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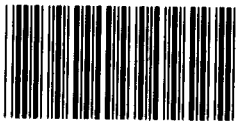
Report to Congressional Committees

June 1992

DURABLE MEDICAL EQUIPMENT

Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments



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Human Resources Division

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June 12, 1992

The Honorable Lloyd Bentsen, Chairman
The Honorable Bob Packwood, Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell, Chairman
The Honorable Norman F. Lent, Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski, Chairman
The Honorable Bill Archer, Ranking Minority Member
Committee on Ways and Means
House of Representatives

This report responds to a provision of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) that required us to study Medicare's payments for durable medical equipment. We include recommendations to the Secretary of Health and Human Services that could reduce unnecessary Medicare payments for such equipment.

We are sending copies of the report to the Secretary, the Director of the Office of Management and Budget, and other interested committees and parties and will make it available to others on request.

Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix II.

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Executive Summary

Purpose

The Congress has expressed concern that Medicare is needlessly spending millions of dollars annually on durable medical equipment that beneficiaries do not medically need. In the Omnibus Budget Reconciliation Act of 1989, the Congress required GAO to (1) review the appropriateness of the medical necessity criteria developed by the Health Care Financing Administration (HCFA) for equipment subject to unnecessary payments and (2) determine whether standardized medical necessity certification forms could help reduce unnecessary payments. The act also required GAO to convene a panel of knowledgeable officials to provide expert views on these issues.

Background

Medicare pays for durable medical equipment, such as hospital beds and wheelchairs, that is medically necessary to treat a beneficiary's illness or injury, and reasonable, considering the equipment's expected benefit. In 1990, Medicare paid about $1.7 billion for durable medical equipment purchases and rentals.

A HCFA manual lists the categories of durable medical equipment eligible for Medicare payment nationally. A category may contain a number of different equipment items, some more costly and sophisticated than others. The manual also contains criteria describing the general medical conditions the beneficiary must have to qualify for coverage. To determine whether a claim should be paid, Medicare carriers—contractors who review and pay claims for this equipment—apply HCFA's criteria and may develop their own supplemental criteria as well. The amount paid varies by item within a category.

Carriers use medical necessity certification forms, completed by physicians, to help determine whether to pay a claim. There are two basic formats. On one, physicians provide a narrative explanation and justification as to why equipment is medically necessary; on the other, they check off statements of medical condition that may apply to the beneficiary.

Unnecessary payment occurs when carriers pay for equipment that is not medically necessary or is more costly than necessary to treat a beneficiary. The Inspector General of the Department of Health and Human Services (HHS) has reported on several supplier and physician practices that result in unnecessary payment for some equipment.

For this report, GAO met with HCFA; carrier, supplier, and HHS Inspector General officials; and GAO's expert panelists. In addition to reviewing Inspector General reports on unnecessary equipment payments, GAO evaluated HCFA medical necessity criteria; obtained forms from 10 carriers and evaluated the effects of three forms; and analyzed HCFA payment data.

Results in Brief

HCFA could reduce Medicare expenditures on durable medical equipment subject to unnecessary payments by developing more detailed coverage criteria that give carriers a clear, well defined, objective basis for paying or denying claims.

To further save Medicare funds, HCFA could also develop medical necessity certification forms for equipment subject to unnecessary payments. Such forms should require physicians to provide narrative explanations that justify the beneficiary's medical need for the prescribed equipment. At carriers that developed this kind of form, Medicare payments for three types of equipment decreased significantly because the forms provided detailed information that resulted in carriers' denial of claims.

Principal Findings

HCFA Coverage Criteria Create Potential for Unnecessary Payments

For the seven equipment categories GAO reviewed, HCFA's coverage criteria generally do not describe (1) the specific medical conditions, and their severity, that a beneficiary must have to qualify for coverage of the equipment; (2) under what circumstances a beneficiary may qualify for equipment that is more sophisticated and costly than standard types; or (3) specific medical conditions that do not qualify for coverage of the equipment. In 1990, allowed charges for these seven categories represented 25 percent of total Medicare-allowed equipment charges. (See pp. 15 and 16.)

Although the purchase and rental fees for different types of equipment vary considerably, HCFA's criteria often do not provide carriers with specific guidance on when to pay for the more expensive equipment that can have a significant effect on Medicare costs. For example, HCFA's wheelchair coverage criteria do not define when costly accessories such as detachable arms or elevating leg rests are medically necessary. Adding

these accessories to a standard wheelchair can almost double Medicare's monthly rental fee. (See pp. 15-17.)

GAO's expert panelists and officials from the 10 carriers GAO contacted agreed that more detailed HCFA criteria could reduce unnecessary Medicare equipment payments. Carrier officials said that more detailed criteria would better enable them to determine whether to pay or deny claims. HCFA officials agreed that more specific HCFA criteria could reduce unnecessary equipment payments. (See pp. 17-19.)

Use of Carrier Forms Reduced Medicare Payments

Significant savings to Medicare resulted from use of three carrier-developed medical necessity certification forms that GAO reviewed. The forms apply to claims for transcutaneous electrical nerve stimulators (TENS), which are used to control chronic pain; power-operated vehicles; and seat-lift chairs. These three equipment categories are recognized by HCFA and carriers as subject to unnecessary payments. The forms were effective because they required physicians to provide a narrative explanation and justification as to medical necessity and gave carriers detailed information with which to determine if claims should be paid. (See pp. 21-33.)

At one carrier, for example, TENS payments decreased 93 percent, from $1.3 million in 1988 to $94,000 in 1989, the first full year the form was in effect. At another carrier, payments for power-operated vehicles decreased from $828,000 in 1988 to $472,000 in 1989, a 43-percent reduction the first full year the form was used. Payments decreased by an additional 36 percent the following year, to $303,000. At both carriers, officials attributed the sharp decline in payments to increased claims denials resulting from use of the form. (See pp. 22-29.)

HCFA instructed carriers to consider using forms requiring narrative physician justifications for two equipment categories subject to unnecessary payments. It plans to develop additional suggested forms for carriers to use but has not decided on their format. (See pp. 31-37.)

Officials from all 10 carriers GAO contacted, as well as GAO's expert panelists, agree that HCFA-developed forms that require written physician justifications could reduce unnecessary Medicare equipment payments. (See p. 34.)

Recommendations

For durable medical equipment subject to unnecessary payments, GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to (1) develop more detailed coverage criteria and (2) require that medical necessity forms being developed by HCFA require physicians to provide narrative justification documenting why the equipment is medically necessary. (See pp. 19 and 35.)

Agency Comments

HHS agreed that the current HCFA coverage criteria often do not provide carriers with specific guidance on when to pay for certain durable medical equipment. However, HHS neither agreed nor disagreed with GAO's recommendation that HCFA develop more specific coverage criteria for equipment HCFA identifies as subject to unnecessary payments. HHS believes that several ongoing initiatives intended to make carriers' coverage decisions more uniform are consistent with GAO's recommendation.

HHS generally disagreed with GAO's recommendation that the medical necessity certification forms being developed by HCFA for equipment subject to unnecessary payments should require physicians to provide narrative justifications documenting why the equipment is medically necessary. HHS believes that durable medical equipment abuses can be handled more effectively by other means that would impose fewer burdens on carriers and physicians and that forms should be compatible, to the maximum extent possible, with electronic claims processing. (See app. I.)

Contents

Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
TENS	transcutaneous electrical nerve stimulator

Introduction

As more Americans live longer, they often require assistance to help sustain them in their daily living activities. Durable medical equipment, such as wheelchairs and hospital beds, enables individuals to function in their homes when they otherwise might need to live in an institutional setting. Because of its concern that Medicare was paying for medically unnecessary equipment, costing the program millions of dollars annually, the Congress required us to review Medicare's payments for equipment subject to unnecessary payments.

Medicare Coverage and Payment Procedures

Medicare is a federal health insurance program authorized by title XVIII of the Social Security Act (42 U.S.C. sections 1395 and following) that covers most Americans 65 years or older and certain disabled Americans under 65 years. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers the program.

There are two parts to Medicare. Part A (Hospital Insurance for the Aged and Disabled) covers services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Part B (Supplementary Medical Insurance for the Aged and Disabled) covers physicians' services and such noninstitutional services as durable medical equipment. In fiscal year 1991, Medicare paid an estimated $115 billion, including $45 billion for all part B services, for 33 million beneficiaries.

To process and pay part B claims, including durable medical equipment claims, HCFA contracts with 34 private insurers, referred to as carriers. They include Blue Cross and Blue Shield organizations and other commercial insurance companies.

