes his living as a lobbyist (see sidebar, page 30) and knows how federal government works. "The feds use a hammer to get your attention," he says. "But CMS went drastic to eliminate fraud. I think we should be looking at more aggressive possibilities," he says. "Legal action is definitely an option." fm

# LEGAL FORUM

By Joseph Romano

**Usually, the Social Security definition of disability is much tougher than the definition under a long-term disability plan.**

***Q:*** *I have an* incomplete *spinal cord injury. My long-term disability carrier through my employer has denied my application because they say the medical reports show that I have movement and feeling, and therefore I am not disabled. I also applied for Social Security Disability Insurance, which is pending. Is there any "definition of disability" you can refer me to that will help to prove my eligibility for long-term disability and SSDI?*

It is very important that your treating doctor writes a narrative report that clearly explains the level of your spinal cord injury, the type of impairments you have, and your inability to perform your job. You should obtain a copy of your long-term disability policy and see how "long-term disability" is defined in the policy. Most long-term disability policies and applications for SSDI use the *Frankel scale functional classification* to determine whether a spinal cord injury is incomplete or complete. A *complete* spinal cord injury occurs when all motor and sensory function is lost below the level of the injury. In an *incomplete* spinal cord injury, there is some motor and/or sensory function below the level of the injury (as you indicate you have). A complete spinal cord injury does not mean the spinal cord has been cut or severed.

The Frankel scale functional classification is as follows:

A. Complete: No preservation of motor or sensory function.

B. Incomplete—preserved sensation only: Preservation of any sensation below the level of injury, except phantom sensations.

C. Incomplete—preserved motor nonfunctional: Preserved motor function without useful purpose; sensory function may or may not be preserved.

D. Incomplete—preserved motor functional: Preserved functional voluntary motor function that is functionally useful.

E. Complete recovery: Complete return of all motor and sensory function, but may still have abnormal reflexes.

Once your medical doctor has reviewed the *definition of disability* in your long-term disability policy, he should compare your limitations with the *Frankel scale functional classification*. You may be able to recover long-term disability benefits, even though you have an incomplete spinal cord injury, if your treating doctor documents, in a detailed narrative report, why you are unable to work, in particular, the level of your spinal cord injury, the nature of your impairments, and how your injury affects your ability to do your job, including but not limited to:

- A list of all medications you are taking and why they are required for your spinal cord injury.
- Spasticity—muscle movement or involuntary jerking, muscle spasms.
- Difficulty bending, lifting, standing, stretching, driving, etc.
- Dysfunctions of the kidney, bladder, and bowel.
- Urinary tract complications.
- Reduced breathing capacity.
- Impairments of the circulatory system.
- Skin/pressure sores (decubitus ulcers).
- Autonomic dysreflexia—dangerously high blood pressure, sweating, chills, headache, and facial flushing (usually occurring in individuals with SCI above the sixth thoracic level).
- Chronic pain.
- Contractures.
- Difficulties in adjusting to temperature changes.
- Psychological and psychiatric coping difficulties.

To increase the chances that your long-term disability application will be accepted, you should have multiple narrative reports from all of your treating doctors, including physiatrists, orthopedists, neurologists, and psychologists/psychiatrists. If you use any aids in ambulating, such as wheelchair, quad cane, or braces, you should enclose photographs/videotapes of you as you use these devices.

Usually, the Social Security *definition of disability* (unable to perform any gainful employment for at least a year) is much tougher than the *definition of total disability* under a long-term disability plan. The fact that the company has denied your application for long-term disability will adversely affect your pending SSDI application. For this reason, you should aggressively fight/appeal the denial of your long-term disability application and closely follow the appeal procedure, including all timelines, in the proof of claim process. NM

*Joseph L. Romano is an attorney who represents catastrophically ill and injured minors and adults. A copy of his book,* The Legal Rights of the Catastrophically Ill and Injured: A Family Guide, *is available upon request. Contact Joseph L. Romano, Esquire, Suite 120, 2 West Lafayette Street, Norristown, PA 19401; 800/331-4134; info@josephromanolaw.com, www.josephromanolaw.com.*

Mr. GRIFFIN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The amendment will be stated.

The legislative clerk read as follows:

The Senator from Michigan (Mr. GRIFFIN) proposes an unprinted amendment numbered 1070.

At the appropriate place in the Act, insert the following new section:

COVERAGE UNDER MEDICARE OF CERTAIN DEVICES SERVING THE SAME SIMILAR PURPOSE AS THAT PEFORMED BY A WHEELCHAIR

-SEC. . (a) Section 1861 (s)(6) of the Social Security Act is amended by inserting after the word "wheelchairs" the following: "(and devices designed to serve the same or similar purpose as that performed by a wheelchair),"

(b) The amendment made by this section shall be effective in the case of services furnished after the date of enactment of this Act.

Mr. GRIFFIN. Mr. President, I have discussed this amendment with the managers of the bill on both sides of the aisle.

This amendment is offered primarily because the bureaucracy in HEW has taken a very arbitrary view interpreting the word "wheelchair" in the Social Security Act as it applies to medicare, and has precluded the coverage of a very fine electric-powered vehicle that is produced in my State specifically for handicapped and invalid people.

The best way to describe what it is is the thing that Margaret Chase Smith used following her operation when she went back and forth from the Senate Office Building over here. Former Senator Charlie Potter had one of these.

They are very maneuverable. They allow a person who is handicapped to get about his home in a dignified way. All handicapped people cannot use them. But it is a great improvement over the wheelchair for many handicapped people.

This amendment is to make it clear to HEW that this should be considered. It is developed and manufactured by a small company in Michigan and the Veterans' Administration has approved it, but the bureaucracy of HEW so far has not.

Mr. President, section 1861(s)(6) of the Social Security Act (now 42 U.S.C. § 1395X(s)(6)), allows for medicare coverage of "durable medical equipment, including . . . wheelchairs used in the patient's home."

Until 1976, the bureaucracy at HEW interpreted the statute to cover the AMIGO wheelchair which is manufactured in Bridgeport, Mich. However, in that year, for no good reason, the regulations were "revised" to preclude the AMIGO wheelchair from medicare coverage.

Because the AMIGO wheelchair is manufactured in my State of Michigan, I have written to officials at HEW on several occasions requesting an explanation for the change in policy. The justification I received can best be characterized as bizarre and ridiculous.

In its reply to my letters, HEW officials refer to the AMIGO wheelchair as a golf cart-type vehicle which could be used by those who are not sick or injured. They also compared the AMIGO wheelchair to room air-conditioners and bathtubs.

This is ridiculous. The AMIGO is not a golf cart-type vehicle; it is used by those who are sick or handicapped and it is used by the patient in his home.

Mr. President, 8 years ago, Allan Thieme of Bridgeport, Mich., designed the first AMIGO wheelchair for his wife, who was suffering from multiple sclerosis and had been using a conventional wheelchair. The AMIGO gives handicapped people more mobility and greater variation of activity than was available with conventional wheelchairs. He accomplished this by making the AMIGO lighter in weight, narrower in width, more maneuverable, and easier to transport than conventional wheelchairs.

As one example of the AMIGO's ability to give the handicapped greater mobility, the chair is equipped with a swivel seat that allows the user to pull up to a normal desk or table and function comfortably without undue awkwardness. In addition, the AMIGO's narrower width allows users to get through doorways—particularly in private homes—that conventional models cannot negotiate.

I first saw the AMIGO wheelchair in operation several years ago when our friend, former Senator Charlie Potter, rode one into my Senate office. Senator Potter's enthusiasm for the AMIGO helped to make me a believer. Later, I saw the AMIGO wheelchair used by our former colleague, Margaret Chase Smith, following an operation.

True to the American spirit of building a better mouse trap, the AMIGO has caught on and is being used by several thousand handicapped Americans. It is very strange that the HEW bureaucracy has been so arbitrary in its refusal to make this device available.

It should be pointed out that the AMIGO wheelchair has been approved by the VA for VA beneficiaries. And, it should be noted that the AMIGO has undergone extensive testing at the prestigious Institute of Rehabilitation at New York University Medical Center, and been found superior to conventional wheelchairs for many handicapped persons.

Mr. President, this amendment and this legislative history should make it clear, once and for all, that the AMIGO is a wheelchair within the meaning of the statute.

Mr. CURTIS. Mr. President, will the distinguished Senator yield?

Mr. GRIFFIN. I yield to the Senator from Nebraska.

Mr. CURTIS. Mr. President, we had an opportunity to examine the amendment. We believe it is in the interest of the beneficiaries that use these machines as well as the social security fund, and we are willing to accept it.

Mr. GRIFFIN. Incidentally, it will cost less than electric-powered wheel chairs that are now being authorized for payment.

Mr. CURTIS. The distinguished manager of the bill joins me in willingness to accept the amendment.

The PRESIDING OFFICER. The question is on agreeing to the amendment of the Senator from Michigan.

The amendment was agreed to.


**Testimony for the Senate Finance Committee Hearing on Medicare's Power Mobility Benefit**

**April 28, 2004**

**Submitted by the ITEM Coalition**

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This testimony is being submitted on behalf of the ITEM Coalition, which is an acronym for Independence Through Enhancement of Medicare and Medicaid. The ITEM Coalition was formed in 2003, and its over 70 member organizations include a diverse set of disability organizations, aging organizations, other consumer groups, labor organizations, voluntary health associations, and non-profit provider associations. The ITEM Coalition's purpose is to raise awareness and build support for policies that will improve access to assistive devices, technologies and related services for people of all ages with disabilities and chronic conditions.

Access to both manual and power operated mobility devices is critical to a large number of Medicare beneficiaries, but the unmet assistive device needs of this population does not end with wheelchairs and power operated vehicles (POVs). From coverage for hearing aids to augmentative communication devices (AACs) to advanced artificial limbs to screen readers for people with vision impairments, the Coalition's mission is a broad one with implications for virtually every person with a disability who relies on assistive devices to be healthy, functional and independent.

We would like to thank Chairman Grassley, Ranking Member Baucus, and the Finance Committee for holding this hearing and bringing attention to the important debate over Medicare's power mobility benefit. We would also like to thank Chairman Grassley for his commitment to this issue and his powerful February 24, 2004 letter to the Centers for Medicare and Medicaid (CMS) Acting Administrator Dennis G. Smith. The letter restated Chairman Grassley's commitment to fighting fraud in the Medicare wheelchair benefit but also raised important questions challenging CMS' December 2003 Power Wheelchair "Policy Clarification." The ITEM Coalition believes Chairman Grassley's letter was instrumental in prompting CMS to subsequently retract the Power Wheelchair Policy Clarification on March 18, 2004. This retraction was consistent with the ITEM Coalition's request that CMS rescind this policy and engage in a dialogue with interested stakeholders when designing more appropriate wheelchair coverage criteria.

