

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**ORDERING MEDICARE EQUIPMENT  
AND SUPPLIES**

**Physicians' Perspectives**



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Inspector General**

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# EXECUTIVE SUMMARY

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## PURPOSE

To report perceptions of physicians about the process of ordering medical equipment and supplies for their Medicare patients.

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## BACKGROUND

In general, Medicare recognizes the physician as the key figure in determining the appropriate utilization of all medical services. Accordingly, Medicare requires that payment for certain non-physician services, such as medical equipment and supplies, are conditional on the existence of a physician's order or certificate of medical necessity which must be kept on file by the supplier.

We are undertaking a series of studies to look at the role of the physician in certifying these non-physician services. This first report is about physicians' perceptions of the certification process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). A subsequent report will look at whether the relationship between the physician and the patient affects the certification of the medical equipment and supplies provided. We based this report on the analysis of questionnaires sent to physicians who certified a sample of 1000 medical equipment or supply items.

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## FINDINGS

### **Two-thirds of Physicians Are Satisfied With the Current Process of Ordering Medical Equipment and Supplies; One-fifth Are Not**

When asked to describe their level of satisfaction with the current Medicare process of ordering medical equipment and supplies, two-thirds of physicians (68 percent) say they are either satisfied or very satisfied with the current process. Approximately one-fifth (22 percent) of physicians are either dissatisfied or very dissatisfied with Medicare's ordering procedure. Regardless of satisfaction, many physicians suggested changes such as making the ordering process easier and less time consuming.

## **Information About Medicare Requirements Plays a Significant Role in Physician Satisfaction Rates**

Seventy-nine percent of physicians who report receiving sufficient information about the requirements for ordering medical equipment or supplies are satisfied. Of physicians who report not receiving enough information, only 46 percent are satisfied. Almost one-quarter of physicians surveyed requested additional information about the ordering process. The most commonly requested information includes more detailed rules and specific criteria regarding Medicare coverage and eligibility. Seventy-five percent of physicians reported they have never received any educational materials from their Medicare carrier concerning the equipment and supply ordering process.

## **Medical Specialty Also Plays a Role**

Pulmonary disease specialists express the most dissatisfaction with the process. Almost one-half (43 percent) of them are dissatisfied as compared to the overall dissatisfaction rate of 22 percent.

## **Half of Physicians View the Certificate of Medical Necessity as Effective; One-fifth Do Not**

While 56 percent of physicians say the certificate of medical necessity is effective, 21 percent say it is not effective and another 23 percent don't know. Physicians view the certificate of medical necessity as an effective monitor of fraud and abuse and quality of care. Sixty-seven percent of physicians report that on the average, it takes less than 15 minutes to complete and sign a certificate. Another 31 percent report that this procedure takes somewhere between 15 and 30 minutes.

## **Some Physicians Have Sometimes Refused to Sign Certificates of Medical Necessity**

Fifty-two percent of physicians say they have at some time refused a request to sign a certificate of medical necessity; however, two-thirds of these physicians say this rarely happens. Of the physicians who have refused to sign a certificate, the supplier has initiated the request approximately one-half of the time. The predominant reason physicians refused to sign these requests is because the patient did not need the equipment or supplies listed on the certificate. Additionally, physicians say their refusal is often because they did not know the patient.

## Some Have Encountered Problems When Ordering Medical Equipment and Supplies

Twenty-one percent of physicians encounter problems when they order medical equipment and supplies for their patients. Among these physicians, the problems include inappropriate equipment and supplies, upgrading and downgrading of equipment and supplies, and patients getting the wrong equipment and supplies. Further, physicians also see unclear rules for ordering medical equipment and supplies as a problem.

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### RECOMMENDATION

We recommend that the Health Care Financing Administration strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies. The following approaches are suggested:

- ▶ directing the carriers to furnish all physician providers with information about ordering medical equipment and supplies including any OIG Fraud Alerts. Of particular interest is the OIG Fraud Alert on Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services which specifically highlights physicians' responsibilities in making certifications for durable medical equipment and supplies, and the legal significance of the certifications. A copy of this fraud alert may be found in Appendix D;
- ▶ routinely providing all physicians with any changes of coverage and payment rules for medical equipment and supplies;
- ▶ providing all physicians with a contact person at the carriers to answer questions about equipment or supplies; and
- ▶ assuring that all certificates of medical necessity sent from the suppliers to physicians include the coverage and payment rules and cost of the equipment for the specific equipment or supplies ordered.