Needed Durable Medical Equipment Covered

Medicare covers the rental or purchase of durable medical equipment that has been prescribed by a physician and is medically necessary to treat a beneficiary's illness or injury. The equipment also must be reasonable relative to the expected benefit. Durable medical equipment is defined as equipment that (1) can be reused by other patients, (2) primarily serves a medical purpose, (3) is generally not useful to a person who is not ill or injured, and (4) is appropriate for home use. Nationwide, there are approximately 48,000 suppliers of durable medical equipment, ranging from local pharmacies to national supplier companies that bill Medicare.

Beneficiaries are responsible for paying 20 percent of Medicare's allowed charge[1] for the equipment. Also, if the equipment supplier does not accept Medicare's allowed charge as payment in full (known as taking assignment), the beneficiary is liable for the difference between Medicare's allowed charge and what the supplier charges.

The Social Security Act lists four categories of durable medical equipment covered by Medicare—hospital beds, wheelchairs, iron lungs, and oxygen tents. For Medicare to pay for other equipment, it must meet the definition of durable medical equipment and be safe and effective. Each equipment category covered by Medicare typically contains a number of different items. Some may be more expensive than others, depending upon the sophistication of the item and the features it contains. For example, the fee allowed for a hospital bed with electronic controls is greater than for one manually operated.

Depending upon which of six general Medicare payment groups it falls under, equipment may be rented and/or purchased. The groups are:

1. Inexpensive or routinely purchased equipment, which may be either rented or purchased;

2. Equipment requiring frequent and substantial servicing, which may only be rented;

3. Customized equipment, which is purchased;

4. Rented equipment for which monthly rental payments stop after a period of time, with only a maintenance payment made thereafter;

5. Oxygen and oxygen equipment, which may only be rented; and

6. Prosthetics and orthotics, which are purchased.

Prior to 1991, carriers calculated their own fee schedules, but beginning with 1991 Medicare is phasing in a national fee schedule system over a 3-year period. The schedule contains minimum and maximum fees for individual durable medical equipment items, exclusive of customized equipment and prosthetics and orthotics.

[1]The allowed charge includes Medicare's payment as well as the amount paid by the beneficiary to meet copayment and annual deductible requirements. After the beneficiary meets the annual deductible requirement, Medicare pays 80 percent of the allowed charge.

In 1990, Medicare-allowed charges for durable medical equipment were $2.1 billion, of which Medicare paid about $1.7 billion.

HCFA's Medicare Coverage Issues Manual identifies the categories of equipment eligible for Medicare payment nationally. It also usually describes the general medical conditions the beneficiary must have for the equipment to qualify for Medicare payment. When reviewing claims, carriers must apply HCFA's criteria but may supplement them with their own more detailed descriptions of qualifying medical conditions. If carriers receive claims for equipment not listed in the manual, they are to determine if the equipment qualifies for Medicare coverage and the medical conditions for payment.

Forms Used to Certify Medical Necessity

Both HCFA and carriers develop medical necessity certification forms to help carrier staff determine whether specific types of equipment are necessary and claims should be paid. The forms have two basic formats. Generally, they require the physician to either (1) provide a narrative explanation and justification for the beneficiary's need for equipment or (2) check off which of the statements of medical condition apply to the beneficiary. Regardless of format, forms typically require the physician to provide a diagnosis of the beneficiary's condition and an estimate of how long the equipment will be needed. Some forms are primarily intended to prevent unnecessary payment for equipment. Others ensure that physicians submit complete information with the claim, thereby saving the carrier from costly and time-consuming follow-up.

Upon receiving a claim, carrier staff determine if information, such as the beneficiary's name, address and identification number, is complete and correct and enter the claim information into a computer. Some claims, such as those that do not involve initial rental payment for a wheelchair, may be automatically processed if they pass certain computer edits and tests. Other claims, such as those involving purchase of a wheelchair that has been substantially modified, may be reviewed by trained claims examiners, nurses, or physicians to determine if the claim should be paid, denied, or suspended for lack of sufficient information.

Unnecessary Payments for Durable Medical Equipment

Unnecessary payment occurs when carriers pay for equipment that is not medically necessary, or is more costly than is medically necessary to treat the beneficiary. The HHS Office of Inspector General (OIG), which has issued a number of reports describing unnecessary payments for durable

medical equipment, has found several contributing factors. They include (1) suppliers, rather than physicians, completing medical necessity certification forms; (2) physicians approving equipment because the beneficiary requested it, not because the physician evaluated the beneficiary's medical need for it; and (3) suppliers waiving the beneficiary's copayment, which diminishes the beneficiary's incentive to question whether the equipment is needed.

Subsequent to these reports, the Congress directed the Secretary of HHS to require prior approval for certain equipment that had been subject to unnecessary payments. Under this provision, contained in the Omnibus Budget Reconciliation Act (OBRA) of 1990, HCFA is to develop and update a list of equipment subject to unnecessary payments. The Congress specified three equipment categories to be included on this list—seat-lift mechanisms,[2] transcutaneous electrical nerve stimulators (TENS),[3] and power- operated vehicles[4] —and any other equipment HCFA determined was subject to unnecessary payments. For each category on the list, carriers are to determine the medical necessity of the listed equipment in advance of a claim being submitted for processing.

Objectives, Scope, and Methodology

The Omnibus Budget Reconciliation Act of 1989 required us to (1) review the appropriateness of HCFA medical necessity coverage criteria for equipment that may be subject to unnecessary payments[5] and (2) determine whether standardized medical necessity certification forms could help reduce unnecessary payments. The act also required us to convene a panel of experts to advise us on these issues. The panel members we selected included a medical director from one carrier and an associate medical director from another carrier, two durable medical equipment supplier representatives, a physician specializing in geriatric medicine, and a representative of an organization representing Medicare beneficiaries.

[2]When used with a chair, the seat-lift mechanism helps a person to stand up or sit down without human assistance.

[3]This device, which usually resembles a portable transistor radio, generates an electrical pulse used to control chronic pain.

[4]These are battery-operated, three-wheeled, light-weight scooters that may be used by disabled people in the home.

[5]As agreed with the committees' staff, we did not include prosthetics and orthotics in the scope of our work.

Our work was performed at HCFA's headquarters in Baltimore, its regional office in Boston, the OIG in Baltimore, and three Medicare carriers—Blue Shield of Massachusetts, Inc., Blue Shield of Florida, Inc., and Pennsylvania Blue Shield. We also contacted seven other carriers—Aetna Life and Casualty (Arizona), Blue Shield of California, Empire Blue Cross and Blue Shield (New York), Nationwide Mutual Insurance Company (Ohio), EQUICOR, Inc. (North Carolina), EQUICOR, Inc. (Tennessee), and Blue Cross and Blue Shield of Texas, Inc.

In addressing our two objectives, we incorporated the views of carrier, OIG, and HCFA officials, as well as our expert panelists. These persons have first-hand knowledge and experience regarding Medicare's payment for durable medical equipment. Utilizing their expert advice was the most efficient and effective method for us to answer the questions raised by the Congress.

To assess the appropriateness of HCFA's medical necessity coverage criteria for equipment subject to unnecessary payments, we asked carrier officials and our expert panelists what standards HCFA's criteria should meet. We then applied these standards to HCFA's criteria for the equipment we identified as subject to unnecessary payments.

To determine if standardized medical necessity certification forms could help reduce unnecessary payments, we asked our expert panelists what characteristics would make a form effective. We then reviewed 37 forms provided by the 10 carriers and identified 22 forms that met the panelists' guidelines. These 22 were primarily for seat-lift chairs and TENS but also for power-operated vehicles and lymphedema pumps.[6]

For three forms, we used HCFA allowed-charge payment data to measure changes in payments for 1 or more years following their use by carriers. The three forms are used for TENS claims in New York, power-operated vehicle claims in Florida, and seat-lift chair claims in Texas. In addition, we contacted officials at the three carriers to determine if other factors, such as requiring that a nurse or physician rather than a claims examiner review claims, affected carrier payment for this equipment.

For one of two reasons, we did not analyze use of the other 19 forms that met the panelists' guidelines. In some cases, no HCFA payment data were available at the time we performed our analysis to determine changes in

[6]Lymphedema is the swelling of an arm or a leg caused by the accumulation of excessive lymph fluid. A lymphedema pump is an inflatable sleeve that fits over an arm or leg and helps move accumulated lymph fluid toward the heart.

payments for equipment for 1 or more years following implementation of the forms. In other cases, changes in the equipment covered by Medicare precluded an effective comparison of costs before and after the forms went into effect.

OBRA 1989 also required us to analyze HCFA's process for identifying equipment that should no longer be covered by Medicare. We found no problems with HCFA's process and, as agreed with the committees' staff, are conveying our findings on this issue in separate correspondence.

We conducted our review from August 1990 to August 1991 in accordance with generally accepted government auditing standards.

HHS provided written comments on a draft of this report. These comments are discussed in chapters 2 and 3 and included in appendix I. We also received comments from carrier medical directors and durable medical equipment supplier representatives who were members of our expert panel. These comments are presented and evaluated where appropriate.