The ITEM Coalition fully understands the need to fight fraud in the Medicare program and fully supports aggressive government efforts to rid the program of fraudulent activity. Every dollar spent by Medicare through fraud is a dollar not spent meeting the assistive device needs of Medicare beneficiaries. However, the ITEM Coalition believes that the issuance and subsequent retraction of the Power Wheelchair Policy Clarification has exposed both outdated coverage policy and widespread confusion that exists under the Medicare wheelchair benefit. It is our hope that this hearing will lead to an objective examination of the current Medicare wheelchair benefit and a modification of coverage policies that will enhance this benefit for Medicare beneficiaries with disabilities of all ages.

**Background**

In December of 2003, as part of "Operation Wheeler Dealer," CMS issued a "Policy Clarification" on power wheelchair coverage. While the Clarification did not technically mandate new coverage criteria, it limited coverage to only those beneficiaries who were confined to a bed or chair constituted, representing a tightening of Medicare coverage policy that for several years in practice permitted wheelchair access to any beneficiary who needed a mobility device to move about his or her residence. In doing so, the Clarification highlighted what the ITEM Coalition believes are overly restrictive and confusing regulations that continue to this day to be detrimental to the health and functionality of many Medicare beneficiaries with mobility impairments.

Following two "Listening Sessions" and a great deal of advocacy from consumer groups, providers, and other stakeholders, CMS and the Durable Medical Equipment Regional Carrier ("DMERC") Medical Directors retracted the Clarification in its entirety, effective March 18, 2004. This retraction was requested by the ITEM Coalition, along with many others, and CMS deserves credit for changing course to address stakeholder concerns. However, retraction of the Policy Clarification has failed to clarify or improve Medicare's coverage criteria for power and manual wheelchairs. The extensive debate surrounding this issue over the past five months has exposed deeply rooted problems, including seriously outdated coverage policies, inconsistent interpretations of federal policy, and widespread confusion. Thus, CMS's assertion that these

benefits would be accessible to beneficiaries in the future using the standards in place prior to the December issuance of the Policy Clarification is not reassuring.

**Medicare's Coverage Criteria**

Medicare's coverage benefit for power wheelchairs deserves serious attention, debate, and revision. The benefit's confusing, arbitrary and archaic verbiage must be updated to reflect the undisputable value, potential and productivity of people with disabilities in society. More specifically, Medicare regulations only provide access to mobility devices if needed for use "in the home" or for those who are "bed or chair confined," therefore preventing beneficiaries from obtaining access to needed mobility devices.

***The "In the Home" Criterion***

The root of the Medicare wheelchair coverage policy debate lies in CMS's reliance on the "in the home" criterion which artificially and arbitrarily limits coverage. This regulation states that Medicare will only provide power mobility for use within the four walls of one's home and not if one needs it to fully participate in work, school, and the community outside of the home. This criterion completely fails to recognize the real needs of individuals with mobility impairments and equates to the devaluation of the worth of a person with a disability. This is an antiquated restriction reminiscent of a time when people in wheelchairs were not expected to leave the home and participate in society. Independent living and community participation are now the benchmarks of a fully functional, healthy person with a mobility impairment, but the in-the-home standard has failed to keep pace with this new reality.

***"Bed or Chair Confined"***

The term "bed or chair confined" is another outdated regulatory standard that, in the ITEM Coalition's view, must be revisited because it fails to ensure that beneficiaries who can get out of bed but have limited mobility can obtain access to a wheelchair, scooter or similar device. Informal CMS/DMERC interpretations throughout the years had extended coverage to individuals who were not strictly bed or chair confined but who were still in genuine need of wheeled mobility. In light of the events of the past few months, the ITEM Coalition's members

can no longer rely on informal understandings about wheelchair coverage. The ITEM Coalition, therefore, would like to work with this Committee, CMS, and others to modernize the "bed or chair confined" standard by modifying the regulations. The need to revisit the Medicare regulations addressing wheelchair coverage was made abundantly clear by the events of the past several months.

***"Ambulatory" and "Non-ambulatory"***

The December 2003 Policy Clarification attempted to restate the concept of when an individual was considered "non-ambulatory" for purposes of access to Medicare wheelchair coverage. The Policy Clarification asserted that it was not changing coverage policy in any respect. But at least one DMERC interpreted this standard as denying coverage for anyone who could walk more than one or two steps with or without assistance from a cane or walker. The retraction of the Policy Clarification stated that the coverage rules prior to the issuance of the Policy Clarification currently apply and that no change to the pre-December rules has occurred.

This means, according to these statements, that Medicare beneficiaries may still be denied mobility devices if they are able to walk more than one or two steps without the assistance of a cane or walker. It also means that in restating coverage policy for the future, CMS gave virtually no consideration to the serious concerns raised by the ITEM Coalition and other organizations such as conditions with waxing and waning symptoms, the effect of fatigue throughout the day, and many other clinical issues. If this is true, the retraction of the Policy Clarification has had no effect whatsoever on Medicare beneficiaries' access to mobility devices and the concern and confusion generated by the Policy Clarification will continue despite its retraction.

Furthermore, at least one DMERC has issued a written bulletin that states that there is no need at this time to define the terms "ambulatory" and "non-ambulatory," claiming instead that "physicians and other clinicians have the knowledge to [prescribe wheelchairs] without being given specific instructions or catch phrases to use in their evaluation." Given the confusion and controversy that has surrounded this issue over the past several months, and given the potential of fraud and abuse that overhangs this benefit category, the ITEM Coalition is concerned that this lack of guidance will have a chilling effect on prescriptions for wheeled mobility for

Medicare beneficiaries, unless additional thought and guidance regarding appropriate coverage criteria are promulgated.

**Functionality and Independence: Coverage Goals**

Unveiled in February, 2001, the President's *New Freedom Initiative* (NFI) was intended to help Americans with disabilities by increasing access to assistive technologies, expanding educational opportunities, increasing the ability of Americans with disabilities to integrate into the workforce and promoting increased access into daily community life. In fact, the NFI listed Medicare's in-the-home restriction on mobility devices as a policy in need of review by the Department of Health and Human Services. The ITEM Coalition applauds these goals, but would prefer that more progress would have been made by now. Medicare's current benefit for power and manual wheelchairs directly contradicts that *New Freedom Initiative's* objectives as it fails to incorporate the basic rights of communal and societal integration, as well as functional improvement, into Medicare's coverage criteria. The NFI's intent is to expand opportunities for people with disabilities. Mobility device coverage policies that force individuals to remain home-bound and dependent must be reformed.

A comprehensive review of the coverage criteria for the wheelchair benefit category must include a discussion on the *value of functional improvement* in the medical necessity determination. Access to various types of mobility devices has a tremendous impact on the ability of an individual with a disability to be healthy, functional and independent. This includes functional improvement in *all* aspects of a person's life. Mobility devices that offer the greatest functional improvement are often labeled by Medicare as "not medically necessary," "convenience items," or "luxury items." These concepts, in our view, have long been in need of review and modification if the mobility device benefit is going to meet the current unmet need, as well as the future needs, of Medicare beneficiaries.

**Conclusion**

The Medicare program simply must do better in providing for the needs of beneficiaries with disabilities and other mobility impairments. While outright fraud must be prosecuted to the full extent under the law, Medicare's mobility device coverage policies must be the subject of comprehensive review and reform. Because Medicare is a guide for other health care coverage policies, its restrictions and out-of-date concepts have ripple effects throughout all federal health programs and private insurance plans. The time has come to modernize coverage policy in the Medicare mobility device benefit category to meet the current and future needs of individuals with disabilities and other mobility impairments. Between the unmet need that exists today and the advances in mobility technology that are breaking new ground in restoring function, the need for CMS to comprehensively address this benefit category has never been greater.

Thank you for your consideration of our views. If we can be of any assistance to the Finance Committee as these issues continue to be considered, please contact us at (202) 349-4260.

The ITEM Coalition Steering Committee,

Henry Claypool
Advancing Independence:
ITEM Coalition Steering Committee Member

Peter W. Thomas
Consortium for Citizens with
Disabilities Health Task Force
ITEM Coalition Steering Committee Member

Paul W. Schroeder
American Foundation for the Blind
ITEM Coalition Steering Committee Member

Lee Page
Paralyzed Veterans of America
ITEM Coalition Steering Committee Member


**ITEM Coalition Members**

Adapted Physical Activity Council

Advancing Independence

Advanced Medical Technology Association

Alexander Graham Bell Association for the Deaf and Hard of Hearing

Alpha One

American Academy of Audiology

American Academy of Neurology

American Academy of Physical Medicine and Rehabilitation

American Association for Homecare

American Association of People with Disabilities

American Association on Health and Disability

American Congress of Community Support and Employment Services

American Congress of Rehabilitation Medicine

American Foundation for the Blind

American Medical Rehabilitation Providers Association

American Music Therapy Association

American Network of Community Options And Resources

American Occupational Therapy Association

American Physical Therapy Association

American Speech-Language-Hearing Association

American Therapeutic Recreation Association

Amputee Coalition of America

Assistive Technology Industry Association

Association for Education and Rehabilitation of the Blind and Visually Impaired

Association for Persons in Supported Employment

Association of Tech Act Projects

Association of University Centers on Disabilities

Blinded Veterans Association

Brain Injury Association of America

Center for Disability Issues and Health Professionals

Center for Independent Living Inc., Berkeley, California

Center for Medicare Advocacy, Inc.

Christopher Reeve Paralysis Foundation

Consortium of Developmental Disabilities Councils

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Council of Citizens with Low Vision International

Council of State Administrators of Vocational Rehabilitation

Disability Service Providers of America

Easter Seals

Epilepsy Foundation

Families USA

Goodwill Industries International, Inc.