### COMMENTS

We received comments on the draft report from HCFA. They generally concur with our recommendation. Based on their comments we changed one of the suggested approaches in our recommendation on providing physicians with information about ordering medical equipment and supplies by expanding it to apply to all physicians not just new ones. The HCFA's comments are reproduced in Appendix E.

We also received comments from the Assistant Secretary for Planning and Evaluation (ASPE). We changed the wording of another of our suggested approaches in the recommendation to clarify that the information about coverage and payment rules had to do with the specific equipment and supplies ordered rather than general guidelines.

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# INTRODUCTION

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## PURPOSE

To report perceptions of physicians about the process of ordering medical equipment and supplies for their Medicare patients.

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## BACKGROUND

In general, Medicare recognizes the physician as the key figure in determining the appropriate utilization of all medical services. Accordingly, Medicare requires that payment for certain non-physician services, such as home health agency, therapy and diagnostic services, as well as medical equipment and supplies, are conditional on the existence of a physician's order. According to Medicare regulation 42 CFR Section 424, the provider of these services is generally responsible for obtaining the physician certification and re-certification statements, and for keeping them on file for verification.

We are undertaking a series of studies to look at the role of the physician in certifying these non-physician services. This first report is about physicians' perceptions of the certification process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). This includes: wheelchairs and hospital beds; prosthetics and orthotics; catheters, ostomy, incontinence, enteral and parenteral nutrition, and wound care supplies. For the purposes of this report, we will refer to DMEPOS as medical equipment and supplies. A subsequent report will look at whether the relationship between the physician and the patient affects the certification of the medical equipment and supplies provided.

### **Medicare Expenditures for Medical Equipment and Supplies**

According to published Health Care Financing Administration statistics (HCFA), in 1995, Medicare paid an estimated \$4.7 billion for medical equipment and supplies under part A and part B of the program. Part A, hospital insurance, covers services which are furnished by hospitals in an inpatient setting, home health agencies, and skilled nursing facilities. Part B, supplementary medical insurance, covers a wide array of non-institutionalized care. These include physician services, medical equipment and supplies, outpatient hospital services, diagnostic laboratory tests, x-rays, and ambulance services.



The HCFA administers Medicare and contracts with private insurance companies to process and pay claims. Contractors that process claims for Part A, such as those for home health agency services, are considered fiscal intermediaries. Contractors that process claims for Part B, such as those for medical equipment and supplies, are considered carriers.

## **Medicare Durable Medical Equipment Regional Carriers**

In October 1993, HCFA began processing claims for medical equipment and supplies through four Durable Medical Equipment Regional Carriers (DMERCs). These four carriers are responsible for all 50 States, the District of Columbia, and Puerto Rico. These entities are responsible for ensuring that coverage requirements are met before approving payment. Although fiscal intermediaries also process some claims for medical equipment and supplies through the Part A coverage of home health agency services, this report will focus only on medical equipment and supplies that are covered by Part B and are processed by the DMERCs.

## **Certification of Medical Equipment and Supplies**

Medicare pays for medical equipment and supplies that are ordered or prescribed by a treating physician and are appropriate for the patient's diagnosis and symptoms as determined by the DMERCs. Suppliers must obtain and keep on file a physician's order or prescription for all the medical equipment and supplies they bill to Medicare.

In addition to HCFA's requirement that suppliers have a physician's order or prescription on file, HCFA requires that certain medical equipment and supplies have a document called a certificate of medical necessity (CMN). It states that the service or item claimed for reimbursement is medically necessary and reasonable. For the reimbursement of these items, a completed CMN must be submitted to the DMERCs.

The items within the following 14 medical equipment and supply groups require a CMN:

- hospital beds
- support surfaces
- lymphedema pumps
- Transcutaneous Electrical Nerve Stimulators (TENS)
- seat lift mechanisms
- parenteral nutrition
- home oxygen therapy
- motorized wheelchairs
- manual wheelchairs
- osteogenesis stimulators
- Continuous Positive Airway Pressure (CPAP) devices
- power operated vehicles
- enteral nutrition
- infusion pumps

The CMNs requirements were revised in October of 1995. They were standardized and reformatted by HCFA and the DMERCs. Each of the aforementioned medical equipment and supply groups now have separate CMNs.