Detailed HCFA Coverage Criteria Could Reduce Unnecessary Medicare Payments

As widely reported for years, unnecessary payment of durable medical equipment has cost Medicare millions of dollars. One factor in unnecessary payments is the lack of clear HCFA coverage criteria for carriers to use in determining if a claim should be paid or denied. In seven categories of equipment that are subject to unnecessary payments, HCFA's coverage criteria often do not define clearly the medical conditions for which payment should be made or when it is appropriate to pay for more expensive equipment to treat a beneficiary. As a result, Medicare is paying for equipment that is not medically necessary. By developing more specific criteria, HCFA could better ensure that carriers do not pay for medically unnecessary equipment, thereby saving Medicare funds. HCFA officials agree that more specific criteria would help reduce unnecessary payments.

Some Equipment Subject to Unnecessary Payments

Unnecessary payment of durable medical equipment costs the Medicare program millions of dollars annually. In some cases, beneficiaries receive equipment that they do not medically need. In other cases, they receive equipment that is more sophisticated than needed or equipment that contains features not medically necessary. Carriers identify unnecessary payments through complaints from beneficiaries and analysis of payment data. OIG and HCFA staff are also important sources for identification of equipment subject to unnecessary payments.

We identified seven equipment categories for which Medicare had experienced unnecessary payments—seat-lift chairs,[1] power-operated vehicles, TENS,[2] wheelchairs, hospital beds, decubitus care equipment,[3] and lymphedema pumps. To do so, we (1) interviewed carrier, OIG, and HCFA officials; (2) reviewed OIG reports on equipment subject to unnecessary payments; and (3) identified equipment categories where allowed charges increased by 50 percent or more from 1986 to 1988, indicating the potential for unnecessary payments, and where allowed charges for any one item within the category totaled $1 million or more in 1988.[4] For each equipment category, HCFA and OIG officials, plus at least 8 of the 10 carriers, agreed

[1]Although OBRA 1990 limited Medicare coverage to the lift mechanism beginning in 1991, we refer to this equipment throughout the report as seat-lift chairs because the problems cited occurred prior to the coverage change.

[2]We included TENS because HCFA plans to reclassify it from a prosthetic item to an item of durable medical equipment.

[3]This includes pads for wheelchairs and beds and other equipment, such as specialized mattresses, used by patients who have or are highly susceptible to decubitus ulcers of the skin, commonly known as bed sores.

[4]At the time of our analysis, 1988 data were the most recent available.

that the equipment was subject to unnecessary payments. In 1990, Medicare allowed charges for these seven categories totaled $514 million, or 25 percent of total Medicare equipment allowed charges for the year.

HCFA Coverage Criteria Create Potential for Unnecessary Payments

HCFA's coverage criteria for durable medical equipment are often vague and subjective. Generally, the criteria for the seven equipment categories we reviewed do not include information that our expert panelists and others believe is necessary. The criteria frequently fail to describe (1) the specific medical conditions for which equipment claims should be paid and their severity; (2) under what conditions Medicare should pay for more costly equipment that is more sophisticated than, or contains additional features not found on, the basic equipment needed to treat a beneficiary; or (3) the specific medical conditions that do not warrant Medicare equipment payments. The lack of clear, well defined HCFA criteria creates the potential for unnecessary payments because the criteria do not give carriers an objective basis for paying or denying claims. Each carrier is left to develop its own supplemental criteria, resulting in an inconsistent approach to preventing unnecessary equipment payments.

Wheelchairs and seat-lift chairs provide two examples of how HCFA's coverage criteria contribute to unnecessary Medicare equipment payments.

Medicare Payments for Wheelchairs

According to HCFA's criteria, wheelchairs are covered if the beneficiary otherwise would be bed- or chair-confined. Power-operated wheelchairs are covered if the patient's condition makes a wheelchair medically necessary and the patient is unable to operate the wheelchair manually. However, HCFA's criteria do not discuss the specific medical conditions that would result in a beneficiary being bed- or chair-confined. Nor do they define the specific medical conditions, and the severity of those conditions, that would render a beneficiary unable to operate a wheelchair manually.

Payment fees vary for the approximately 14 different types of wheelchairs covered by Medicare (see table 2.1). In 1990, Medicare's allowed charges for all wheelchairs and accessories totaled $177.8 million.

Table 2.1: National Maximum Monthly Rental Fees for Four Types of Wheelchairs

Fees based on 1990 dollars

Type of wheelchair	National maximum monthly rental fee
Light-weight	$ 52.03
Semireclining	75.81
High-strength, light-weight	91.14
Power-operated	282.22

Although the fees for different types of wheelchairs vary considerably, HCFA's criteria do not give carriers specific guidance on when to pay for the more expensive types covered by Medicare. Yet the carrier's payment decision on the type of wheelchair needed by a beneficiary can have a significant effect on Medicare costs.

The lack of specific HCFA coverage criteria for wheelchair accessories and customized wheelchairs billed by suppliers have resulted in unnecessary payments, carrier and HCFA officials reported. HCFA's criteria do not define when optional accessories, such as detachable arms or elevating leg rests are medically necessary. Yet these accessories add significantly to Medicare payments. The national maximum monthly rental fee of a standard wheelchair with these accessories is $65.26, or 79 percent more than the standard wheelchair without these accessories, which is $36.50 per month. Suppliers sometimes add accessories to the chair, a carrier official told us, thereby increasing Medicare costs. But without HCFA criteria with which to decide whether the costly accessories are medically necessary, carriers must develop their own supplemental criteria. This results in inconsistencies among carriers in preventing unnecessary payments.

Suppliers also have billed for customized wheelchairs when actually they only made certain modifications to one of the other types of wheelchairs covered by Medicare. To qualify as customized under HCFA's criteria, the wheelchair must be uniquely constructed or substantially modified for a specific patient and be so different that the customized wheelchair cannot be grouped with another type of wheelchair covered by Medicare. However, HCFA's criteria do not clearly distinguish the type or extent of the modifications that must be made to a wheelchair to classify it as customized. Instead, HCFA relies on the carriers to determine what constitutes a customized wheelchair and the medical conditions for payment. As a result, carriers have paid for customized wheelchairs, rather than for other types that are less expensive.

Medicare Payments for Seat-Lift Chairs

HCFA's criteria state that seat-lift chairs may be covered for patients with severe arthritis of the hip or knee or those with muscular dystrophy or other neuromuscular diseases when it has been determined that the patient can benefit therapeutically from its use. The severity of the condition must be such that the patient would otherwise be bed- or chair-confined. However, the criteria do not define "severe," which our expert panel told us may be interpreted in many different ways. Moreover, the criteria do not describe the specific other neurological diseases that would qualify for coverage or define conditions that are unacceptable for coverage. For example, an associate medical director at one carrier told us that HCFA's seat-lift chair criteria should preclude payment for patients with severe pulmonary disease, as such patients should be bed- or chair-confined. A HCFA official told us that HCFA is in the process of developing more specific criteria for this equipment category.

In a 1989 report,[5] the OIG concluded that HCFA's coverage criteria significantly increased one carrier's payments for seat-lift chairs by contributing to unnecessary payments for this equipment. A durable medical equipment supplier, using nationwide television and newspaper advertising and toll-free telephone numbers, was soliciting numerous orders from Medicare beneficiaries for this equipment, the OIG found. The supplier completed medical necessity certification forms for the beneficiaries' physicians, and some physicians signed them without fully evaluating the beneficiaries' need for the seat-lift chair. As a result of the supplier's activities, Medicare allowed charges for seat-lift chairs at this one carrier almost doubled between 1987 and 1988, from $26.5 million to $50.2 million. The increased payments were due in part to inadequate HCFA coverage criteria, the report said. Specifically, the criteria did not require physicians to perform medical tests that would objectively measure the beneficiary's medical need for the seat-lift chair, and provide a clearer basis for identifying and denying medically unnecessary claims.

More Detailed HCFA Criteria Favored by Expert Panel, Carriers

Our expert panelists and officials from the 10 carriers we contacted agreed that HCFA's development of more detailed coverage criteria could reduce unnecessary Medicare payments for durable medical equipment. HCFA's criteria should more clearly define what medical conditions qualify or do not qualify for Medicare coverage, the panelists said. Wherever possible, the criteria should contain objective measures for determining if a claim should be paid, they added. Also, more detailed criteria would provide for

[5]HHS, OIG, Audit of Medicare Part B Payments for Seat Lift Chairs to Queen City Home Health Care, Nationwide Mutual Insurance Company, Columbus Ohio, July 6, 1989.

more objective payment decisions among carriers for equipment subject to unnecessary payment, according to the panelists. Carrier officials said that more detailed criteria would better enable them to determine whether to pay or deny a claim.