Helen Keller National Center

Inclusion Research Institute

Long Island Center for Independent Living

Medicare Rights Center

The Miami Project to Cure Paralysis

National Association for Home Care and Hospice

National Association for the Advancement of Orthotics and Prosthetics

National Association of Councils on Developmental Disabilities

National Association of Protection and Advocacy Systems

National Association of Rehabilitation Research and Training Centers

National Campaign for Hearing Health

National Coalition for Disability Rights

National Council on Independent Living

National Family Caregivers Association

National Multiple Sclerosis Society

National Organization on Disability

National Rehabilitation Hospital – Center for Health and Disability Research

National Respite Coalition

National Spinal Cord Injury Association

National Stroke Association

National Vision Rehabilitation Cooperative

NISH

Paralyzed Veterans of America

Research Institute for Independent Living

Rehabilitation Engineering and Assistive Technology Society of North America

Self Help for Hard of Hearing People

Service Employees International Union

Spina Bifida Association of America

The Arc of the United States

Topeka Independent Living Resource Center

United Cerebral Palsy Associations

United Spinal Association

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Medicare Rights Center **NEWS**

FOR IMMEDIATE RELEASE
April 28, 2004

Contact: Deane Beebe
Communications Director
212-204-6219

**Medicare Wheelchair Coverage Rules "Imprison" People with Disabilities**

New York, NY—Medicare's coverage rules for wheelchairs and other mobility devices force over 140,000 Americans into unnecessary isolation and lead to higher health care costs, according to a recent study by the Medicare Rights Center, a national consumer group.

"The administration's interpretation of the Medicare law imprisons people in their homes, causing unnecessary pain and suffering," said Robert M. Hayes, an attorney who is president of the Medicare Rights Center. "It is wrong and it is illegal."

*"Forcing Isolation: Medicare 'In the Home' Coverage Standard for Wheelchairs,"* recommends that the Centers for Medicare and Medicaid Services (CMS) change its interpretation of the Medicare law that currently denies coverage of mobility devices, such as power wheelchairs, for use outside of one's home.

Under current policy, the administration will pay 80 percent of the cost of a power wheelchair for a person with Medicare who needs it to move from a bedroom to a kitchen, but not for a person who requires such assistance to leave home for medical care, shopping or even employment, the report found.

"Changes in technology, medicine and law require coverage of equipment that allows a person with disabilities to participate in community activities," Mr. Hayes said.

The consumer group also recommends that CMS require case-by-case assessments and evaluations by specially trained professionals to guard against unnecessary expenses and ensure that people receive the proper equipment for their needs. Currently, doctors prescribe mobility devices and certify their medical necessity, but there is no requirement that they have training in

– more –

rehabilitative medicine.

In response to a Medicare Rights Center survey to presidential candidates, Senator John Kerry said that he would support administrative initiatives to expand Medicare's coverage of wheelchairs and other durable medical equipment needed to function outside the home http://www.medicarerights.org/MRC_Candidate_Questionnaire.pdf.

Although President George W. Bush has yet to respond to the group's Medicare questionnaire, Mr. Hayes said he was hopeful that the President would support the study's key recommendations. "Although CMS will not modernize its interpretation without White House approval," he said, "President Bush's father was a strong supporter of the Americans with Disabilities Act. This President has said that he is too.

"The ADA, common sense, and common decency cry out to change a policy that sentences people with disabilities to needless isolation."

The Medicare Rights Center's study *"Forcing Isolation: Medicare 'In the Home' Coverage Standard for Wheelchairs,"* is available at http://www.medicarerights.org/policybrief_03162004_frameset.html.

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**Medicare Rights Center** (MRC) is the nation's largest independent source of information and assistance for people with Medicare. Founded in 1989, MRC helps older adults and people with disabilities get good, affordable health care.

1460 Broadway, New York, NY 10036 212-869-3850 www.medicarerights.org

**Robert M. Hayes**
**President**
**Medicare Rights Center**
**1460 Broadway, 17th Floor**
**New York, NY 10036**

**Statement for the Record**

**Re: Senate Finance Committee Hearing of April 28, 2004: "Taking the Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program"**

Mr. Chairman:

The Medicare Rights Center (MRC) is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities get good affordable health care. We are glad that the committee has taken time to address the important subject of Medicare's power wheelchair coverage, as the proper coverage of power mobility devices is a matter of grave concern for many of the people with Medicare we counsel every day. That said, Mr. Chairman, we seek to call your attention to both sides of the power wheelchair coverage issue. Rooting out fraud and abuse is part of the battle; also critical is ensuring that Medicare covers power mobility devices for all who legitimately need them.

Older adults and people with physical disabilities can get Medicare coverage for mobility devices, like wheelchairs, walkers and scooters, which are necessary for use in their homes. However they cannot get coverage for mobility devices that are solely for functioning outside their home. Since the institution of Medicare's coverage standards for mobility devices and other kinds of durable medical equipment nearly four decades ago,[i] advances have been made in three critical areas: improvements in design of mobility devices that allow people to participate more fully in their communities; widespread societal recognition that with appropriate accommodations many limitations on functioning can and should be lifted; and recent court decisions requiring that individuals with disabilities be provided with the necessary supports to live as independently as possible in their communities. The current interpretation of Medicare's coverage standards for mobility devices does not reflect these advances.

The Centers for Medicare and Medicaid Services' (CMS) interpretation of Medicare's coverage standard prevents people from getting needed medical equipment to function within their communities. By contemporary medical and legal standards, the interpretation is unreasonable and quite likely unlawful. The Medicare statute neither specifies that durable medical equipment is exclusively for use in the patient's home nor bars consideration of an equipment's use outside the home. There is no indication of Congressional intent to support this limitation of coverage.

CMS has both the authority and the responsibility to interpret the Medicare statute so as to be consistent with historical developments in law, technology and social mores.

United States Supreme Court precedent holds that agencies are "charged with the administration of [a] statute in light of everyday realities."[ii] Everyday realities have changed since Medicare was launched in 1965. Laws such as the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and the Ticket to Work and Work Improvements Incentives Act of 1999 reflect a broad, bipartisan commitment to increasing community integration of people with disabilities. This commitment is evident in judicial decisions, including *Olmstead v. L.C. ex rel. Zimring*, and executive orders, such as President George W. Bush's New Freedom Initiative, a set of proposals to promote opportunities for Americans with disabilities to learn and develop skills, engage in productive work, make choices about their daily lives, and participate fully in their communities.

Developing political and legal standards are consistent with medical opinion: the costs of isolation for people with disabilities can include poorer health outcomes and higher systematic health costs. Also, scientific evidence indicates that people who get inappropriate mobility devices given their needs develop secondary medical conditions. In light of technological advances that today make appropriate equipment available and community integration possible, CMS has a responsibility to update its interpretation of the Medicare statute. While CMS must rightly be concerned with costs associated with a more modern interpretation of Medicare's coverage policy, other insurers have found that an appropriate standard has not led to an explosion in the provision of more expensive mobility devices.

MRC recommend that the Centers for Medicare and Medicaid Services: (1) correct its Medicare coverage policy to cover medically appropriate mobility devices that help maintain or improve functioning for people in the environments they are likely to encounter in their daily routines (both inside and outside of the home), and (2) guard against unnecessary expenses for Medicare by incorporating mandatory equipment evaluations to ensure that people receive equipment that matches their needs.

For a more go to http://www.medicarerights.org/policybrief_03162004.pdf.

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[i] Pursuant to 42 U.S.C. 1395x(n), durable medical equipment is medical equipment that a doctor orders for use in the home. These items must be reusable, such as walkers, wheelchairs or hospital beds.

[ii] *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 863 (1984)

United States Senate
Committee on Finance

April 28, 2004

"Taking the Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program"

Submitted for the record by:

National Coalition for Assistive and Rehab Technology
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Washington, DC 20036

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The National Coalition for Assistive and Rehab Technology (NCART) is a coalition of suppliers and manufacturers of assistive and rehab technology products and services. NCART's primary focus is to ensure adequate consumer access to appropriate technology and services.

**Introduction**

NCART is submitting this statement for the official hearing record of the Senate Committee on Finance's April 28, 2004 hearing entitled "Taking the Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program." NCART will provide comments to testimony as well as corresponding reports and announcements released in response to the hearing.

NCART supports efforts to eliminate fraud, abuse and waste in the Medicare program. NCART has provided input to CMS on ways to address abuse and waste including documentation requirements, recommendations regarding credentialing, and more appropriate power wheelchair HCPCS codes. NCART strongly believes that revised HCPCS coding for power wheelchairs is a foundation block for addressing fraud and abuse. To this end, NCART re-submitted HCPCS code applications to the Centers for Medicare and Medicaid Services (CMS) in March of this year for power wheelchairs.

NCART agrees strongly that CMS and its contractors as well as all appropriate government agencies should work diligently and methodically to eliminate fraud and abuse of the Medicare program. NCART supports higher and more relevant supplier standards, together with accreditation, as ways of ensuring that qualified and ethical suppliers gain entry into the Medicare program. Moreover, we believe that there is a need to segregate high-end rehab and assistive technology products and require that Medicare beneficiaries receive only these products through knowledgeable and experienced suppliers. While CMS develops and implements policies regarding new supplier enrollment as well as checks and balances that will facilitate prompt identification of fraud and abuse, NCART encourages earnest consideration be given to improving consumer protection by establishing requirements for the use of only qualified, credentialed staff to perform technology assessments, fittings and training relative to rehab and assistive technology[1]. We stand willing to work jointly with CMS

[1] Definition of rehab and assistive technology: Rehab technology products and services, are defined as those products and services prescribed by a physician, that:

- Primarily address and provide wheeled mobility; or
- seating and alternative positioning; or
- ambulation support; or
- environmental controls to meet the physiologic and functional needs of people with disabilities - as well as assisting these people in performing their daily living activities;
- **and** are provided under at least one of the following situations:
    - o - the consumer has a primary diagnosis which results from childhood or adult onset disease, injury or trauma; **or**

in the revision of new supplier standards to ensure that these standards meet the needs of CMS and provide quality assurances for Medicare beneficiaries.

## HCPCS Coding

NCART agrees with the OIG's recommendation that a new coding system for K0011 power wheelchairs that accounts for the variety in models and prices be established. To that end, NCART submitted code applications to CMS in March of this year after two years of effort developing the code characteristics, testing criteria and clinical indicators. Broad consensus was reached through industry and clinician outreach. A strong knowledge of the technology and its application is critical when making coding decisions that will generate proper payment but also ensure access to medically appropriate technology. We encourage CMS to accept the coding system developed by the industry and to further accept the recommended ANSI RESNA testing criteria.

In addition, we advocate the development of clinical indicators and functional levels for each of the levels of technology. NCART strongly supports the recommendations of Dr. Laura Cohen regarding the development of a coding scheme analogous to that used for lower limb prostheses (LLP). We agree that this policy which acknowledges the different levels of functionality of beneficiaries first and then, based on clinical indicators, links functional classifications to HCPCS codes, would be the most appropriate system for qualifying and paying for mobility devices. We believe this structure will meet CMS needs for objective, consistent and predictable claims review and will assure that payment will be based on the least costly, medically appropriate device. Moreover, clinical indicators, functional levels and diagnosis codes when used together can serve as critical support for medical need.