CMNs now have four sections: A, B, C, and D. Section A is to be filled out by suppliers. Section B lists the clinical justifications or the medical necessity of the device. This section is not to be filled out by the supplier, but may be completed and signed by a non-physician clinician, or a physician's employee. Section C contains information regarding the cost of the device and is to be filled out by the supplier. Section D must be signed by the physician certifying the medical necessity of the device and that the information in Section B is correct. With certain exceptions, this certifying physician cannot have any financial or contractual relationship with the supplier of the item. As of 1997, the physician signing section D must also be the patient's treating physician.

## **Office of Inspector General Activities**

There have been many OIG efforts related to the utilization of non-physician services, including the role of physician authorization in the provision of these services. An OIG study entitled "The Physician's Role in Home Health Care" (OEI-02-94-00170) found that at least 91 percent of the physicians who certified the plan of home health care had a pre-existing relationship with the patient for whom the plan was designed.

Other related OIG work includes an audit of Medicare home health agency services in California, Illinois, New York and Texas (A-04-94-02121) to determine whether payments for these fulfilled Medicare reimbursement requirements. The results of this audit showed that physicians did not always review or actively participate in developing plans of care they signed. The auditors said that physicians relied heavily on home health agencies to make homebound determinations and develop the plans of care for home health services.

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## **METHODOLOGY**

Using a 1 percent sample of HCFA's 1996 National Claims History (NCH) data, we selected a stratified, random sample of 1000 medical equipment and supply items. We stratified our sample between codes that require a CMN and codes that do not. We then further stratified the CMN codes between oxygen and non-oxygen items. This ensured that oxygen related line items were not over-represented in our sample.

Within the non-CMN stratum, we selected medical equipment and supply line items from HCPCS codes where each item cost was more than \$103 or where HCFA allowed more than \$260,000 in 1996. These codes accounted for 96 percent of all the medical equipment and supply line items in 1996 and 99 percent of the total monetary amount

allowed by HCFA in 1996. We further divided the 724 non-CMN codes into three separate groups: one containing five codes which account for 30 percent of all non-CMN line items; another with 20 codes which account for an additional 30 percent; and, finally, one with the remaining non-CMN codes. This prevented any over-representation in our non-CMN stratum. We randomly selected 200 line items from each of the 5 stratum for a total of 1000 items.

## Physician Survey

We mailed a questionnaire to the physicians certifying equipment for the 1000 line items in our sample in November 1997 to gain their perceptions of the certification process. Physicians responded to questions about their level of satisfaction with the process for ordering medical equipment and supplies, their experiences with CMNs, and whether or not they would suggest any changes to the current process. Response estimates and confidence intervals for key questions in our survey are listed in Appendix A.

We conducted a second and third mailing to non-respondents and 695 questionnaires were returned to us, for an overall response rate of 69 percent. Our response rates between strata were almost identical: 70 percent for non-CMN items (strata 1, 2, and 3) and 68 percent for CMN items (strata 4 and 5). We then weighted the data collected from these 695 questionnaires by stratum.

Of the 305 physicians who did not complete the questionnaire, 243 physicians did not respond at all. Of the remaining 62 physician non-respondents, 38 physicians could not be located and 24 physicians were retired and refused to fill out the survey. We conducted a non-respondent analysis of all physicians in our sample by analyzing several variables that may have influenced responses. See Appendix B for this analysis.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

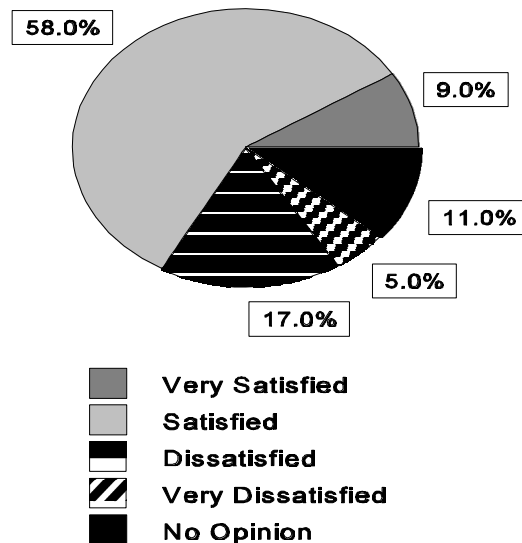
# FINDINGS

## Two-thirds of physicians are satisfied with the current process of ordering medical equipment and supplies; One-fifth are dissatisfied