As a basis for developing more specific criteria, HCFA could use criteria already prepared by carriers for equipment subject to unnecessary payment, our panelists said. They also proposed that HCFA convene a meeting of carrier medical directors to develop a consensus on additional criteria to follow when a pattern of unnecessary payments is first identified with a category of equipment. By so doing, the carriers could more quickly undertake a uniform action to prevent unnecessary payments while HCFA developed its more detailed criteria.

HCFA Acts to Reduce Unnecessary Equipment Payments

Aware that durable medical equipment is subject to unnecessary payments, HCFA has taken or announced a number of actions designed to forestall them. Additionally, HCFA officials agreed with us that criteria as detailed as possible would help prevent unnecessary equipment payments. They cautioned, however, that the criteria cannot be all-inclusive.

In 1989, HCFA began requiring suppliers to have a physician's prescription in hand prior to delivering seat-lift chairs, TENS, power-operated vehicles, and certain decubitus care equipment to a beneficiary. Without it, the carrier is not to pay the claim for such equipment. This requirement was intended to prevent suppliers from delivering to a beneficiary equipment that had not been ordered by a physician. In 1990, HCFA suggested that all carriers use medical necessity certification forms for seat-lift chairs and TENS and provided carriers with the suggested forms. The forms give carriers more detailed information with which to determine whether this equipment is medically necessary.

HCFA announced another initiative, to reduce unnecessary equipment payments that result from a supplier practice known as carrier shopping, in November 1991. Current Medicare policy allows suppliers to bill the carrier serving the area in which the point of sale occurs. Through various schemes, some suppliers have had their claims processed by carriers with less stringent coverage criteria or high payment fees, rather than the carrier where the beneficiary lives. Under HCFA's initiative, claims would be processed by the latter carrier.

In November 1991, HCFA proposed that it consolidate the processing of durable medical equipment claims, as well as claims for prosthetics, orthotics, and supplies, from 34 carriers to 4 regional carriers. This action will improve efficiency and reduce variance in equipment coverage policies among carriers, HCFA believes. HCFA indicated that it plans to issue its final regulation authorizing the designation of regional carriers by June 1992.

In addition to these actions, HCFA officials agreed with us that giving carriers more specific criteria could reduce Medicare costs for equipment subject to unnecessary payments and that the criteria should be as specific as possible for such equipment. However, listing all possible conditions for coverage could become unreasonable, they told us.

Conclusions

By developing more specific coverage criteria that clearly define conditions for payment, HCFA could reduce unnecessary payments for the seven equipment categories we reviewed. More specific HCFA criteria would give carriers a more objective and nationally uniform basis for deciding if equipment is medically necessary or more costly equipment is needed to treat the beneficiary. Currently, HCFA coverage criteria often do not provide carriers with this specific guidance and carriers use their own criteria for making payment decisions.

Recommendation

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to develop and issue specific coverage criteria for equipment HCFA identifies as subject to unnecessary payments.

Comments and Our Evaluation

HHS agreed that HCFA's current coverage criteria often do not provide carriers with specific guidance and that carriers use their own criteria for making decisions, but it did not agree or disagree with our recommendation. HHS noted that developing criteria that encompass all possible conditions for coverage would probably be an impossible task. It also pointed out that developing national coverage criteria would require publication of a notice to the public, an extremely lengthy and difficult process. However, HHS said that it believed some ongoing Department initiatives concerning durable medical equipment would help to make carrier decisions more uniform and are consistent with our recommendation. These initiatives include (1) establishing a medical directors' working group charged with developing model coverage criteria

for carriers to use, (2) establishing four regional carriers to process equipment claims, and (3) revising regulations to clarify existing equipment coverage policies that are now contained in manual instructions.

We agree that HHS's initiatives likely will result in more uniform decisions among carriers and that having the medical directors' working group develop model coverage criteria is a positive step towards correcting the problems that we identified. However, HCFA cannot ensure that carriers will use criteria developed by the medical directors' working group unless it requires carriers to use the criteria. Therefore, we believe that HCFA should promulgate regulations requiring all carriers to incorporate these criteria in their coverage decisions.

We recognize that HCFA cannot develop coverage criteria that contain all possible conditions for covering equipment subject to unnecessary payments. However, HCFA has already developed specific criteria for certain equipment that are consistent with our recommendation. We believe that HCFA can make its criteria for equipment subject to unnecessary payments more specific by better defining (1) the medical conditions and the severity of those conditions that warrant payment, (2) when to pay for equipment that is more costly or sophisticated than the basic equipment needed to treat a beneficiary, and (3) specific medical conditions that do not justify equipment payments. When developing its criteria, HCFA and the medical directors working group could draw upon the detailed criteria that individual carriers have developed for certain equipment.

Carrier medical director and equipment supplier representatives on our panel supported our recommendation.

Medical Necessity Certification Forms Result in Medicare Savings

One factor that contributes to unnecessary durable medical equipment payments is that physician's prescriptions often do not provide sufficiently specific information regarding the beneficiary's medical condition and why the equipment is needed. Requiring physicians to justify equipment by completing medical necessity certification forms is one way for carriers to obtain specific information needed to adjudicate claims.

Three carriers that developed and used their own medical necessity certification forms for equipment subject to unnecessary payments have saved significant amounts of Medicare funds. The forms, which are described in this chapter, are effective because they require physicians to explain and justify prescriptions for equipment and give carriers more detailed information with which to determine whether claims should be paid.

Recognizing the effectiveness of forms in reducing unnecessary Medicare payments, HCFA has suggested that carriers use forms requiring written physician justifications for two equipment categories subject to unnecessary payment. HCFA also plans to develop suggested forms for other equipment subject to unnecessary payments and issue them as instructions to carriers. It has not, however, decided on their format.

Forms Have Reduced Unnecessary Equipment Payments

Forms requiring narrative justifications are effective in reducing unnecessary equipment payments because they provide carriers more detailed information about the beneficiary's medical condition and equipment need, our expert panelists agreed. While forms based on the check-off format ("yes" or "no") also give carriers information needed to process a claim, they generally do not provide the same level of detail needed to determine if claims should be paid.

Of the 37 forms provided to us by the 10 carriers, 22 consisted primarily of questions requiring narrative physician justifications. Among these 22 forms, we identified 3 for which HCFA payment data[1] were available to measure changes in payments for 1 or more years following use of the forms. We could not evaluate the effectiveness of the other 19 forms because either

1. HCFA payment data were unavailable to determine changes in equipment payments for 1 or more years following the implementation of the forms, or

[1]Payment data throughout this chapter refer to allowed charges.

2. the forms went into effect at the same time HCFA began covering a more sophisticated and costly item of equipment. This precluded an effective comparison of costs before and after the forms became effective.

Among the three forms for which we analyzed payment data, two were developed when carriers noticed significant increases in equipment payments. These forms were used for (1) TENS claims in New York and (2) power-operated vehicle (that is, battery-operated, three-wheeled, light-weight scooter) claims in Florida. The Texas carrier developed a form for seat-lift chair claims in response to a HCFA concern about the effect on Medicare costs of mass marketing of this equipment to beneficiaries. HCFA and carriers recognize that these three equipment categories have been subject to unnecessary payments.

TENS Form Reduced Medicare Payments

After Empire Blue Cross and Blue Shield issued its medical necessity certification form for TENS in November 1988, payments for this equipment were significantly reduced. The TENS, which generates an electrical pulse to control pain, is covered by Medicare for beneficiaries with chronic intractable pain or for short-term use for postoperative pain.

The Empire Blue Cross and Blue Shield form gives carrier staff information they need to determine if HCFA's criteria have been met and if the equipment is medically necessary. As shown in figure 3.1, physicians must describe (1) the medical condition necessitating beneficiary use of the TENS, (2) the course of treatment used to alleviate pain before use of the TENS and the results of that treatment, and (3) all other major conditions for which the patient is being actively treated. This form replaced the carrier's prior TENS form that was based on the check-off format.

Figure 3.1: TENS Certification Form (Empire Blue Cross and Blue Shield)

TENS CERTIFICATION FORM

(PLEASE PRESS FIRMLY. THIS IS A THREE PART FORM) THIS FORM CAN NOT BE COMPLETED BY SUPPLIER OF EQUIPMENT

PATIENT INFORMATION (PRINT OR TYPE)		ATTENDING PHYSICIAN INFORMATION (PRINT OR TYPE)
PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)		PHYSICIAN'S NAME (FIRST, MIDDLE INITIAL, LAST)
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		PHYSICIAN'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
PATIENT'S MEDICARE NUMBER	ADDRESS ABOVE IS ☐ PATIENT'S HOME ☐ NURSING HOME ☐ OTHER	ATTENDING PHYSICIAN'S IDENTIFICATION NUMBER

TO BE COMPLETED BY PRESCRIBING PHYSICIAN. For Rental Only.