In addition, NCART believes that reported practice of routinely adding unnecessary and expensive wheelchair accessories will be eliminated by proper delineation of power wheelchair bases that includes identification of applicable accessories and when they are appropriate for use with various base codes. This information combined with clinical indicators, functional levels and diagnosis will assist CMS in controlling utilization of wheelchair accessories as well.

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- o - the consumer has a primary diagnosis or symptomotology that is neuromuscular in nature; **or**
- o - the consumer requires adaptive seating or positioning equipment; **or**
- o - the consumer is under age 21; **or**
- o - the consumer has a diagnosis that indicates a need for other assistive technology including, but not limited to, speech generating devices, computer access or environmental controls.

## Coverage

The existing coverage policy for power wheelchairs which states the beneficiary must be "bed or chair confined", unable to operate a manual wheelchair but capable of safely operating a power wheelchair are listed by the OIG as the first of three main controls in place to help limit abuse of the wheelchair benefit. NCART respectfully disagrees with the ability of the current policy to in any way limit abuse. In fact, it is the absence of any decisive criterion for the various levels of power mobility that we believe has contributed to increased utilization and overpayment of the K0011 code. It is, unfortunately, as easy to qualify for a K0011, the highest reimbursed code within the power wheelchair category, as it is to qualify for a K0012 or K0010 which are reimbursed at a lower rate and in some cases will adequately meet the beneficiary's needs. Moreover, it is easier to qualify for a K0011 than it is a power-operated vehicle (POV), which is even less costly to Medicare than any of the power wheelchair codes and again may meet the more limited power mobility needs of some beneficiaries. NCART believes that in addition to a need for updating the national coverage policy for all mobility, it is imperative that coverage criteria, clinical indicators and functional levels be developed for each level of power mobility in conjunction with revisions to the national code set.

OIG testimony describes its study of a random sample of 300 claims and an OIG report alleges, "31 percent of reviewed claims did not meet coverage criteria for any type of wheelchair. An additional 45 percent of reviewed claims did not meet Medicare's coverage criteria for the K0011 power wheelchair, but may have met criteria for another, less expensive mobility device". NCART believes that the conclusions reached by the OIG are flawed because the OIG provided no explanation of the criteria used to interpret the medical necessity of the claims. Furthermore, our assertion that the conclusion is flawed is based on the absence of any stated coverage policy that would distinguish the various power wheelchair codes. As a result, the OIG has no way of determining whether a less expensive power wheelchair is warranted. OIG even stated in their testimony that "problems might arise because coverage criteria for different types of mobility devices may not be explicit enough". While it may be true that a less costly device may have met beneficiary needs, there is no existing coverage policy that provides guidance in that area. Moreover, as CMS is aware, the concept of "bed or chair confined" is not clear and has been interpreted in several ways over the last decade.

NCART appreciates the CMS' initiative to develop more coverage guidance. However, we are concerned that initial input is limited to convening clinicians from HHS and other government agencies to refine and describe the conditions that are associated with the current coverage definition and to develop draft guidance for determining whether a patient meets the definition of "bed or chair confined." NCART strongly urges CMS to include non-government clinicians who are actively involved in prescribing motorized wheelchairs and clinicians/suppliers who evaluate, assess and fit beneficiaries for power wheelchairs to ensure that the consumer receives the medically appropriate wheelchair and necessary components/accessories. Without the input of currently practicing clinicians and suppliers, CMS' guidance will lack important "real life" experience. There is current information, for example, regarding the impact of manual

propulsion on post-polio patients. It is crucial that this type of information be considered as CMS moves to clarify its coverage of this important benefit.

NCART agrees with the testimony of Henry Claypool when he asserts that CMS is using an overly restrictive misinterpretation of statutory language in the Social Security Act that indicates equipment "used in the patient's home" is covered under Part B to limit when Medicare will pay for a wheelchair for a beneficiary. When read in full context, a more appropriate interpretation would be that Congress was using this phrase to distinguish payment for items under Part B versus a hospital or skilled nursing facility where these devices would be covered under Part A. Not only is it impossible for an attending physician to make technology recommendations based only on the constraints of their patient's home environment, it is inappropriate for a physician not to address the patient's complete medical need to facilitate proper health.

## Pricing

NCART agrees with testimony by witnesses asserting that reimbursement levels for some K0011 power wheelchairs may be too high. However, we disagree with any assumption that reimbursement for all products currently billed using K0011 is too high. In fact, many products provided to the most severely disabled Medicare beneficiary are reimbursed below an acceptable level. Many of the power wheelchairs that are medically necessary for beneficiaries that are also in need of powered seating systems, ventilator trays, or specialized seating, cost the supplier more to provide than the current fee schedule amount. It is critical for any analysis of Medicare pricing to include a thorough understanding of the technology currently included in the K0011 code. Not doing so would prevent the more severely involved Medicare beneficiaries from having access to certain medically necessary devices.

Furthermore, NCART disagrees with the presumption that excessive reimbursement is a result of legislation enacted in 1987 mandating that charges be based on historical pricing or through applying gap-filling methodology to retail prices. We believe it is the broad, generic grouping of products into codes that causes flawed pricing to be established. While there may in fact be valid reasons for seeking another methodology for determining pricing, we believe that inadequate coding is at the root of the problem. When a broad range of technology and its corresponding retail pricing are grouped into one code, the result is a price that is too high for some products and too low for others. To the extent that the differential is substantial, such as the case with the K0011, it has the potential to facilitate abuse and attract unethical people to the industry.

NCART strongly believes that the pricing information used in the OIG report is inappropriate and should not be used to determine whether payments should be reduced. The OIG report indicates that its pricing information came from websites, two national wholesalers and suppliers who negotiated directly with the manufacturers and distributors of K0011 power wheelchairs. Prices for products on websites do not reflect the level of services required by Medicare. The use of wholesale pricing is inappropriate because wholesalers do not sell and do not provide product to consumers or bill Medicare. They merely re-sell to suppliers. Therefore, this pricing also does not reflect

any of the costs associated with providing the product or billing Medicare. The same is true in using pricing negotiated directly with the manufacturer. Manufacturer negotiated prices merely indicate the cost some suppliers have been able to negotiate. Moreover, the stated costs are deceptive because the report does not indicate the type of wheelchair for which the pricing was established or the volume commitments associated with the contracted price. It is highly unlikely that the prices obtained by the OIG from the small number of suppliers represents routinely available pricing to all suppliers. Most important, supplier equipment cost does not reflect the total costs associated with providing product or billing Medicare. Additionally, higher supplier standards, accreditation and other expenses associated with the delivery of medical devices serve to increase these costs. NCART believes that no pricing comparison can be made without first understanding the service/delivery model associated with positive outcomes for Medicare beneficiaries requiring power mobility. In addition, a thorough analysis of the costs associated with billing the Medicare program must be completed.

NCART believes strongly that there is not enough information available regarding the costs associated with providing product to Medicare beneficiaries. Importantly, the OIG acknowledges that actual Medicare program savings could be less than the amount it identified because "potential supplier administrative costs related to furnishing K0011 power wheelchair to Medicare beneficiaries were not included in the prices reviewed." We caution the OIG and CMS that there are significant costs related to providing beneficiaries with product and submitting claims to the Medicare Program. . Specifically, in the area of rehab and assistive technology there are additional costs related to the technology assessment, initial and subsequent fittings, initial and on-going training, assembly, maintenance and repairs that are not reimbursement by Medicare through the price of the device or through separate charges. It is extremely important for CMS to have a solid understanding of the costs associated with providing products to Medicare in general, but especially those related to the smaller segment of rehab and assistive technology.

In addition, Medicare offers no prior authorization process. The current ADMC process is inadequate. As a result, suppliers are required to provide service and equipment with no assurance of payment. The cost of providing equipment and associated services in the area of rehab and assistive technology is very high. Suppliers assume a tremendous financial liability when serving Medicare beneficiaries. Due to the complexity of the equipment, there is a high rate of initial denials in this area. High costs are also associated with financing equipment, i.e., the cost of borrowing money, and other costs while suppliers work through the various levels of review in order to secure remuneration. Many suppliers of rehab and assistive technology report that while Medicare is less than 20% of their overall business, it is often more than 50% of their accounts receivable. Days outstanding with Medicare far exceed other payers for this type of technology. This is due to Medicare's lack of prior authorization. Moreover, the institution of a prior approval process could also significantly strengthen CMS's efforts to reduce fraud and abuse.

NCART questions why CMS would use its IR authority to adjust payment amounts for HCPCS code K0011 if CMS is going to replace the K0011 code with multiple HCPCS

codes. NCART recommends CMS first work to establish and implement new codes and develop pricing for those codes and apply the gap-filling methodology using routinely provided products. Further, CMS should allow an adequate period of time to judge the effectiveness of new codes before making any decisions regarding the need for additional reductions in reimbursement for power mobility. As CMS stated in its testimony, once there are multiple codes for power wheelchairs, CMS will be able to establish payment amounts more in line with the actual item provided.

NCART questions the OIG methodology for determining market place prices for power wheelchairs. As the OIG stated, it found that only 33 of the 96 models on the SADMERC product classification list were provided to Medicare beneficiaries. Thoughtful conclusions cannot be reached using the raw data provided by the OIG. All products listed as K0011 on the SADMERC classification list are not equal in terms of medically necessary features, product capability or quality. In addition, the SADMERC classification list is not a list of products that were used in determining the fee schedule. It is merely a tool that allows manufacturers and payers to know the appropriate code to use when billing for a product.

Due to HIPAA implementation, all manufacturers of power wheelchairs are likely to have their products code verified by the SADMERC in order to facilitate the sales and marketing of their products. Due to the fact that many payers, Medicaid included, have reimbursement tied to the Medicare fee schedule either through regulation or legislation, it becomes extremely important for valid data to be considered in regards to pricing. Without careful consideration as well as valid and appropriate data, price reductions could restrict access to medically necessary technology and instead limit access to only the most basic technology. NCART believes that a new coding structure will further assist in helping CMS analyze what they are paying for and determine its medical appropriateness. Moreover, it is critical for CMS to develop careful understanding of the products behind the pricing before reaching conclusions regarding the need to reduce reimbursement. CMS must ensure that while they make every effort to pay appropriately for power wheelchairs, it remains critical for all consumers to have access to the most appropriate device that will meet their medical and functional needs. Before CMS can implement pricing based on inherent reasonableness, CMS must establish that the data it relies upon is truly representative of products provided generally to beneficiaries. We believe any evaluation prior to establishing a new code set will be invalid. The use of median pricing of the most frequently provided K0011 products would not appropriately represent the smaller Medicare population of people with disabilities, since the products provided to this smaller segment of Medicare beneficiaries are not large in number.