Sixty-eight percent of physicians are satisfied; twenty-two percent are dissatisfied

When asked to describe their level of satisfaction with the current Medicare process of ordering medical equipment and supplies, two-thirds of physicians (68 percent) say they are either satisfied or very satisfied with the current process (See Figure A below). Approximately one-fifth (22 percent) of physicians are either dissatisfied or very dissatisfied with Medicare's ordering procedure. The remaining 11 percent expressed no opinion.

**Figure A**  
**Proportion Of Physicians Satisfied With Ordering Process**



According to physicians, the process of ordering medical equipment and supplies generally occurs in several different ways. Most often the physician gives a prescription to the patient who takes it to the supplier. When the patient is in the hospital, the physician usually contacts the hospital discharge planner or social worker who orders the equipment or supplies. When the patient is receiving home health care, the physician may discuss the equipment or supplies with the home health agency person who actually places the order. Most physicians indicate that they, along with the patient or patient's family, make the decision about what equipment or supplies the patient needs and which supplier to get it from.

Most physicians (61 percent) also report that they find out whether the patient received the equipment or supplies through some sort of follow-up with the patient. More than half (54 percent) of the physicians describe the needed item in detail, while just over one-quarter (27 percent) say that the supplier makes the decision about the particular brand of item to be furnished.

Regardless of satisfaction, many physicians suggest changes to the current Medicare process for ordering medical equipment and supplies. Of the 22 percent of physicians who are dissatisfied, almost all suggest improvements to the present ordering system. Physicians report that they would like a simpler and less time consuming durable medical equipment ordering process. For example, one physician responded, "it is extremely difficult to give each request careful attention." However, physicians also report concerns that there are not always enough safeguards in the process. One physician summed these contrasting opinions with his statement, "It's never easy for either side when it comes to paperwork, but the paper trail is necessary to prevent abuses."

Physicians' satisfaction levels do not differ significantly based upon the DMERCs that process their claims for medical equipment and supplies. Further, satisfaction levels are similar among the four US geographic regions that are designated by the Census Bureau: Northeast, Midwest, South, and West. Finally, physicians who order equipment that requires a certificate of medical necessity (CMN ) have identical satisfaction rates (79 percent) as physicians who do not. See Appendix C for this analysis.

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## **Information about Medicare requirements plays a significant role in physician satisfaction rates**

### **Physicians that receive sufficient Information are more likely to be satisfied**

Seventy-nine percent of physicians who report receiving sufficient information about the requirements for ordering medical equipment or supplies are satisfied. Of physicians who report not receiving enough information, only 46 percent are satisfied.

Almost one-quarter of physicians requested additional information about the ordering process. The most commonly requested information includes more detailed rules and specific criteria regarding Medicare coverage and eligibility. Some physicians suggest that doctors who are new providers should get a packet of information on the Medicare process for ordering durable medical equipment. One respondent requested that a manual be distributed to all physicians about the certification of Medicare covered durable medical equipment.

Physicians also report the need for additional information regarding the criteria for ordering equipment and supplies. In fact, 75 percent of physicians reported they have never received any educational materials from their Medicare carrier concerning the equipment and supply ordering process. One physician echoed the sentiments of many with his comment, “I am unclear as to the standards to be applied and documentation required. I would like more education....”

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## **Medical specialty also plays a role**

### **Pulmonary disease specialists are the most dissatisfied**

Pulmonary disease specialists express the most dissatisfaction with the process. Almost one-half (43 percent) are either dissatisfied or very dissatisfied, as illustrated in Table A below. Reasons cited for physicians’ dissatisfaction include too much paperwork, complex forms, and time constraints. One pulmonologist expressed these thoughts, “I am being asked to re-document the need for equipment to treat chronic illnesses which never go away. Please stop making us do this over and over again.”

General surgeons and ophthalmologists are the most satisfied among all specialties. Only 5 percent of general surgeons and 6 percent of ophthalmologists expressed some degree of dissatisfaction. The dissatisfaction rate of the remaining physician specialties ranges between 17 percent and 29 percent. This is close to the overall physician dissatisfaction mean of 22 percent.