1. Are you the Attending Physician? YES ___ NO ___ If yes, how long _____ ?

   If No, please explain your involvement with the beneficiary: _____

   Diagnosis _____ Date last seen for this diagnosis before prescribing TENS. _____

2. What course of therapy or treatment was used to alleviate pain prior to using TENS? What were the results? _____

3. Condition for which TENS unit is prescribed? (Acute postoperative pain must include surgical procedure, date and place of surgery. Chronic pa must include a definitive diagnosis, anatomical location of pain and date diagnosis was established.)

4. List all other major conditions for which the patient is also being actively followed or treated.

PRESCRIBING PHYSICIAN INFORMATION (PRINT OR TYPE)	CERTIFICATION	
PHYSICIAN'S NAME	I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS PRESCRIPTION AND ARE MADE A PA HEREOF	
PHYSICIAN'S OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE)	SIGNATURE OF PRESCRIBING PHYSICIAN	
	PROVIDER IDENTIFICATION NUMBER	DATE SIGNED MM DD YY
	STATE LICENSE NUMBER	SPECIALTY

INSTRUCTIONS

RENTAL OF TENS

- Part 1 of the form should be completed by the prescribing physician. The supplier of the TENS Unit **CANNOT** comple the prescription form.
- Attach the completed prescription form (Part 1) to the claim form for submission.

PURCHASE OF TENS

- The prescribing physician must conduct a two-month evaluation to determine if the use of a TENS Unit on a long ter basis is appropriate.
- If the results of the evaluation indicate that long term use is appropriate, Part 2 of the form should be completed by tl prescribing physician. The supplier of the TENS Unit **CANNOT** complete the prescription form.
- Attach the completed prescription form (Part 2) to the claim form for submission.

CLAIMS SUBMISSION

- A seperate TENS Certification Form must be completed for the Rental and Purchase. Each form must be an origin Photocopies are not acceptable.
- The rental and Purchase Certification can be submitted with one claim form if the supplier wishes to bill both the rent and purchase on a single claim.

SUBMIT ORIGINAL FORMS ONLY. PHOTOCOPIES CAN NOT BE ACCEPTED.

PART 1 - YELLOW COPY - RENTAL ONLY PART 2 - PINK COPY - PURCHASE ONLY PART 3 - GOLDEN ROD COPY - PHYSICIAN RECORD COPY NOT ACCEPTABLE AS PROOF

Several factors prompted development of the form:

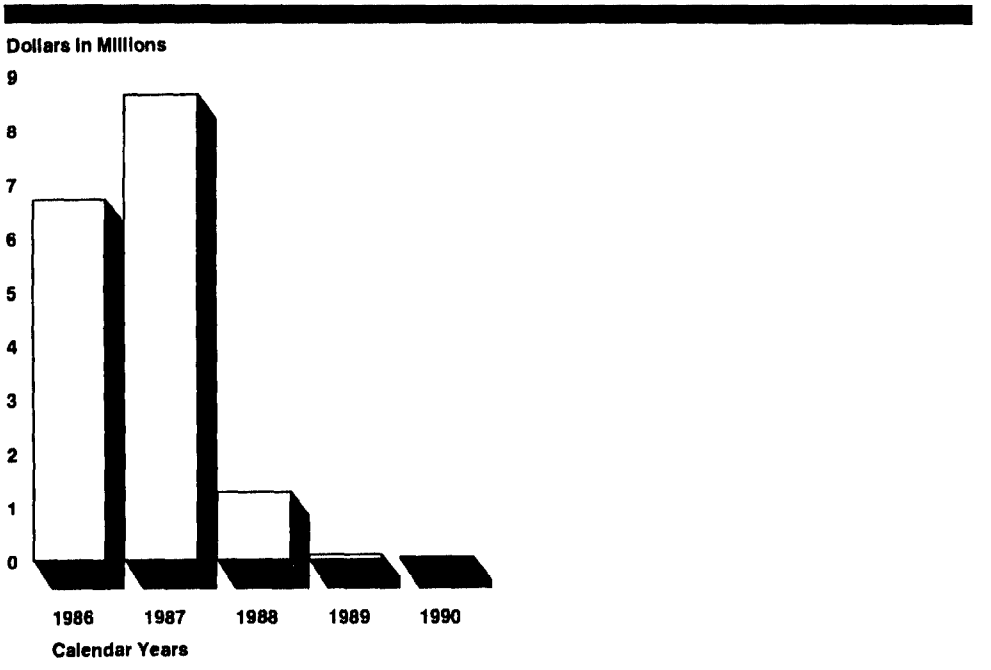
1. The carrier's payments for TENS increased by 28 percent in 1 year, from $6.7 million in 1986 to $8.6 million in 1987.

2. HCFA and the carrier had expressed concerns that many TENS claims paid for by Medicare were not medically necessary.

3. A Federal Bureau of Investigation inquiry found that a major local supplier of the TENS was altering the diagnoses and dates that the equipment was supplied to the beneficiary.

After introduction of the new form in 1988, the carrier's payments for TENS declined sharply, from $8.6 million in 1987 to $1.3 million in 1988, an 85-percent reduction (see fig. 3.2). Several other factors also contributed to lower payments. In 1987, the carrier significantly reduced its allowed fee for TENS; additionally it withheld payment on claims submitted by the supplier that was under federal investigation.

Figure 3.2: Payments for TENS by Empire Blue Cross and Blue Shield (1986-90)



During the first full year that the form was in effect, carrier payments for TENS decreased by an additional 93 percent, from $1.3 million in 1988 to $94,000 in 1989. TENS payments in 1990 by Empire Blue Cross and Blue Shield totaled $44,000, a further 53-percent reduction from 1989. A carrier official responsible for program safeguard activities attributed the sharp payment decline from 1988 to 1990 to use of the TENS form and to aggressive review and follow-up of information provided by physicians, which resulted in significant denials of TENS claims.

Form Covering Power-Operated Vehicles Also a Money Saver for Medicare

Another form that effectively reduced unnecessary Medicare payments was one implemented by Blue Shield of Florida in December 1988 to cover power-operated vehicles. These are three-wheeled, light-weight, battery-operated scooters that have a short turning radius, making them convenient for home use by beneficiaries. To qualify for Medicare payment, the beneficiary must be chronically disabled, have a medical need for a wheelchair, and be unable to operate a wheelchair manually. These same criteria apply to power-operated wheelchairs.

The carrier developed its form for several reasons:

1. The carrier's payments for power-operated vehicles had increased significantly between 1986 and 1987—from $56,000 to $1.5 million. During that time, television reports showed elderly people using this equipment outside their homes, such as on the golf course, raising carrier concern about unnecessary payments.

2. Suppliers were actively advertising this equipment to beneficiaries, stating that Medicare would pay for the equipment, thereby providing an incentive for beneficiaries to place an order. Also, physicians sometimes prescribed this equipment because they felt pressured by the beneficiary who had seen the equipment advertised, the OIG found, not because the physician had determined a medical need for it.

The form that Blue Shield of Florida developed gives staff information that helps them determine whether the beneficiary's medical condition meets HCFA's requirements for Medicare payment. As shown in figure 3.3, the form is two-part:

- Rx 1, which is completed for a variety of equipment categories, requires the physician to provide basic information about the beneficiary.

- Rx 3 requires the physician to provide specific information about the beneficiary's need for a power-operated vehicle, including (1) a description of the beneficiary's disabling conditions, such as amputation or paralysis; (2) a description of the circulation, neurological, and muscular status of the beneficiary's arms and legs not affected by amputation or paralysis and (3) identification of other medical conditions requiring use of a power-operated vehicle.

Figure 3.3: Power-Operated Vehicle Certification Form (Blue Shield of Florida)

[redacted]

DURABLE MEDICAL EQUIPMENT

MEDICARE PART B

Rx 1 **Required for All DME**

Dear Physician: *Cooperation in completing this form will insure that patient receives full Medicare considerati since reimbursement is based on the lease expensive medically appropriate equipment. Incomplete informat may result in a reduction or denial of claim and/or a delay in payment.*

1. PATIENT INFORMATION

Name: _____ HIC # _____ Telephone _____
Address: _____ City: _____ State: _____ Zip: _____

2. Dates equipment required: From _____ thru _____ - _____ Months

☐ Original Prescription ☐ Prescription Renewal Date of Rental/Purchase _____
Diagnoses _____ Date Last Seen: _____
ONSET OF DIAGNOSIS _____ SEVERITY _____ PROGNOSIS _____