NCART strongly believes that any use of IR would be premature. Instead, NCART recommends the development of new codes and pricing with a subsequent evaluation period to judge the effectiveness of these steps in bringing pricing in line.

NCART strongly opposes the use of competitive bidding for rehab and assistive technology. We believe that competitive bidding would result in a limitation of products based on price alone and this limitation would have a severe negative impact

on clinical outcomes associated with the provision of high-tech rehab and assistive technology.

CMS indicates it will phase in competitive bidding for power wheelchairs based on the "revised mobility device codes" beginning in 2007. NCART strongly disagrees with the use of competitive bidding for specialty rehab and assistive technology devices. NCART is willing to work with CMS and HHS to identify technology that we feel is inappropriate for this process in accordance with the language set forth in the Medicare Modernization Act. NCART further recommends impaneling a working group consisting of physicians with training and experience in rehabilitation of persons with significant disabilities requiring high-tech rehab and assistive technology, experienced (and credentialed) occupational and physical therapists, and manufacturers and providers of high tech rehab and assistive technology products and services. The purpose of this panel should be to develop a definition of therapeutically advantageous rehab and assistive technology products and identify the specific items and codes, which would be excluded from any competitive bidding processes.

**Comparisons to the VA Program and Pricing are Inappropriate**

The Medicare Program is dramatically different than the Veteran Administration in all respects: administrative, procedural, infrastructure, service and delivery reimbursement, etc. Any comparisons are inappropriate. A few of these differences are described here.

One way that the VA purchases wheelchairs directly from the manufacturers is through the Federal Supply Schedule. In this case, prices are negotiated on a mass wholesale basis. In contrast, the Medicare Program does not purchase wheelchairs on a wholesale basis; rather, it reimburses singular retail transactions, on a beneficiary-by-beneficiary basis. Even the largest Medicare Part B supplier could not begin to achieve the economies of scale of the federal government.

Another, more recent practice is National Blanket Purchasing Agreements (BPA). In the case of a National BPA, the VA develops a RFP outlining their product requirements in detail including the number of units they agree to purchase from the manufacturer. There is a single winner of these contracts. While this process ensures that the VA is paying the lowest possible price for a device, it potentially compromises the outcome for the patient. Written correspondence with the VA from The United Spinal Association indicates their concern "that these BPA's will inevitably result in reduced options for veterans in need of mobility assistive devices, and lead to the establishment of a "one-size fits all" mentality in prescribing these devices...Additionally, this process could lead to erroneously prescribed assistive devices that ultimately will do more harm than good".

The VA Hospital infrastructure absorbs personnel and many other administrative costs that a Medicare Part B supplier is required to provide. Oftentimes the VA contracts and pays separately for necessary equipment-related services such as assessments, fittings, assembly, delivery, education, etc. In addition, there is no third party billing costs

associated with the VA system. As such, the VA system does not require the preparation and submission of paperwork to document medical necessity and supplementary information as does Medicare. In fact, the VA pays through the use of a credit card. And, in situations where the manufacturer or supplier does not accept the credit card, the VA pays within 30 days of receipt of the invoice.

**Documentation to Support Medical Necessity**

NCART questions what guidelines the OIG used in determining medical necessity. Moreover, we suggest that what the study demonstrates is a lack of proper documentation attesting to medical necessity. Appropriate documentation is an issue suppliers struggle with on a daily basis when serving Medicare beneficiaries. NCART believes it is critical for CMS to establish specific documentation requirements to prove medical necessity. We encourage CMS to consider the following documents be maintained by the supplier in the patient's record:

- Physical evaluation documents- used to identify clinical indicators and determine the patient's functional level.
- In the area of rehab and assistive technology, a technology assessment document used to determine the appropriate technology for the individual client tied to the clinical indicators identified by the physical evaluation.

CMS testimony states that the DMERCS tried many different techniques to ensure that claims met CMS coverage requirements but "unfortunately, the wheelchair industry objected to the increased scrutiny due to excessive administrative requirements, thus stalling actions on an industry-wide basis". NCART member companies, under the auspices of the former rehab section of the National Association of Medical Equipment Suppliers (NAMES) sent a letter to the Region B DMERC (see exhibit) applauding the DMERC Medical Director for establishing the requirement of OT or PT notes for all claims submitted for K0011 power wheelchairs. NCART continues to believe this is a very valuable document to support medical necessity.

DME providers need specific guidance from CMS and the DMERCs as to the specific documentation that the DMERCs will consider sufficient in the event of a pre- or post-payment audit. CMS must acknowledge that physicians commonly do not keep in their progress notes consistent information regarding all the criteria that would necessarily qualify a beneficiary for a particular item. Because of this, suppliers should be allowed to work with physicians to obtain additional evidence to document medical necessity. A letter of medical necessity written by a physician, physician's assistant or other appropriate allied health professional and signed by the physician should be accepted as documentation that supports medical need. The key is that the physician completed this other documentation, although it may not be part of the physician progress notes.

CMS needs to provide the DMERCs with more specific guidance regarding the documentation that will be deemed sufficient to support medical necessity. In practice, the DMERCs have inconsistent requirements and subjective judgments which impose operational difficulties on multi-region suppliers. For example, CMS should direct the

DMERCs that physician-generated documentation outside the progress notes should be treated as if that documentation were in the progress notes.

When a physician has prepared a letter of medical necessity ("LMN") or other documentation that is specific to a patient and details the reasons why the patient requires a particular item, CMS and the DMERCs should accept the LMN or other physician documentation as a statement of the patient's actual medical condition. Oftentimes, physicians will create this LMN or other documentation and keep it in the patient record. Importantly, the DMERCs should accord the same weight to this physician LMN or other documentation as they do to physician progress notes. This approach makes sense given the reality that suppliers have no ability to ensure that physicians' progress notes address all Medicare coverage criteria for a particular item.

**Supplier Requirements**

We agree strongly that supplier standards must be revised and higher thresholds established for entering the Medicare program. NCART fully supports CMS' third initiative to implement stronger quality controls on the process for suppliers receiving a Medicare Part B supplier number. In fact, NCART has recommended that every Medicare Part B mobility supplier be accredited by a national accreditation organization. This measure will help ensure that only legitimate providers are able to bill the Medicare Program on behalf of beneficiaries. However, in Mr. Kuhn's testimony, he states " CMS will ensure that beneficiaries get high-quality mobility services by... continuing to scrutinize applications from potential suppliers to make sure they are qualified". NCART disagrees with the notion that scrutinizing applications ensure that a supplier is qualified to provide rehab and assistive technology devices. In fact, we believe that the provision of inappropriate technology costs the Medicare program significant dollars and has a significant negative impact on the clinical outcome of Medicare beneficiaries. NCART has recommended that CMS adopt a requirement that all suppliers of specialized rehab and assistive technology employ credentialed staff to attend to and oversee activities related to assessments and fittings of equipment.

**NCART Recommendations**

NCART offers the following recommendations to strengthen and protect the Medicare power wheelchair program:

Adopt the coding system developed by the industry and submitted by NCART and accept the recommended ANSI RESNA testing criteria. NCART also encourages the development of criteria analogous to that used for lower limb prostheses (LLP), which acknowledges the different levels of functional levels of beneficiaries first, and then based on clinical indicators, links functional classifications to HCPCS codes

Update the national coverage policy for all mobility. In addition, it is imperative that coverage criteria and clinical indicators be developed for each level of power mobility in conjunction with revisions to the code set.

Establish procedures to allow CMS to quickly identify potentially problematic anomalies in utilization trends. CMS should establish an advisory council including the medical community, supplier/manufacturer industry and internal staff to review coding, current clinical practice as well as any changes in pricing that may affect utilization.

Establish specific documentation requirements to prove medical necessity. NCART further recommends CMS consider forms to be maintained by the supplier in the patient's record:

- Physical evaluation form- used to identify clinical indicators and determine the patient's functional level.
- In the area of rehab and assistive technology, a technology assessment form used to determine the appropriate technology for the individual client.

Create a true prior authorization process that would allow appropriate documentation to be submitted to facilitate a meaningful up-front review of the beneficiary's medical necessity, same or similar identification and other routine causes for denial. The prior approval would be definitive and would satisfy the requirements of any post-payment reviews.

Create an appropriate working group to develop a definition of therapeutically advantageous rehab and assistive technology products and identify specific items and codes to be excluded from any competitive bidding processes. To be effective, the working group should consist of physicians with training and experience in rehabilitation of persons with significant disabilities requiring high-tech rehab and assistive technology, experienced (and credentialed) occupational and physical therapists and manufacturers and providers of high tech rehab and assistive technology products and services

Implement stronger quality controls on the process for suppliers receiving a Medicare Part B supplier number. CMS should adopt a requirement that all suppliers of specialized rehab and assistive technology employ credentialed staff attend to and oversee activities related to assessments and fittings of equipment.

Perform a through analysis of the impact on Medicare beneficiaries with functional limitations that are being denied access to mobility devices due to the current interpretation of "used in the patient's home".

**Summary**

NCART applauds Senator Grassley and the Committee for investigating this important issue. We are pleased that the Committee has asked the GAO to oversee the progress CMS makes in its efforts to eliminate all forms of fraud and abuse in the Medicare program. We look forward to working with this Committee to address these important issues.

NCART desires to work in an advisory capacity to CMS in the revision of new supplier standards to ensure that these standards meet the needs of CMS and provide quality assurances for Medicare beneficiaries without adding unnecessary costs to suppliers. During the revision process, NCART encourages consideration be given to improving consumer protection through the use of credentialed personnel to perform clinical evaluations and technology assessments.

Finally, NCART is in the process of developing information that will allow a better understanding of the costs associated with providing equipment and billing the Medicare program. NCART is committed to assisting this Committee and CMS in assuring quality products and services are provided to meet the needs of beneficiaries at an appropriate level of payment.

# EXHIBIT

April 23, 1999

Adrian Oleck, M.D.
Medical Director, DMERC Region B
AdminaStar Federal
8115 Knue Road
Indianapolis, IN 46250

Dear Dr. Oleck:

The National Association for Medical Equipment Services (NAMES) Re/hab Section represents re/habilitation technology companies that provide enabling technology in areas such as wheeled mobility, alternative seating and positioning, ambulation equipment and augmentative communication devices, helping people with disabilities to obtain increased access and independence within their communities.