Table A  
**Physician Dissatisfaction By Specialty**

<b>Specialty</b>	<b>Percent Dissatisfied</b>
Pulmonary Disease	43%
Physical Medicine and Rehabilitation	29%
Family Practice	28%
Cardiology	25%
Internal Medicine	22%
<b>Overall Specialty Average</b>	<b>22%</b>
General Practice	22%
Other	19%
Orthopedic Surgery	18%
Ophthalmology	6%
General Surgery	5%

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## **Half of physicians view the certificate of medical necessity as effective**

**While 56 percent of physicians say the CMN is effective, 21 percent say the CMN is not effective and another 23 percent don't know**

Physicians in support of the CMN say it allows them to review the condition of their patients. The form reminds physicians to periodically check their patients' status and analyze current and future equipment needs. Further, physicians point to the CMN as an effective monitor of fraud and abuse. One physician stated, "I believe that the vast majority of times the CMN assures the proper use of medical equipment."

Physicians who report the CMN as not being effective question whether or not the form assures improved utilization. These physicians also suggest that CMNs present additional unnecessary paperwork burdens and are often cumbersome.

However, 67 percent of physicians report that on the average, it takes less than 15 minutes to complete and sign a CMN. Additionally, another 31 percent report that this procedure takes somewhere between 15 and 30 minutes. Only 2 percent of physicians report spending more than thirty minutes to complete and sign a CMN.

### **Physicians report the supplier sometimes fills out Section B**

Section B of the CMN lists the clinical justifications or the medical necessity of the device. This section is not to be filled out by the supplier. This section may be completed by a non-physician clinician or a physician's employee as well as the physician. When the physician signs the CMN, he agrees to the accuracy of the information provided in Part B.

When asked who usually fills out Section B of the CMN, physicians usually gave more than one answer. One-fourth of physicians (24 percent) responded that the supplier sometimes fills it out. Additionally, 78 percent reported that the physician sometimes completes this section. Other responses include therapists or home health agency staff.

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## **Some physicians have sometimes refused to sign certificates of medical necessity**

### **Half of physicians have refused to sign a CMN at least once**

While 52 percent of physicians say they have at some time refused to sign a CMN request, two-thirds of these physicians say this rarely happens. Of the physicians who have refused to sign a CMN, the supplier has initiated the request approximately one-half of the time. The predominant reason physicians refused to sign these requests is because the patient did not need the equipment or supplies listed on the CMN. Additionally, physicians say their refusal is often because they did not know the patient.

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## **Some have also encountered problems when ordering medical equipment and supplies**

### **One in five physicians have encountered problems when ordering equipment and supplies**

Twenty-one percent of physicians encounter problems when they order medical equipment and supplies for their patients. Of these physicians, problems include inappropriate equipment and supplies, upgrading and downgrading of equipment and supplies, and



providing the wrong equipment and supplies. Physicians believe that inappropriate equipment and supplies and the wrong equipment and supplies are the greatest problems. Further, physicians request clearer ordering rules and detailed descriptions of equipment and supplies they order. One physician stated, “I would appreciate any updated equipment need criteria to ensure who qualifies for what equipment and what specific criteria must be met during the ordering process.”

# RECOMMENDATION

We recommend that the Health Care Financing Administration strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies. The following approaches are suggested:

- ▶ directing the carriers to furnish all physician providers with information about ordering medical equipment and supplies including any OIG Fraud Alerts. Of particular interest is the OIG Fraud Alert on Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services which specifically highlights physicians' responsibilities in making certifications for durable medical equipment and supplies, and the legal significance of the certifications. A copy of this fraud alert may be found in Appendix D;
- ▶ routinely providing all physicians with any changes of coverage and payment rules for medical equipment and supplies;
- ▶ providing all physicians with a contact person at the carriers to answer questions about equipment or supplies; and
- ▶ assuring that all certificates of medical necessity sent from the suppliers to physicians include the coverage and payment rules and cost of the equipment or supplies for the specific equipment or supplies ordered.

## COMMENTS

We received comments on the draft report from HCFA. They generally concur with our recommendation. Based on their comments we changed one of the suggested approaches in our recommendation on providing physicians with information about ordering medical equipment and supplies by expanding it to apply to all physicians not just new ones. The HCFA's comments are reproduced in Appendix E.

