

GAO

Testimony

Before the Committee on Finance, U.S.
Senate

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

MEDICARE

**CMS Did Not Control Rising
Power Wheelchair Spending**

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Highlights of [GAO-04-716T](#), a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicare spending for power wheelchairs, one of the program's most expensive items of durable medical equipment (DME), rose 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.

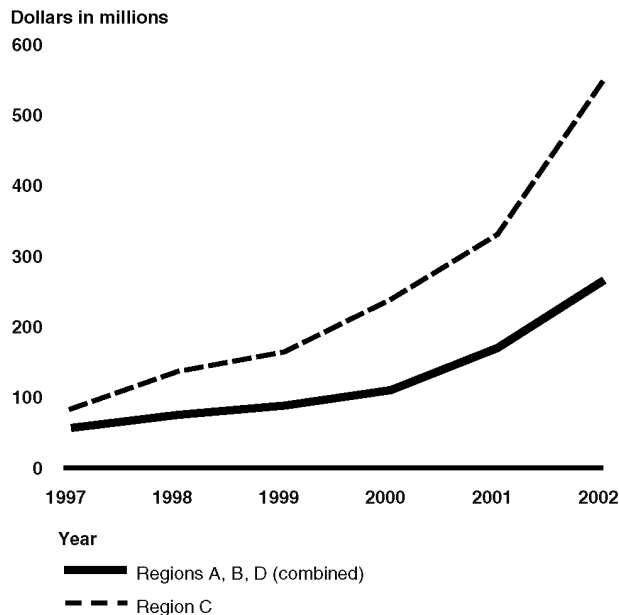
MEDICARE

CMS Did Not Control Rising Power Wheelchair Spending

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—

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

²Medicare 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

³Testimony 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).

⁴U.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).

⁵Pub. 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

⁶MMA § 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.

⁷The 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

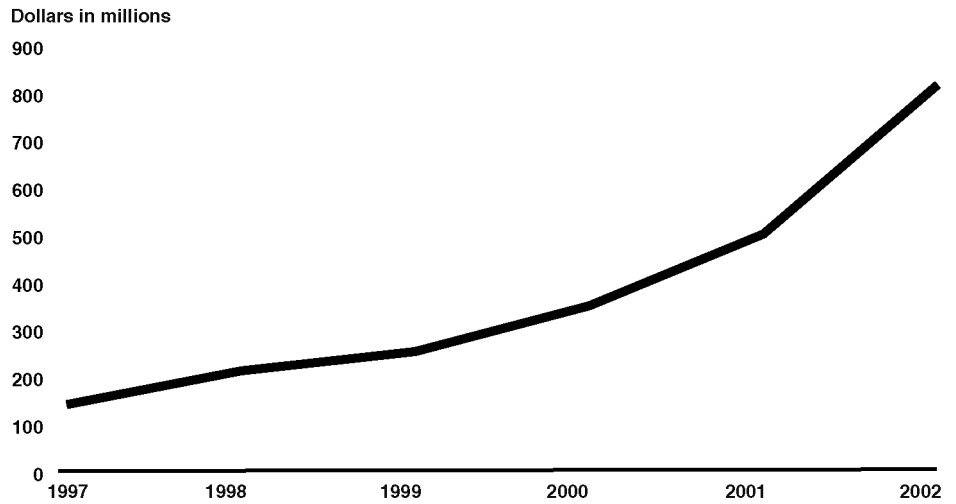
Although there were multiple warning signs over a 6-year period that growth in claims and payments for power wheelchairs may have been excessive, CMS did not lead a full-scale, coordinated effort to address the issue until September 2003. CMS has recently taken actions to reduce improper payments for 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



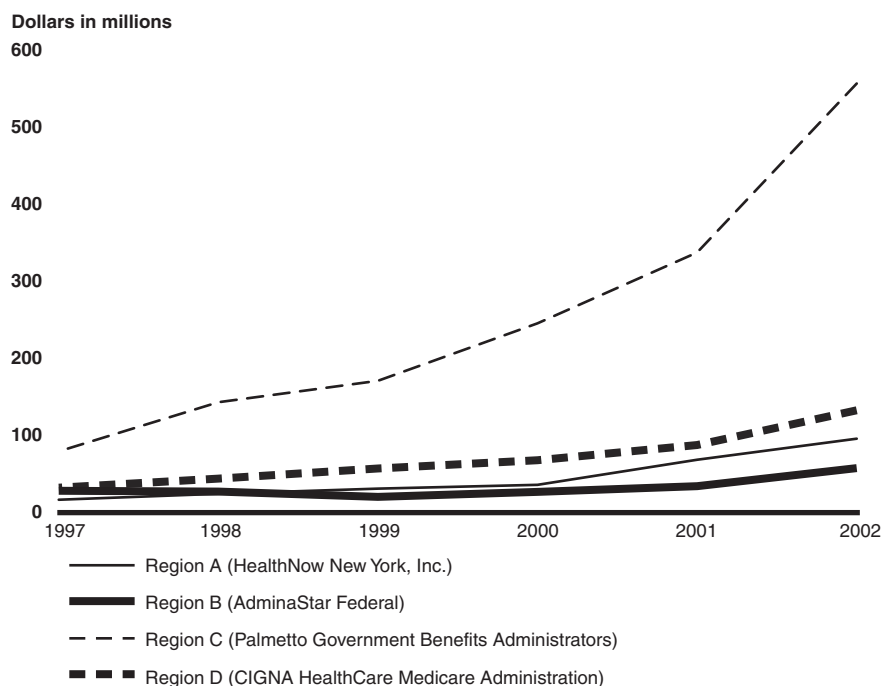
Source: CMS.