I am writing on behalf of the members of the NAMES Re/hab Council to commend the Region B DMERC for taking a strong position on claims for K0011 power wheelchairs. The Council supports the requirement of additional documentation such as the recommended evaluation of the beneficiary's functional capabilities and limitations. The Council recognizes that many HME services providers may find this requirement to be burdensome, but believes that this is a good step to ensure that consumers receive equipment most appropriate for accommodation of their functional limitations.

There are certain areas of the new policy that the NAMES Re/hab Council requests written clarification of. In the Region B Council " Q & A" dated February 24, 1999, the DMERC states, "...we would give consideration to wheelchair evaluations performed by an appropriately credentialed physical or occupational therapist, even if that person was an employee of the supplier or under contract with the supplier." Will the DMERC recognize PT/OT evaluations done by employees of suppliers in every case when submitted as additional documentation to support K0011 claims, or are there criteria that must be met to ensure the DMERC's "consideration" of such documentation?

Additionally, the Region B DMERC Supplier Bulletin (December 1999) listed several factors that may be included in this type of evaluation and stated that there was no particular form that must be completed. Is the DMERC considering developing an evaluation form in the future, and are more

specific guidelines available for suppliers?

One of the Council's general concerns is consistency in policy and procedure across the four DMERCs. We are aware that other actions such as pre-payment reviews and post payment audits are being conducted by other Regions regarding K0011 claims, we urge you to work with the other DMERCs to ensure consistency and reduce confusion among suppliers and beneficiaries.

Again, we support this new requirement and look forward to receiving clarification on the aforementioned issues. I may be reached at (703) 836-6263. Thank you.

Sincerely,

Elizabeth A. Gallenagh
Director, Re/hab & Reimbursement

cc: Paul Hughes, M.D.
Paul Metzger, M.D.
Robert D. Hoover, Jr. , M.D.

STATEMENT FOR THE RECORD

UNITED STATES SENATE

COMMITTEE ON FINANCE

Hearing on Powerwheelchairs
April 28, 2004

"TAKING TAXPAYERS FOR A RIDE: FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM"


SUBMITTED BY:

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Pride Mobility Products Corp. is the world's leader in the design, development and manufacture of mobility products—power chairs, scooters and lift chairs—for people with disabilities and mobility impairments. With corporate offices in Exeter, Pennsylvania and subsidiaries in the United Kingdom, the Netherlands, Italy, Canada and Australia, Pride is devoted to establishing the global representation that will ensure our ability to best serve our customers.

Pride strongly supports the efforts of CMS to investigate and remove fraudulent businesses operating as phony mobility providers in our industry. Pride supports requirements that are in the best interest of the industry which nullify the actions of inappropriate HME business models without inhibiting the business of ethical, responsible providers. On this note, Pride alerted CMS in early 2003 of potentially fraudulent activity taking place in the Houston, TX area.

Pride will continue to fight to rid fraud from our industry while simultaneously assuring continued access to medically necessary mobility products for all disabled Americans in need of such products.

In response to the recent Senate Finance Hearing on power wheelchairs, Pride submits for the record the following information:

## 1. APPROPRIATE PAYMENT FOR MOTORIZED WHEELCHAIRS

Pride recommends to CMS that when considering the use of Inherent Reasonableness to adjust payments for motorized wheelchairs, CMS must address the following concerns:

- Data used by the OIG to compare pricing between the Medicare program and other payers such as the VA do not take into consideration operational expenses incurred by a Medicare provider.
  - The total operational overhead of the VA (evaluation, set-up, service, business expenses, insurance, etc.) is subsidized by the Government.
  - An independently owned and operated HME company must account for such expenses.
  - It is not uncommon for an HME company to have 25% of all outstanding A/R in payment peril (claims review, denials, challenges in obtaining co-pays, etc.)
  - HME companies normally operate day to day business in relation to collecting the primary payment from a patient's insurance company (overhead costs, payroll, expenses, insurance, vehicles, etc.)
  - Most additional payments from secondary insurance, co-pays, etc., would constitute gross profit
  - Additional costs to Medicare providers stemming from mandatory provider accreditation will even further increase operational expenses for HME providers.
  - The VA program purchases in quantity directly from manufacturers with prices negotiated on this basis. HME providers do not garner such purchasing power when negotiating with distributors/manufacturers.
  - As outlined in the August 13, 1999 Federal Register, to make a valid comparison between Medicare reimbursement and VA payments, CMS added a 67% price mark-up to VA wholesale prices.

- Conclusions made from data used by the OIG to compare pricing between the Medicare program and median prices from retail, supplier negotiated, and wholesale prices do not reflect an accurate cost comparison as this data was not received from a viable source of suppliers, manufacturers, and payers.

- CMS, GAO, and OIG each recommended in testimony that CMS should consider the reclassification of current HCPCS Codes for motorized wheelchairs to better reflect current technology and the wide array of available products within the market. The use of Inherent Reasonableness to adjust payments for motorized wheelchairs should be delayed until such time that a restructuring of the codes is implemented and analyzed for cost savings to the Medicare program.

- A 2002 report released by Janet Rehnquist, Inspector General for the Department of Health and Human Services, indicated that data obtained to compare current Medicare reimbursement rates for power wheelchairs to the VA, Medicaid, and the Federal Employee Health Benefit Plan demonstrated that the difference in Medicare rates are less than the required 15% needed to justify the use of Inherent Reasonable to adjust payment rates as outlined in 42 CFR Part 405.

## 2. NATIONAL COVERAGE POLICY – WHEELCHAIRS

Pride recommends to CMS that when addressing the coverage requirements for motorized wheelchairs, CMS must address the following:

- CMS indicated in testimony that in its "Three-pronged Approach", it is "examining steps to supplement previous coverage guidance regarding 'bed- or chair- confined' from a clinical and functional perspective." This process will consist of a gathering of clinicians from within HHS and other government agencies to examine clinical and functional characteristics to predict who would benefit from a power wheelchair and to develop guidance to the DMERCs when making local coverage decisions.

  - This process would unfortunately be limited to the restrictive, outdated policy for wheelchairs that is bound by statute and does not take into consideration a patient's functionality or safety.
  - This process limits the clinical perspectives to only those clinicians within DHHS - CMS will not allow for the opportunity of outside clinicians from within the industry (Physical Therapists, Occupational Therapists, Physicians) who evaluate, prescribe, and treat beneficiaries for this equipment on a daily basis.

- The industry is examining drafting a proposal to the current National Coverage Policy for wheelchairs that addresses conditions and scenarios that affords access to medically necessary mobility products for all disabled Americans in need of such products. Pride would like to urge CMS to work with the industry on this proposal to ensure a cost-effective policy is developed that benefits Medicare beneficiaries and providers as well as CMS.

  - A revision to the National Coverage Determination should be developed based upon clinical considerations of patient functionality, independence, and safety.
  - A revision to the National Coverage Determination should establish a standard for coverage that encompasses 85% of the potentially qualifying candidates for motorized wheelchairs.

## 3. FRAUD AND ABUSE

Pride recommends to CMS that when addressing fraud and abuse within the motorized wheelchair benefit, CMS should consider the following:

- Mandatory Provider Accreditation would assure only quality providers who meet Medicare and community standards are available to provide Medicare covered items/services to Medicare beneficiaries.

- Medicare providers must adhere to mandatory on-site inspections from CMS agents to assure compliance with all established Medicare Provider Standards.

- As outlined in the MMA, CMS should develop and implement the procedures to assign and oversee an accrediting organization to be responsible for the accreditation process for all Medicare providers.

- Representation from the industry is essential in the development and implementation process for Provider Accreditation to assure open communication and insight is provided between CMS and the industry.

- A Special Task Force and Implementation Strategy to combat fraud and abuse consisting of representatives of CMS, OIG, GAO, and the industry.

Pride Mobility Products Corp. recommends to the Senate Finance Committee to request CMS to consider the following procedures to address the issue of fraud within the wheelchair industry:

1. **Fraud Task Force** – With industry assistance, organize a Special Task Force and Implementation Strategy to combat fraud and abuse. CMS, OIG, and the industry can work together to eliminate fraud. The industry would serve on the task force with CMS representatives.

2. **Comprehensive Coverage Policy** – CMS should establish a clear national coverage policy for mobility products. This would establish national guidelines that would end confusion over coverage policy.

3. **Provider/Supplier Accreditation** – Requirement for all Medicare/Medicaid mobility suppliers to be accredited by a nationally recognized accrediting organization. This measure will improve the standards for suppliers.

4. **Advanced Rehab Certification** – Requirement for a strict certification plan for medical suppliers who provide advanced rehab equipment for disabled pediatric and the severely disabled. This will help ensure that only qualified, certified individuals are responsible for the treatment of individuals with severe disabilities.

5. **Medical Documentation Requirements** – Establish that a certificate of medical necessity (signed by a physician) with a corroborated state licensed Physical Therapist or Occupational Therapist evaluation is required documentation to establish non-ambulation and whether a mobility product (e.g.; power wheelchair) is medically necessary. This will provide clarity for providers and physicians as to the proper documentation requirements to establish medical necessity.

6. **Advisory Group on Mobility Issues** - Appoint representatives from groups representing persons with disabilities, consumers and the industry to advise CMS on issues related to mobility questions. The group would be a sounding board for CMS, so that they could better gauge the impact of any new policies or guidelines.

7. **New Code Development** – CMS should establish new codes for mobility equipment as the industry has recommended. There is such a vast range of technology that old codes need to be updated to adequately differentiate between the products.

8. **Establish Advertising Best Practices** – Establish clear advertising regulations for the health care industry. This will help prevent non-compliance with Medicare Standards. Many other industries have advertising requirements and regulations, the power wheelchair industry can also accept them.

9. **Fraud Reporting System** – We will work with CMS to establish an enhanced fraud and reporting system, which will help curtail fraud, as well as encourage people to report any irregularities.

10. **Regulatory Reform** – Implement the Regulatory Reform procedures outlined in the Medicare Modernization Act that establish a clear procedure for reviewing medical claims and providers to determine compliance with established documentation requirements. It is essential that clarity in medical documentation be established to achieve efficient claim processing.