We also received comments from the Assistant Secretary for Planning and Evaluation (ASPE). We changed the wording of another of our suggested approaches in the recommendation to clarify that the information about coverage and payment rules had to do with the specific equipment and supplies ordered rather than general guidelines.

## Confidence Intervals For Key Survey Questions

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We calculated confidence intervals for 14 key questions from the physician questionnaire. The response estimate and 95 percent interval are given for each of the following:

1. How would you describe your level of satisfaction with current Medicare process for ordering medical equipment and supplies?  
“Very or somewhat satisfied” response estimate: 68%  
Lower interval: 66%  
Upper interval: 70%
2. Would you make any changes to the process of ordering medical equipment and supplies?  
“Yes” response estimate: 54%  
Lower interval: 51%  
Upper interval: 57%
3. Have you ever received any educational materials from your Medicare carrier regarding the provision of medical equipment or supplies?  
“No” response estimate: 75%  
Lower interval: 73%  
Upper interval: 77%
4. Do you feel that you have been provided sufficient information with regard to the criteria for ordering medical equipment and supplies for Medicare beneficiaries?  
“No” response rate: 23%  
Lower interval: 21%  
Upper interval: 26%
5. Who primarily decided the patient needed the equipment or supplies?  
“I did” and “the patient or the patient’s family” response estimate: 82%  
Lower interval: 80%  
Upper interval: 84%

6. Who primarily selected the company that provided the equipment or supplies?  
“I did” and “the patient or the patient’s family” response estimate: 55%  
Lower interval: 52%  
Upper interval: 57%
  
7. Generally, how does the process of ordering medical equipment and supplies work for you?  
“I give a prescription to a patient who takes it directly to the supplier”  
response rate: 62%  
Lower interval: 60%  
Upper interval: 65%
  
8. When you order equipment or supplies, who generally describes the type of item in detail?  
“I do” response rate: 54%  
Lower interval: 51%  
Upper interval: 56%
  
9. How do you know if your patients receive the equipment or supplies?  
“I follow up/I call or see the patients” response rate: 61%  
Lower interval: 58%  
Upper interval: 63%
  
10. Have you ever encountered any problems when ordering equipment or supplies for your patients?  
“Yes” response rate: 21%  
Lower interval: 19%  
Upper interval: 22%
  
11. In your opinion, is the use of the CMN effective to assure the proper utilization of medical equipment and supplies?  
“Yes” response rate: 56%  
Lower interval: 53%  
Upper interval: 58%

12. Have you ever received a request to sign a CMN that you refused to sign?  
“Yes” response rate: 52%  
Lower interval: 50%  
Upper interval: 55%
  
13. What are some of the reasons that you did not sign these requests?  
“The patient did not need the equipment or supplies” response rate: 70%  
Lower interval: 67%  
Upper interval: 73%
  
14. Who is most likely to initiate a request that you do not sign?  
“The supplier” response rate: 44%  
Lower interval: 41%  
Upper interval: 47%
  
15. On the average, how long does it take you to complete and sign a CMN?  
“Less than 15 minutes” response rate: 67%  
Lower interval: 64%  
Upper interval: 70%

## Non-respondent Analysis

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When questionnaires are used to collect data, the results may be biased if non-respondents differ from respondents. For this inspection, a physician for whom a questionnaire was not received is a non-respondent. A total of 695 questionnaires were completed, for an overall response rate of 69 percent. The remaining 305 questionnaires were not completed, for a non-respondent rate of 31 percent. Table B illustrates the number of responses and the response rate by strata without weights:

Table B  
**Physician Response Rate By Strata**

Strata	Number	Response Rate
1	144	72%
2	152	76%
3	126	63%
4	147	73%
5	126	63%
<b>Total Respondents</b>	<b>695</b>	<b>69%</b>

To test for the presence of any non-response bias, we analyzed the variables that might influence whether or not a physician would respond to the questionnaire. For the physicians in our sample, we examined geographic region, Durable Medical Equipment Regional Carriers, and physician specialty. These categorical variables were weighted and tested using Chi-square with the appropriate degrees of freedom. The results for this analysis are presented in tables B-1, B-2, and B-3. The Chi-square values given in the tables provide a test of the difference between the distribution of the respondents and that of the non-respondents for the variable of interest. Also provided in the tables are the response rate by the different values of the variables.