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

⁸This information was not available from region A.

⁹U.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

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

¹²Suppliers 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.

¹³CMS 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 business¹⁵ and this is reflected in the supplier standards. CMS has authority, however, to impose additional requirements¹⁶ 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 suppliers¹⁷ 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.

¹⁴Medicare 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).

¹⁵42 U.S.C. § 1395m(a)(17) 2000.

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

¹⁷MMA § 302(a)(1), 117 Stat. 2223.

¹⁸MMA § 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

¹⁹GAO-02-833T.

²⁰MMA § 302(b), 117 Stat. 2224.

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

²²63 Fed. Reg. 687 (Jan. 7, 1998).

²³Medicare, 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.

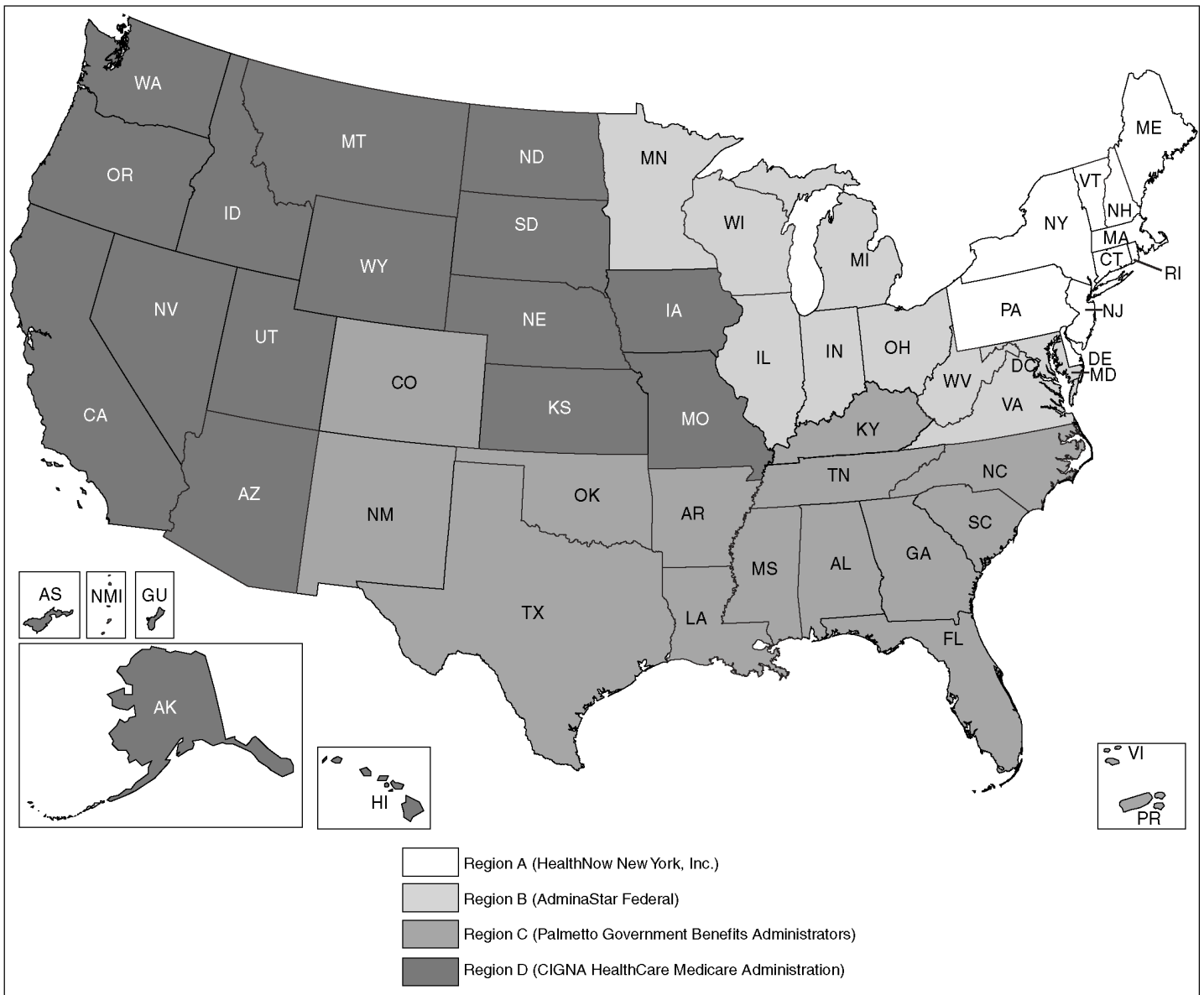
Mr. Chairman, this completes my prepared statement. I will be happy to answer questions you or other Members of the Committee may have.

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.

²⁶CMS 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

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

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites Media Print Mail Stop

Address Go Links

Google Search Web 120 blocked AutoFill Options

INCREASING YOUR MOBILITY... AND QUALITY OF LIFE

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

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

Cost for an Electric Wheelchair

Payment by Insurance through Medicare


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

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

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

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

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



Source: Internet Web site.

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