3. PATIENT LOCATION

Home ☐ ACLF ☐
N H Resident ☐ ECF/SNF ☐
NH Patient ☐ Other ☐

NAME OF FACILITY: _____
ADDRESS: _____
_____ ZIP: _____
ADMISSION DATE: _____ DISCHARGE DATE: _____

4. WHAT IS THE PATIENT'S CONDITION CONCERNING MOBILITY:

a. Bed Confined? ☐ Yes ☐ No — If Yes check % of time 25 ☐ 50 ☐ 75 ☐ 100 ☐
b. Wheelchair Confined? ☐ Yes ☐ No — If Yes check % of time 25 ☐ 50 ☐ 75 ☐ 100 ☐
c. Ambulatory? ☐ Yes ☐ No — Assisted by Person ☐ Assisted Walker/Cane ☐ Outside Home ☐
d. Patient can ambulate more than 25 feet with walker or cane? ☐ Yes ☐ No
e. Room confined? ☐ Yes ☐ No
f. House confined? ☐ Yes ☐ No

5. GENERAL EQUIPMENT

	(SUPPLIER INDICATE CODE)		(SUPPLIER INDICATE CODE)
☐ a. Blood Glucose Monitor (Rx 2)	_____	☐ i. Seat Lift/Patient Lift (Rx 2)	_____
☐ b. Decubitus Care Equipment—Beds (Rx 4)	_____	☐ j. Sitz Bath (Rx 2)	_____
☐ c. Decubitus Care Equipment—W/C (Rx 3)	_____	☐ k. TENS/PENS (Rx 8)	_____
☐ d. Hospital Beds (Rx 4)	_____	☐ l. Traction/Trapeze (Rx 4)	_____
☐ e. Oxygen Equipment (Rx 6)	_____	☐ m. Wheelchairs (Rx 3)	_____
☐ f. Paraffin Bath (Rx 2)	_____	☐ n. Power Vehicles (Rx 3)	_____
☐ g. Pneumatic Compressors (Rx 2)	_____	☐ o. Other: _____ (Rx 1)	_____
☐ h. Respiratory Equipment (Rx 5)	_____	_____ (Rx 1)	_____

DESCRIPTION OF EQUIPMENT PRESCRIBED: _____

THE PHYSICIAN MUST COMPLETE RX ATTACHMENT AS NOTED.

RX MUST BE COMPLETED, SIGNED AND DATED BY THE ATTENDING PHYSICIAN FOR ADJUDICATION OF DME CLAIM.

Physicians Name and Address _____
_____
_____
Referring Physician: _____
Telephone No _____
Medicare Provider # _____

Supplier's Name and Address _____
_____
_____
Telephone No. _____
Provider # _____ EMC Sender # _____
Equipment is: ☐ New ☐ Used Warranty Years _____

I certify active treatment of this patient. This equipment is part of my course of treatment and is "**reasonable and medically necessary**", a is not a convenience item. To my knowledge the above information is accurate.

_____ _____
Attending Physicians HANDWRITTEN Signature Date

1402-1288SR

DURABLE MEDICAL EQUIPMENT
Medicare Part B

Rx 3 — WHEELCHAIRS POWER VEHICLES

SUPPLIER INFORMATION
Purchase/Rental Date: _____
Supplier/Provider No.: _____
EMC Sender Number: _____

Patient's name: _____ HIC # _____

1. Does Patient now own or rent any wheelchair? ☐ Yes ☐ No Date purchased or rented _____
   a. If Yes, indicate brand name and model number: _____
   b. List features of present wheelchair: _____

ALL WHEELCHAIRS

1. Is Patient's condition such that alternative would be bed or stationary chair confined? ☐ Yes ☐ No
2. Can Patient walk more than 25 feet with a cane or walker? ☐ Yes ☐ No
3. Is patient capable of operating standard wheelchair; or ☐ Yes ☐ No
   capable of operating a manual one-arm drive wheelchair? ☐ Yes ☐ No
4. List any special features required and reason for need: _____

POWER OPERATED ELECTRIC

INDICATE BRAND NAME AND MODEL NUMBER _____

5. A. **Documentation for Amputees:** Date of amputation: _____
   a. Location, type and reason for amputation(s): _____
   b. Does Patient use prosthesis? ☐ Yes ☐ No — Explain: _____
   c. State physical condition of all remaining extremities, including circulation, neurological, muscular status, etc. _____

   B. **Documentation for Paralysis Patients:** Date of onset: _____
   a. Location and type _____
   b. State physical condition of all remaining extremities, including circulation, neurological (sensory and motor), muscular status, etc. _____
   c. Level of Cord Lesion _____
   d. Has Patient received rehabilitation? ☐ Yes ☐ No
   Date: _____ Name/Address of Institution: _____
   e. Prognosis: _____

   C. Documentation of other conditions requiring use of Power Operated Vehicle: _____

6. Is Patient's peripheral/perceptual vision sufficient to operate power vehicle safely? ☐ Yes ☐ No

DECUBITUS CARE EQUIPMENT

1. Does Patient have or is Patient susceptible to decubitus ulcers? ☐ Yes ☐ No

RX MUST BE COMPLETED, SIGNED AND DATED BY THE PRESCRIBING PHYSICIAN FOR ADJUDICATION OF DME CLAIM.

I certify active treatment of this Patient. This equipment is part of my course of treatment and is "reasonable and medically necessary", and is not a convenienc item. To my knowledge, the above information is accurate.

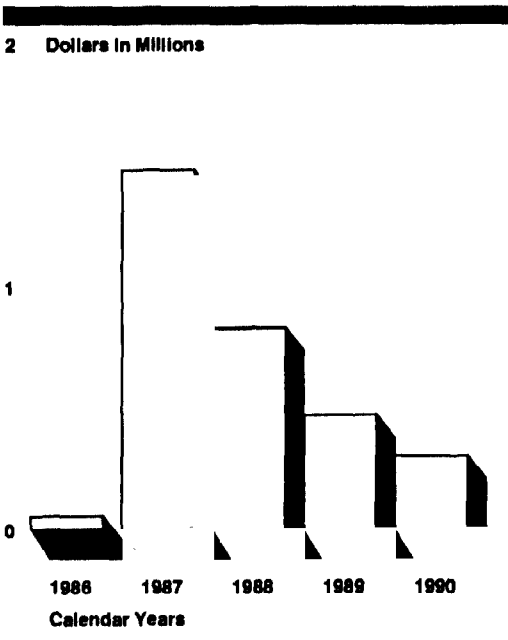
_____ _____
Prescribing Physician's Handwritten Signature Date

THIS FORM MUST BE ACCOMPANIED BY FORM RX 1

7425-1288SR

Between 1988 and 1989, the first full year the form was in effect, the carrier's payments for power-operated vehicles decreased by 43 percent, from $828,000 to $472,000 (see fig. 3.4). Payments decreased by an additional 36 percent between 1989 and 1990, to $303,000. The sharp decline in these 2 years was attributed by a carrier official to two factors. The first was use of the form, which resulted in greater claims denials and eventually fewer claims for this equipment. The other factor was use of registered nurses, rather than claims examiners, to review claims for this equipment. As they are more highly trained, registered nurses are better able to determine if information provided by the physician justifies Medicare payment for a power-operated vehicle.

Figure 3.4: Payments for Power-Operated Vehicles by Blue Shield of Florida (1986-90)



Seat-Lift Chair Form Reduced Medicare Payments

A third medical necessity form, one targeted at seat-lift chairs and implemented by Blue Cross and Blue Shield of Texas, Inc., in February 1986, also saved Medicare money. This equipment helps beneficiaries to stand or sit without human assistance. Prior to January 1991, Medicare paid for seat-lift chairs for beneficiaries with severe arthritis of the knee or hip or for those with muscular dystrophy or other neurological diseases when they could benefit therapeutically from the chair. The chair had to be included in the physician's course of treatment. Further, Medicare required that the chair likely would effect improvement, or arrest or retard

deterioration in the beneficiary's condition, and that the severity of the condition was such that the alternative would be bed or chair confinement. Since January 1991, Medicare has paid for the seat-lift mechanism only.

The carrier developed the form in response to a HCFA notification that suppliers were mass-marketing seat-lift chairs directly to beneficiaries. By creating beneficiary-generated demand for the chair, the promotion resulted in an increase in carrier payments of almost 500 percent between 1985 and 1986, from $755,000 to $3.5 million.

After implementing its form, the carrier found that suppliers rather than physicians were completing it. A beneficiary would then present the completed form to a physician for signature to enable Medicare payment. In response to this situation, the carrier in 1987 did the following:

- Incorporated into the form a statement that the carrier had access to the physician's medical records for subsequent review. This served as a warning to the physician that the carrier might follow up on claims to ensure that the seat-lift chairs were medically necessary. The carrier also added several questions concerning the beneficiary's medical need for the seat-lift chair.
- Instituted a policy requiring a nurse's review of seat-lift chair claims and forms.
- Began calling physicians and beneficiaries to verify information contained on the form.

Like the other two carrier forms, the seat-lift chair form is designed to give Blue Cross and Blue Shield of Texas staff the information they need to determine if the claim is payable. As figure 3.5 shows, physicians must respond in writing to a number of questions, including (1) how long has the beneficiary been treated and for what medical diagnosis, (2) what is the therapeutic value of the seat-lift chair to the beneficiary, (3) can the beneficiary walk when in a standing position, and (4) what is the beneficiary's treatment program and how has it affected the beneficiary's diagnosis?