Table B-1  
**Geographic Region**

	Respondents		Non-Respondents		Total	Response Rate
Northeast	62603.61	20%	22827.42	16%	85431.03	73%
Midwest	75503.61	24%	35977.64	26%	111481.25	68%
South	128250.45	40%	61614.44	44%	189864.89	68%
West	50456.71	16%	19126.42	14%	69583.13	73%
<b>Total</b>	<b>316814.38</b>	<b>100%</b>	<b>139545.92</b>	<b>100%</b>	<b>456360.30</b>	<b>69%</b>
CHI-SQUARE = 2.38 Degrees of Freedom = 3						

Table B-2  
**Durable Medical Equipment Regional Carriers**

	Respondents		Non-Respondents		Total	Response Rate
Region A	62588.04	19%	23992.45	15%	86580.49	72%
Region B	73518.87	22%	38621.84	24%	112140.71	66%
Region C	131585.18	40%	73349.88	46%	204935.06	64%
Region D	61067.50	19%	22692.24	15%	83759.74	73%
<b>Total</b>	<b>328759.59</b>	<b>100%</b>	<b>158656.41</b>	<b>100%</b>	<b>487416.00</b>	<b>68%</b>
CHI-SQUARE = 5.79 Degrees of Freedom = 3						

Table B-3  
**Physician Specialty**

	Respondents		Non-Respondents		Total	Response Rate
General Practice	32752.73	10%	16918.96	12%	49671.69	66%
General Surgery	11799.07	4%	7418.73	5%	19217.80	61%
Cardiology	8091.05	2%	3659.92	3%	11750.97	69%
Family Practice	53930.38	17%	25022.69	17%	78953.07	68%
Internal Medicine	96206.08	30%	55235.16	38%	151441.24	64%
Ophthalmology	18632.00	6%	1199.24	1%	19831.24	94%
Orthopedic Surgery	12230.46	4%	4213.56	3%	16444.02	74%
PMR	7560.38	2%	3440.45	2%	11000.83	69%
Pulmonary Disease	31448.39	10%	7993.13	6%	39441.52	80%
Other	53159.64	15%	19448.40	13%	72608.04	73%
<b>Total</b>	<b>325810.18</b>	<b>100%</b>	<b>144550.24</b>	<b>100%</b>	<b>470360.42</b>	<b>69%</b>
CHI-SQUARE = 26.83 Degrees of Freedom = 9						

Tables B-1 and B-2 show no statistically significant differences between respondents and non-respondents for geographic region and Durable Medical Equipment Regional Carrier. In order for the results to be statistically significant at the 95 percent confidence level, the Chi-square value must be higher than 7.81 with 3 degrees of freedom.

Table B-3 shows a statistically significant difference between respondents and non-respondents with respect to type of physician specialty. A Chi-square value higher than 16.9 with 9 degrees of freedom suggests that physician specialty may influence whether or not a physician responded to the questionnaire. In order to test whether this difference introduced any bias, we analyzed the rates of overall satisfaction with the Medicare process for ordering medical equipment and supplies, for differences between internal medicine and all other physician specialties. We analyzed physician satisfaction in this way because internal medicine demonstrated a high percentage of the overall non-respondents. No significant difference exists as Table B-4 illustrates below.



Table B-4  
**Satisfaction: Internal Medicine vs. All Other Specialties**

	<b>Respondents</b>		<b>Non-Respondents</b>		<b>Total</b>	<b>Satisfaction Rate</b>
Internal Medicine	60300.52	30%	17419.68	28%	77720.20	78%
All Other Specialties	136870.41	70%	45193.21	72%	182063.62	75%
<b>Total</b>	<b>197170.93</b>	<b>100%</b>	<b>62612.89</b>	<b>100%</b>	<b>259783.82</b>	<b>76%</b>
CHI-SQUARE = 0.35 Degrees of Freedom = 1						

Tables B-1, B-2, and B-4 show no statistically significant differences between respondents and non-respondents for any of the variables tested. Given the results of this analysis, we believe that the inspection findings fairly represent the experience and opinions of physicians to whom the questionnaires were sent. We therefore believe that our survey results can be generalized to the universe of physicians who ordered Medicare medical equipment and supplies during 1996.