# STATEMENT OF RAMP

## Before the Committee on Finance United States Senate

## APRIL 28, 2004

## CONCERNING MEDICARE PAYMENTS FOR POWER WHEELCHAIRS

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**Restore Access to Mobility Partnership (RAMP) is a coalition working to reform Medicare policy to ensure that all beneficiaries have access to mobility products. Members include: The American Association of Homecare; Invacare Corporation; The MED Group; Mobility Products Unlimited, LLC; Pride Mobility; The Scooter Store; and Sunrise Medical.**

**Introduction**

RAMP submits this statement for the official hearing record of the Senate Committee on Finance's April 28, 2004 hearing entitled "Taking the Taxpayers for a Ride: Fraud and Abuse in the Power Wheelchair Program." RAMP strongly supports all efforts to eradicate fraud and abuse in the provision of motorized wheelchairs under the Medicare Program and has, in fact, a series of recommendations detailed below that we believe would significantly decrease the opportunity for fraud and abuse within this benefit.

RAMP member organizations alerted the Centers for Medicare and Medicaid (CMS) Administrator over a year ago to the fraud and abuse related to power wheelchairs in the Houston area. We are committed to working with the various government agencies to ensure that unscrupulous individuals cannot obtain a Medicare billing number, and cannot provide items and services to Medicare beneficiaries.

RAMP members fully support efforts to protect the financial integrity of the Medicare program. We also believe that there are significant opportunities for CMS and industry to work together to reduce fraud, waste and abuse. However, efforts to fight fraud should not and need not come at the beneficiary's expense. Patients who need power wheelchairs in order to function in their home should have access to the equipment that will enable them to live independently.

**RAMP Response to OIG Reports**

At the April 28, 2004 hearing, the Office of Inspector General (OIG) released two reports regarding power wheelchairs. The first is entitled, "A Comparison of Prices for Power Wheelchairs in the Medicare Program,"[1] the second is entitled "Medicare Payments for Power Wheelchairs."[2] Following are RAMP's responses to these reports.

1. OIG Report on Prices for Power Wheelchairs

   - RAMP strongly supports the OIG's recommendations that Medicare should adopt a new coding system to better describe the power wheelchairs actually provided to beneficiaries.

   - New HCPCS Codes Obviate Need for CMS to Use IR on K0011 HCPCS Code: RAMP questions why would CMS use its "inherent reasonableness" (IR) authority to adjust payment amounts for HCPCS code K0011 if CMS is going to replace the K0011 code with multiple HCPCS codes? As CMS stated in its testimony, once there are multiple codes for power wheelchairs, CMS will be able to establish payment amounts more in line with the actual item provided. RAMP recommends CMS first work to establish and implement new codes and develop pricing for those codes using the gap-filling methodology. Further, CMS should allow an adequate period of time to judge the effectiveness of these steps before

[1] OIG Report OEI-03-03-00460, April 2004.
[2] OIG Report OEI-03-02-00600, April 2004

making any decisions regarding the need for additional reductions in reimbursement for power mobility.

- RAMP Questions the OIG's methodology for determining Market place prices for power wheelchairs:

In many respects, the OIG study creates an inaccurate or incomplete basis for serving as a comparison to Medicare prices. In many instances, the OIG identified the limitations in their own analysis.

  - As the OIG stated, it found that only 33 of the 96 models on the SADMERC (Statistical Analysis Durable Medical Equipment Regional Carrier) product classification list were provided to Medicare beneficiaries. Yet it draws pricing comparisons, for instance, against products listed on internet websites. How does this smaller list of 33 models compare to the power wheelchairs on the Web sites of power wheelchair suppliers? If different products were provided, then the comparison is inapt.

  - As the OIG noted, some of the suppliers from whom the OIG obtain wheelchair pricing data, may not provide products to beneficiaries, may involve different products or have different cost structures by virtue of the fact that they do not do business with Medicare. Thoughtful conclusions cannot be made using the raw data provided by the OIG. All products listed as K0011 on the SADMERC classification list are not equal in terms of medically necessary features, product capability or quality.

  - OIG's use of the SADMERC Product Classification list does not yield helpful price comparisons because this is not the list of products that were used in determining the Medicare fee schedule. It is merely a tool that allows manufacturers to know the appropriate code to use when billing for a product. Due to HIPAA implementation, all manufacturers of power wheelchairs are likely to have their products code verified by the SADMERC in order to facilitate the sales and marketing of their products, regardless of whether they would have been sold to Medicare beneficiaries.

  - Due to the fact that many payers, including state Medicaid programs, have payment levels tied to the Medicare fee schedule, either through regulation or legislation, it becomes extremely important for valid data to be considered in regards to pricing.

  - A new coding structure will further assist in helping CMS analyze what they are paying for as an additional benefit beyond the impact on pricing.

- Careful understanding of the products behind the pricing is critical for CMS before using pricing information to reach conclusions regarding what CMS should be paying for product. CMS must ensure that while they make every effort to pay appropriately for power wheelchairs it remains critical for beneficiaries to have access to the most appropriate device to meet their medical and functional needs.

- Medicare Part B Suppliers Incur Many Costs Beyond Product Acquisition: Importantly, the OIG acknowledges that actual Medicare program savings could be less than the amount it identified because "potential supplier administrative costs related to furnishing K0011 power wheelchair to Medicare beneficiaries were not included in the prices reviewed." We caution the OIG and CMS that there are significant overhead and administrative costs related to providing beneficiaries with product and submitting claims to the Medicare Program. Moreover, with many suppliers being accredited (or soon being required to be accredited), this is an additional cost to the supplier. There are many costs of doing business that suppliers incur, including inventory management, to extensive paperwork (obtaining documentation from the physician and other clinicians), delivery, and maintenance and service. For instance, the costs of doing business with Medicare have risen dramatically in the last six months, as suppliers have had to invest heavily in infrastructure to gather medical records and other supplemental documentation to demonstrate the medical necessity of power wheelchairs.

- The OIG's Limited Data Collection does not Meet CMS's Criteria for IR Payment Adjustments: The OIG reviewed invoices and purchase orders from suppliers who had negotiated prices of K0011 power wheelchairs with manufacturers and distributors. The OIG's review, however, was limited to only 8 suppliers and 36 individual prices. This limited data cannot be used as the basis for an "inherent reasonableness" payment reduction because such a small amount of pricing data cannot be representative of the thousands of suppliers providing power wheelchairs to beneficiaries. CMS must adhere to the strict requirements of in its interim final regulation on "inherent reasonableness."[3] As that regulation requires, CMS ensure the use of valid and reliable data when exercising this authority. CMS must establish that the data it relies upon is truly representative of products provided generally to beneficiaries. For example, when exercising its IR authority, CMS must ensure that sampled prices fully represent the range of prices nationally, and must consider whether the distribution of sampled prices from localities surveyed is fully representative of the distribution of the U.S. population, must consider the products generally used by beneficiaries and collect prices of these products. Further, when using its IR authority, CMS must understand and incorporate many and varied costs associated with providing the various levels of technology and submitting claims to Medicare. The OIG limited data collection does not begin to meet CMS's own requirements for exercising its IR authority.

[3] 67 *Federal Register* 76,684 (December 13, 2002),

2. OIG Report on Medicare Payments for Power Wheelchairs

The second OIG report purports to assess whether beneficiaries who received power wheelchairs met the Medicare coverage criteria for these items. RAMP believes that this study can only reflect compliance with Medicare's current and vague documentation requirements, not the true medical need of beneficiaries. Because no one conducted an independent evaluation of patients' physical conditions, the report's conclusions are vastly overstated. Overall, this report best illustrates the serious limitations with the current Medicare coverage policy and the documentation that Medicare uses to make decisions of medical necessity.

- In the end, the report raises more questions than answers:
    - For how many of the 300 claims did the OIG receive no response from the physician?
    - For claims where the OIG did receive documentation from the physician, how does the OIG know whether the physician did provide the medical records that were most relevant?
    - Given that physicians are not familiar with the Medicare coverage details, how could the physicians be expected to send information that would be responsive/would address the coverage requirements?
- We applaud OIG's recommendation that the DMERCs revise the K0011 coverage policy to include specific information about the specific medical conditions for which Medicare will cover this item, including an assessment of the individual's functional abilities.
- This OIG study was effectively one of documentation regarding power wheelchairs rather than a study of beneficiary need. In fact, the only way to assess true medical need would be to send reviewers to do a complete assessment of the beneficiary.
- Physicians Are the Gatekeepers of Medical Necessity, Not Beneficiaries: While we believe it is appropriate for DMERCs to obtain documentation from the ordering physician to substantiate medical necessity, contacting the beneficiary to determine medical necessity is not appropriate. The Medicare Program relies on physicians to be the gatekeepers and determine medical necessity. The only appropriate beneficiary contact in this instance would be to verify that delivery had occurred.
- DME providers need specific guidance from CMS and the DMERCs as to the specific documentation that the DMERCs will consider sufficient in the event of a pre- or post-pay audit. We recommend that the following documentation beyond the CMN should be used by CMS/DMERCs to determine medical necessity:

- Any Physician-Generated Document Should Be as Credible as Progress Notes. CMS needs to acknowledge that physicians commonly do not keep in their progress notes consistent information regarding all the criteria that would necessarily qualify a beneficiary for a particular item, as the OIG likely experienced first hand with this report. Suppliers should be allowed to work with physicians to obtain additional evidence to document medical necessity. A letter of medical necessity (LMN) written by a physician or physician's assistant and signed by the physician should be accepted as documentation that supports medical need. CMS should direct the DMERCs that physician-generated documentation outside the progress notes should be treated as if that documentation were in the progress notes. The key is that the physician completed this other documentation; although it may not be part of the physician progress notes. Importantly, the DMERCs should accord the same weight to this physician LMN or other documentation as they do to physician progress notes. This approach makes sense given the reality that suppliers have no ability to ensure that physicians' progress notes address all Medicare coverage criteria for a particular item.

3. Comparisons to the VA Program and Pricing are Wholly Inapt

- The Medicare Program is wholly different than the Veteran Administration (VA) in that it procures products separately from services. In fact, in testimony before another Senate Committee in 2002, the General Accounting Office acknowledged important differences between the VA and the Medicare Program. In comparing the VA to the Medicare Program, GAO cautioned, "[T]o assure access for beneficiaries across the country and to be certain that providers get a fair price and remain in the market, there would need to be some markup from the VA Federal Supply Schedule."[4] In addition, there are other important distinctions; a few of these critical differences are described here.

- The VA purchase wheelchairs in bulk directly from the manufacturers, under the Federal Supply Schedule; prices are negotiated on a mass wholesale basis. In contrast, the Medicare Program does not purchase wheelchairs on a wholesale basis; rather, it pays for singular retail transactions, on a beneficiary-by-beneficiary basis. Even the largest Medicare Part B supplier could not begin to achieve the economies of scale of the federal government.