Figure 3.5: Certification of Medical Necessity for Seat-Lift Chair Form (Blue Cross and Blue Shield of Texas)

Form Approved
OMB No.0938-0222

CERTIFICATION OF MEDICAL NECESSITY FOR SEAT LIFT CHAIR

1. Supplier _____
2. Beneficiary Name _____
3. HIC _____

   Address _____

   Telephone Number _____
4. How long have you been the attending physician? _____

   If not the attending physician, please explain your involvement with the beneficiary: _____
5. What is the diagnosis that warrants the need for a seat lift chair?
6. How long have you been treating the beneficiary for this diagnosis?
7. Date last seen for this diagnosis _____
8. Describe the current treatment program and its effect on the diagnosis listed above _____
9. Is rehabilitation part of the program? Explain: _____
10. What is this seat lift chair's therapeutic value to the beneficiary?
11. Can/Does the beneficiary ambulate when in a standing position?

12. Can the beneficiary get out of a conventional chair without assistance?

_____

13. How does the beneficiary get up out of the chairs in your office? ___

_____

14. Since some of the same muscles are used in rising and walking, please explain why the beneficiary is chair/bed confined but can ambulate.

_____

_____

_____

15. How many weeks or months do you expect the patient will need the seat lift? _____

As attending physician, you may wish to provide additional information regarding your treatment of this Medicare beneficiary. A page may be attached to this form for this purpose. Please date and sign any attachment.

I certify that the aforementioned is correct. I understand that intentional misrepresentation of diagnoses, services, or medical necessity documentation hereby submitted, constitutes fraud and may be subject to prosecution and/or imposition of civil money penalties by the federal government. My medical records are available for review at the following address:

Please Print

Physician's Name _____

Physician's Address _____

_____

Office Telephone Area Code ( ) _____

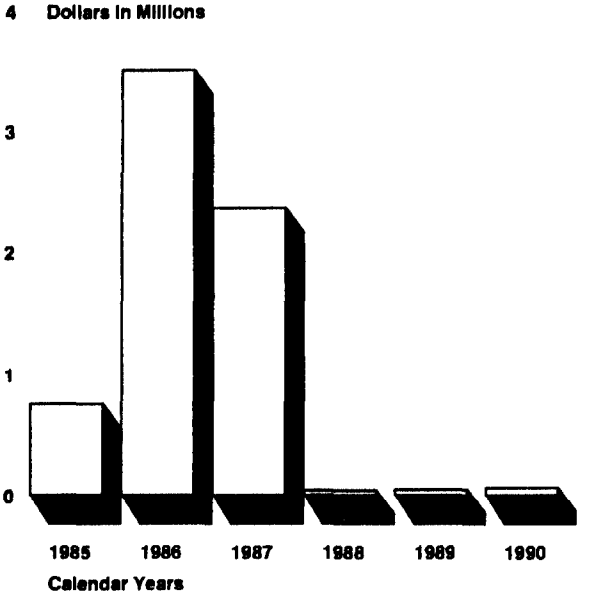
Office Hours _____

_____	_____	_____
Prescribing Physician's Signature	Physician's Medicare Provider Number	Date Signed

_____
DATE PRESCRIBED

Between 1986 and 1987, the carrier's payments for seat-lift chairs declined by 31 percent, from $3.5 million to $2.4 million (see fig. 3.6). This was the first year that both the form and intensified medical review of seat-lift chair claims were in effect. In 1988, payments decreased to $36,000, a 98-percent reduction from 1987; they have averaged $51,000 for 1989 and 1990. The form and intensified medical review resulted in increased denials and decreased payments for seat-lift chairs in Texas, a carrier official said. In addition, use of the form and the increased denials contributed to cessation of operations in the state by a major supplier of seat-lift chairs during 1987, according to the official.

Figure 3.6: Payments for Seat-Lift Chairs by Blue Cross and Blue Shield of Texas (1985-90)



HCFA Encourages Carriers to Use Forms to Reduce Unnecessary Payments

HCFA recognized that medical necessity forms requiring narrative physician justifications are effective in reducing Medicare expenditures on equipment subject to unnecessary payments. Accordingly, it suggested that carriers use forms that follow this format for two categories of equipment—seat-lift chairs and TENS—where unnecessary payments had been identified. HCFA also plans to develop additional suggested forms that carriers should use for other equipment subject to unnecessary payments and to issue the suggested forms as instructions to carriers. It has not, however, decided on what format these suggested forms should follow.

Carrier officials and our expert panelists support HCFA's development of forms that require the physician to justify why equipment is medically necessary.

When HCFA instructed carriers in June 1990 to consider using medical necessity forms for the two equipment categories, its instructions contained the questions and other information that carriers should incorporate in their forms. HCFA patterned the suggested forms after those developed by Blue Cross and Blue Shield of Texas for seat-lift chairs and by Empire Blue Cross and Blue Shield for TENS, described above. Both forms require written physician justifications. They were the most comprehensive and detailed of those prepared by carriers for these two equipment categories, according to a HCFA official.

Rather than issue a standard form, HCFA chose to provide instructions to carriers. By doing so, HCFA allowed carriers to tailor their forms to their local medical policy and the extent of the unnecessary payments the carriers experienced with these two equipment categories.

HCFA will pursue a similar course in developing suggested medical necessity forms for other equipment subject to unnecessary payments. In November 1991, HCFA convened a durable medical equipment working group to help develop form requirements. Once these requirements have been prepared, HCFA plans to issue the suggested forms as instructions to carriers, just as it did for its suggested seat-lift chair and TENS forms. As of May 1992, HCFA had not decided whether these suggested forms will require physicians to provide narrative justifications about the beneficiary's medical need for equipment or to check off statements of medical condition contained on the form.

Officials from all 10 carriers we contacted agreed that HCFA-developed forms for equipment subject to unnecessary payments should require the physician to describe the therapeutic value of the prescribed equipment and that these forms could save Medicare funds. Our expert panelists also agreed that HCFA's forms should require the physician to supply narrative explanations about the beneficiary's medical condition.

Conclusions

HCFA can save Medicare expenditures on durable medical equipment subject to unnecessary payments by developing medical necessity certification forms that require physicians to justify in writing why equipment is medically necessary. For the three carrier-developed forms

using this format that we analyzed, Medicare payments decreased significantly following their implementation. Given the detailed information provided by physicians, carriers could better determine if beneficiaries had a justified medical need for the equipment and if claims should be paid. HCFA has instructed carriers to consider using forms of this type for two categories of equipment subject to unnecessary payments. It plans to develop additional suggested forms for equipment subject to unnecessary payments and, as before, issue them as instructions to carriers rather than as standard HCFA forms. However, the format for these suggested forms has not yet been determined.

Recommendation

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to require that the medical necessity certification forms being developed by HCFA for equipment subject to unnecessary payments require physicians to provide detailed narrative justification documenting the medical necessity for the prescribed equipment.

Comments and Our Evaluation

HHS generally disagreed with our recommendation, stating that we did not provide convincing evidence to show that medical necessity forms that require narrative justifications are the preferred approach to solving abuses in the durable medical equipment area. HHS stated that other factors we cited were of equal or greater importance in reducing equipment payments at the carriers that used forms. HHS believes that there are alternative, more effective means for preventing unnecessary payments that would consume fewer administrative resources, impose less of a paperwork burden on physicians, and be consistent with the Department's efforts to promote electronic claims processing. These other means would allow carriers to (1) target their medical review actions against providers and medical equipment suppliers that abuse the program and (2) quickly adjust their operations to changing circumstances. Where forms are to be used by carriers, HHS said that carriers must have the option to use a form based on a check-off format because these forms can facilitate electronic claims processing and save administrative costs.

Our recommendation is consistent with HCFA's prior development of medical necessity forms for seat-lift chairs and TENS that required physicians to provide narrative justifications. HCFA recommended in June 1990 that all carriers use this type of form to reduce unnecessary payments for these two equipment categories. Also, officials from all 10 carriers we

contacted support the use of forms that require narrative responses from physicians because such forms are effective in reducing unnecessary payments.

Our recommendation was not intended to impose paperwork requirements on physicians or hinder HCFA's efforts to promote electronic claims processing. Rather, our intention was to extend an existing HCFA practice, which requires all carriers to use forms requiring narrative physician explanations for seat-lift chairs and TENS, to other situations where HCFA decides that a form could reduce unnecessary equipment payments.

Although we found that medical necessity forms requiring narrative physician justifications were effective in reducing unnecessary payments, we recognize that such forms are not the only approach to reducing equipment abuses. Using this type of form is but one means of preventing unnecessary payments, and we note in our report other tools that HCFA has used or is proposing to use. We agree with HHS that other tools, such as intensified medical review, contributed to reduced carrier payment for TENS, power-operated vehicles, and seat-lift chairs. However, we pointed out that the three carriers specifically developed their forms as a means to reduce unnecessary payments and that carrier officials believe that their forms were the key reason for the decrease in payments. Although the carriers also intensified their medical review of equipment claims, it was the detailed information on the completed forms that enabled carrier staff to better determine if payment was justified or should be denied.

We also agree that the alternative means HHS suggests to prevent unnecessary equipment payments would likely help carriers. However, our recommendation addresses those cases where HCFA decides a form should be used and does not preclude HHS initiating other means aimed at solving abuses in the durable medical equipment area.

Our panelists were divided in their views on our recommendation. The two carrier medical directors agreed that forms requiring narrative physician responses are an effective way for physicians to communicate with the carrier about why a beneficiary needs equipment and to reduce unnecessary payments. Panelists representing medical equipment suppliers disagreed with our recommendation, stating that forms requiring a narrative response would not effectively control unnecessary payments or limit program costs. They believe that the effects of increased OIG scrutiny, federal indictments, and negative media coverage may have had

more to do with reduced Medicare payments at the three carriers than the carriers' use of forms.

We disagree with the equipment suppliers' views. As we discussed above, carriers believe that their forms were the key reason for reduced equipment payments. Also, HCFA has endorsed forms requiring narrative responses from physicians as a means to reduce unnecessary payments for two equipment categories.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 21 1992

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments"

Overview

In response to concern that Medicare is needlessly spending money on durable medical equipment (DME) that beneficiaries do not medically need, Congress required GAO to: review the appropriateness of the medical necessity criteria developed by the Health Care Financing Administration (HCFA) for equipment subject to unnecessary payments; and determine whether standardized medical necessity certification forms could help reduce unnecessary payments.

According to GAO, HCFA could reduce Medicare expenditures on equipment subject to unnecessary payments by developing more detailed coverage criteria that provide carriers with a clear, well defined, and objective basis for paying or denying claims. In addition, GAO believes HCFA could save Medicare funds by developing medical necessity certification forms for equipment subject to unnecessary payments that require physicians to provide narrative explanations that justify the beneficiary's medical need for the prescribed equipment. GAO found that Medicare payments for three types of equipment decreased significantly at carriers that developed this kind of form because carriers received detailed information that resulted in their denial of claims.

The Department announced in November of 1991, a package of initiatives that includes regulatory and legislative proposals, as well as a variety of administrative activities with respect to DME, prosthetics, orthotics, and supplies. These activities and proposals are aimed at deterring the incidence of abusive practices in furnishing this equipment and establishing more reasonable payment amounts.

We believe that some of the activities being undertaken by HCFA as part of this initiative are consistent with the recommendations being made by GAO. For example, HCFA has established two work groups comprised of medical directors, one for DME and one for prosthetics and orthotics. These work groups will be required to examine the 100 most used and/or abused items and develop model coverage and medical review processes for these items. The work groups will also be examining documentation requirements and establishing model certificate of medical necessity forms to be used by the carriers.

In addition, a final regulation will be issued shortly that will establish four regional carriers to process claims for DME, prosthetics, orthotics, and other supplies.

GAO Recommendation

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to develop and issue specific coverage criteria for equipment HCFA identifies as subject to unnecessary payments.

Department Comment

We agree that current coverage criteria often do not provide carriers with specific guidance and carriers use their own criteria for making decisions.

It is not clear how detailed GAO wants HCFA to be in issuing specific coverage criteria. We would like to point out, however, that the development of coverage criteria that encompasses all possible conditions for coverage and noncoverage is probably an impossible task. Furthermore, in most cases, national coverage criteria would require publication of a notice to the public, which is an extremely lengthy and difficult process.

We believe that the following activities which are already underway will help to make carrier decisions more uniform:

- As stated above, HCFA has established two medical directors' work groups charged with the task of assisting all Medicare medical directors in developing more consistent coverage policies, local medical guidelines, documentation requirements, and prepayment screens for some of the most problematic high-dollar DME, prosthetic, orthotic, and supply codes.

- We believe that consolidating from 34 to 4 carriers will result in more consistent coverage policy, utilization review, and documentation requirements. This initiative will help rectify some of the carrier inconsistencies in coverage by fostering the development of region-wide medical review guidelines.

- We are also in the process of revising regulations at 42 CFR 410.38 to clarify existing policies pertaining to the scope and conditions applicable to coverage of DME. The regulations as revised would include many of the coverage requirements regarding DME that are

now only found in manual instructions. By describing and clarifying these requirements in the regulations, we will strengthen the legal defensibility of our coverage policies and provide greater assurance that payment is only made for items intended by the DME benefit. This effort will also assist carriers in making more consistent medical necessity determinations on coverage of DME under Medicare.

GAO Recommendation

GAO recommends that the Secretary of Health and Human Services direct the Administrator of HCFA to require that the medical necessity certification forms being developed by HCFA for equipment subject to unnecessary payments require physicians to provide detailed narrative justification documenting the medical necessity for the prescribed equipment.

Department Comment

We do not agree that GAO has brought forth convincing evidence to show that medical necessity forms which require narrative justifications are the preferred approach to solving abuses in the DME area. At best, GAO has shown that such forms may have had some role, in combination with other factors, in resolving a limited number of local problems in the past.

GAO analyzed the possible effects of 3 forms (1 each at 3 carriers) by reviewing payment data for specific items before and after implementation of the forms. Aside from the fact that GAO reviewed a small, nonrandom sample (dozens of forms were not considered for various reasons), there are a number of problems in GAO's use of data to draw conclusions. The primary problem is that GAO attributes most of the observed reduction in payments made by the 3 carriers to the use of the forms, even though other factors were of equal or greater importance. GAO acknowledges some of these other factors, but does not analyze their effects, nor is its list of additional factors exhaustive.

For example, GAO acknowledges that the carriers involved became more stringent generally in their application of existing coverage requirements at the same time that the forms were implemented. The New York carrier began to "aggressively" contact physicians and beneficiaries about their claims for transcutaneous electrical nerve stimulators (TENS) equipment, and reduced the Medicare allowances. The Florida and Texas carriers began to use registered nurses to review claims for power-operated vehicles and seat lift chairs, respectively. Other factors, such as increased Office of Inspector General

scrutiny of these abused items, and Federal indictments initiated against fraudulent suppliers, helped to reduce the number of claims for the items reviewed by GAO. We believe that all of these factors also had a role in eliminating the abuses studied by GAO.

We believe that there are more effective ways to handle DME abuses that will, at the same time, consume fewer administrative resources and impose less of a paperwork burden on physicians. In general, we believe that GAO should consider the advantages of a targeted medical review strategy over its recommended approach. In this regard, we would like to point out that the Department has proposed to give the carriers flexibility to use prior authorization for either selected items of DME that have been subject to abuse or for individual suppliers that have engaged in abusive practices. If given this authority, carriers could target medical review resources to known problem areas and yet retain the ability to quickly adjust their operations to changing circumstances.

The prior authorization strategy would also be more consistent with the Department's efforts to promote electronic claims processing. Similarly, we believe that, in those cases where medical necessity certification forms are to be used by carriers, carriers must have the option to use a "check-off style" form to facilitate electronic claims processing. (Of course, this check-off form could always be supported by a requirement that the physician's written prescription must always be on file.) Forms with "check-off" boxes or scale indicators can be efficiently accommodated into the electronic media claims environment, resulting in substantial administrative cost savings. Forms which require a narrative response are far less amenable to electronic transmission; as a result, such forms entail high data entry and handling costs for the carriers. GAO's panel of experts, which supported narrative medical necessity certifications, did not, to our knowledge, provide GAO with any data on the cost and paperwork implications associated with the narrative form approach.

Finally, there may be some instances in which it is appropriate to require narrative responses from physicians. In such cases, we believe that carriers should have some flexibility in implementation, and avoid over-reliance on the use of "buzz words." For example, GAO is correct in noting that, in the case of seat lift chairs and TENS, HCFA has asked the carriers to consider using a list

of suggested questions in their medical necessity certification forms. However, the carriers have the discretion to omit questions, or augment the list with additional questions, in keeping with their local medical policy requirements.

In summary, we believe that medical review strategies, such as prior authorization, which allow carriers to target their review are preferable to across-the-board documentation requirements. In those cases where medical necessity certification forms are used by carriers, we believe that the forms used should be compatible, to the maximum extent possible, with electronic claims processing.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Janet L. Shikles, Director, Health Financing and Policy Issues, (202) 512-7119 John C. Hansen, Assistant Director, (202) 512-7114
Boston Regional Office	Robert Dee, Evaluator-in-Charge Thornton Harvey, Senior Evaluator Stephen Licari, Evaluator

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