- Unlike the Medicare program, the VA as purchaser is responsible for distribution, fitting, chair adjustment, repairs and responding to patient complaints. It incurs the inventory and financing costs that would normally be born by a durable medical equipment supplier.

[4] Testimony of Leslie Aronovitz, General Accounting Office, June 12, 2002, hearing before a Subcommittee of the Committee on Appropriations, United Stated Senate.

- The VA often pays separately for necessary equipment-related services such as delivery fees, technicians, consumer education, etc.

- The VA's government status and volume purchasing power enables it to purchase items at significantly lower prices that are afforded either the retail or the home care class of trade.

- Unlike the Medicare Program, The VA has no written prescription requirements, no Assignment of Benefits (AOB) is necessary, no proof of delivery requirements are delineated, Medicare supplier standards do not have to be met, there is no billing of co-payment amounts, no billing of deductibles, and no third party collection efforts. All these Medicare requirements add costs to the Medicare Program's total delivered cost.

**RAMP Response to CMS Initiative**

RAMP generally applauds CMS' three-pronged initiative. We have the following recommendations, however, that would improve CMS' initiatives addressing power wheelchair issues.

1. Coverage Guidance Development Needs Practicing Clinician Input at the Outset: CMS' initiative to develop more coverage guidance is limited to convening clinicians from HHS and other government agencies to refine and describe the conditions that are associated with the current coverage definition and to develop draft guidance for determining whether a patient meets the definition of "bed or chair confined." **We strongly urge CMS to include non-government clinicians who are actively involved in prescribing motorized wheelchairs and clinicians who evaluate and fit beneficiaries** for power wheelchairs to ensure that the consumer receives the medically appropriate wheelchair and necessary components/accessories. Without the input of currently practicing clinicians, CMS' guidance will lack important "real life" current medical practice, etc.

2. New Codes Will Address Many Issues: CMS' second initiative is to develop a new set of codes, in conjunction with the National Coding Panel, to better describe the wide array of available power wheelchairs and to set Medicare fee schedules that are more closely aligned with the actual product provided. We applaud this initiative, and **strongly recommend that CMS review the industry's detailed coding recommendations for motorized wheelchairs.** The industry's submission also provides clinical indicators for each of the six recommended new codes; these clinical indicators could serve as the basis for Medicare coverage policy descriptions. Moreover, clinical indicators, functional levels and diagnosis codes when used together can serve as critical support for medical need.

3. Stronger Supplier Standards: RAMP also fully supports CMS' third initiative to implement stronger quality controls on the process for suppliers receiving a Medicare Part B supplier number. In fact, RAMP has recommended that every Medicare Part B mobility supplier be accredited by a national accreditation organization. This measure will help ensure that only legitimate providers are able to bill the Medicare Program on behalf of beneficiaries.

**RAMP's 10-Point Plan**

RAMP, the Restore Access to Mobility Partnership, recommends a 10-point plan that would help CMS fight fraud without harming the people who require power wheelchairs to increase their mobility. We recommend establishing an accreditation process for suppliers, implementing a clear and clinically appropriate documentation process and appointing a fraud task force.

Specifically, RAMP recommends:

1. **Fraud Task Force** – With industry assistance, CMS and the OIG should organize a Special Task Force and Implementation Strategy to combat fraud and abuse. CMS, OIG, and the industry can work together to eliminate fraud. The industry would serve on the task force with CMS representatives.

2. **Comprehensive Coverage Policy** – CMS should establish a clear national coverage policy for mobility products. This would establish national guidelines that would end confusion over coverage policy.

3. **Provider/Supplier Accreditation** – Require all Medicare mobility suppliers to be accredited by a nationally recognized accrediting organization. This measure will improve the standards for suppliers.

4. **Advanced Rehab Certification** – Requirement for a strict certification plan for suppliers who provide advanced rehabilitation equipment for disabled pediatric and the severely disabled. This will help ensure that only qualified, certified/credentialed individuals are responsible for the treatment of individuals with severe disabilities.

5. **Medical Documentation Requirements** – Establish that a certificate of medical necessity (signed by a physician) with a corroborated state licensed Physical Therapist or Occupational Therapist evaluation is required documentation to establish non-ambulation and whether a mobility product (e.g.; power wheelchair) is medically necessary. This will provide clarity for providers and physicians as to the proper documentation requirements to establish medical necessity.

6. **Advisory Group on Mobility Issues** – CMS should appoint representatives from groups representing persons with disabilities, consumers and the industry to

advise CMS on issues related to mobility questions. The group would be a sounding board for CMS, so that they could better gauge the impact of any new policies or guidelines.

7. **New Code Development** – CMS should establish new HCPCS codes for mobility equipment as the industry has recommended. There is such a vast range of technology that old codes need to be updated to adequately differentiate between the products.

8. **Establish Advertising Best Practices** – Establish clear advertising guidelines for the health care industry. This will help prevent non-compliance with Medicare Standards. Many other industries have advertising requirements and regulations; the power wheelchair industry can also accept them.

9. **Fraud Reporting System** – We will work with CMS to establish an enhanced fraud and reporting system, which will help curtail fraud, as well as encourage people to report any irregularities.

10. **Regulatory Reform** – Implement the Regulatory Reform procedures outlined in the Medicare Modernization Act that establish a clear procedure for reviewing medical claims and providers to determine compliance with established documentation requirements. It is essential that clarity in medical documentation be established to achieve efficient claim processing.


Expanding Opportunities for Veterans
and All Paralyzed Americans

**STATEMENT FOR THE RECORD**

**UNITED SPINAL ASSOCATION**

**BEFORE THE SENATE COMMITTEE ON FINANCE**

**"TAKING TAXPAYERS FOR A RIDE:**

**FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM"**

**WEDNESDAY APRIL 28, 2004**

*Submitted by:*

*Jeremy Chwat*
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**Introduction**

This testimony is being submitted on behalf of the United Spinal Association. United Spinal Association is a national disability advocacy organization dedicated to enhancing the lives of individuals with spinal cord injury or disease (SCI/D) by assuring quality health care and advocating for the civil rights and independence of individuals with disabilities.

We applaud the Senate Committee on Finance for holding this hearing, and greatly appreciate the opportunity to comment on fraud and abuse in the power wheelchair program and its affects on the Medicare power wheelchair coverage policy and beneficiaries. United Spinal is hopeful that this hearing will highlight the need to update the Medicare power wheelchair coverage policy. We urge CMS to create a balanced policy that deters and detects fraud while preserving beneficiary access to power wheelchairs.

**Medicare Fraud and Power Wheelchairs**

Fraud in the power wheelchair industry is a real issue. According to a September 9, 2003 Center for Medicare and Medicaid Services (CMS) press release, Medicare payments for power wheelchairs have increased by 450% since 1999. While it is imperative to root out fraud and abuse in power wheelchair purchasing, it is equally important to ensure beneficiary access to power mobility. Power wheelchairs play an integral role in assisting millions of disabled and elderly Americans live independent lives, and allows them to be active participants in and positive contributors to our communities. More and more CMS demonstrates a willingness to compromise the rights and independence of individuals with disabilities in the name of fighting fraud and abuse. While United Spinal Association applauds the Department of Health and Human Services (HHS) and CMS efforts to identify and control fraud and abuse, persons with disabilities find themselves, yet again, innocent bystanders in this battle.

On September 9, 2003, HHS and CMS announced their 10-point initiative - "Operation Wheeler Dealer". The goal of this initiative is to curb fraud, waste and abuse in the Medicare program as it relates to unscrupulous providers of power wheelchairs. In response to this 10-point initiative, CMS and its four national Durable Medical Equipment Regional Carriers (DMERCs) released in December 2003 a Medicare policy coverage clarification. This clarification stated that CMS and its DMERCs will no longer allow Medicare coverage and reimbursement for manual or power wheelchairs for any patient who can take more than one step, even with the assistance of a cane, crutch or walker, to transfer from a bed to a chair. Stated plainly, the ability to take one step (or even multiple steps) does not necessarily negate the need for a mobility assistance device. The clarification defined these patients as ambulatory, essentially precluding their qualifying for a wheelchair.

The December 2003 policy clarification did very little to root out fraud and abuse at the source – the wheelchair providers. Rather, it had potential to harm innocent Medicare beneficiaries who require power wheelchairs to maintain their independence and quality of life.

In reality, this "anti-fraud" initiative unfairly and significantly limits patient access to wheeled mobility. On March 18th, CMS rescinded this clarification.

**Update Medicare National Coverage Policy**

Current Medicare national coverage policy for power wheelchairs is out-dated and antiquated. In order to prevent future restrictive policy clarifications such as the clarification from December 2003, CMS must modernize and develop a new national power wheelchair coverage policy. United Spinal Association recommends CMS reinterpret the original Medicare statute concerning power wheelchairs, and use this opportunity to clarify and redefine such terms as "in-the-home", "otherwise bed or chair confined" and "non-ambulatory". The language in the new coverage policy should reflect nearly 40 years of legal advancements such as the U.S. Supreme Court *Olmstead* decision and the Americans with Disabilities Act, societal advancements such as acceptance into the American workforce, and technological advancements such as power wheelchairs.

In its efforts to modernize, CMS must not further limit access to power and manual wheelchairs in its Medicare coverage policy as it did in the clarification. Such policies have many implications for people with disabilities and for the aging community, and therefore for CMS as well. These implications include an increase in patients moving into nursing homes or assisted living facilities; increased reliance on full time caregivers for accomplishing daily living activities; and, the possibility of increased fractures resulting from a higher likelihood of falls. Actually, providing patients with the necessary power or manual wheelchair would probably end up costing Medicare less than what it will end up paying as a result of increased payments for assisted living facilities, rehabilitation units and additional hospital visits.

**Concluding Remarks**

It is undeniable that, in order to achieve and sustain community involvement, people with disabilities require access to mobility devices such as power wheelchairs. To this end, it is incredibly discouraging to watch CMS attempt to limit access to power wheelchairs through Medicare in its efforts to curb fraud and abuse. It is certainly possible to create a balanced policy that deters and detects fraud while preserving beneficiary access to power wheelchairs. United Spinal Association urges the Senate Committee on Finance to encourage CMS to update its Medicare national power wheelchair coverage policy. CMS must strike a balance in its efforts to root out fraud and abuse while still preserving beneficiary access to power wheelchairs.



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