## Statistical Tests for Key Findings

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We computed Chi-square values for differences in physicians’ overall satisfaction for eight variables. All variables were analyzed at the 95 percent confidence level. As shown in Table C-1 below, some variables demonstrate statistically significant satisfaction differences and some variables do not. The direction of the differences below are discussed in the findings of this report.

Table C-1  
**Chi-Square Values for Testing Significance of Differences in Satisfaction**

<b>Variable</b>	<b>Degrees of Freedom</b>	<b>Chi-Square</b>	<b>Significant Satisfaction Difference</b>
Physician Specialty	9	22.37	Yes
Provided Sufficient Criteria for Ordering	1	15.71	Yes
Problems When Ordering	1	4.57	Yes
Refused to Sign a CMN	1	11.21	Yes
CMN Effective to Assure Proper Utilization	1	73.97	Yes
DMERC	3	1.85	No
Geographic Region	3	1.69	No
CMN Requirement	1	0.01	No

**OFFICE OF  
INSPECTOR  
GENERAL****SPECIAL FRAUD ALERT****PHYSICIAN LIABILITY FOR CERTIFICATIONS IN THE  
PROVISION OF MEDICAL EQUIPMENT AND SUPPLIES AND  
HOME HEALTH SERVICES**

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January 1999

**T**he Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections, and investigations.

To reduce fraud and abuse in the Federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes that obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify segments of the health care industry that are particularly vulnerable to abuse. Copies of all OIG Special Fraud Alerts are available on the internet at:

**<http://www.dhhs.gov/progorg/oig/frdalrt/index.htm>**

We are issuing this Fraud Alert because physicians may not appreciate the legal and programmatic significance of certifications they make in connection with the ordering of certain items and services for their Medicare patients. While the OIG believes that the actual incidence of physicians' intentionally submitting false or misleading certifications of medical necessity for durable medical equipment or home health care is relatively infrequent, physician laxity in reviewing and completing these certifications contributes to fraudulent and abusive practices by unscrupulous suppliers and home health providers. We urge physicians and their staff to report any suspicious activity in connection with the solicitation or completion of certifications to the OIG. Physicians should also be aware that they are subject to substantial criminal, civil, and administrative penalties if they sign a certification knowing that the information relating

to medical necessity is false, or with reckless disregard as to the truth of the information being submitted. While a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be facilitating the perpetration of fraud on Medicare by suppliers or providers. Accordingly, we urge all physicians to review and familiarize themselves with the information in this Fraud Alert. **If a physician has any questions as to the application of these requirements to specific facts, the physician should contact the appropriate Medicare Fiscal Intermediary or Carrier.**

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## THE IMPORTANCE OF PHYSICIAN CERTIFICATION FOR MEDICARE

The Medicare program only pays for health care services that are medically necessary. In determining what services are medically necessary, Medicare primarily relies on the professional judgment of the beneficiary's treating physician, since he or she knows the patient's history and makes critical decisions, such as admitting the patient to the hospital; ordering tests, drugs, and treatments; and determining the length of treatment. In other words, the physician has a key role in determining both the medical need for, and utilization of, many health care services, including those furnished and billed by other providers and suppliers.

Congress has conditioned payment for many Medicare items and services on a certification signed by a physician attesting that the item or service is medically necessary. For example, physicians are routinely required to certify to the medical necessity for any service for which they submit bills to the Medicare program.

Physicians also are involved in attesting to medical necessity when ordering services or supplies that must be billed and provided by an independent supplier or provider. Medicare requires physicians to certify to the medical necessity for many of these items and services through prescriptions, orders, or, in certain specific circumstances, Certificates of Medical Necessity (CMNs). These documentation requirements substantiate that the physician has reviewed the patient's condition and has determined that services or supplies are medically necessary.

Two areas where the documentation of medical necessity by physician certification plays a key role are (i) home health services and (ii) durable medical equipment (DME). Through various OIG audits, we have discovered that physicians sometimes fail to discharge their responsibility to assess their patients' conditions and need for home health care. Similarly, the OIG has found numerous examples of physicians who have ordered DME or signed CMNs for DME without reviewing the medical necessity for the item or even knowing the patient.

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## PHYSICIAN CERTIFICATION FOR HOME HEALTH SERVICES

Medicare will pay a Medicare-certified home health agency for home health care provided under a physician's plan of care to a patient confined to the home. Covered services may include skilled nursing services, home health aide services, physical and occupational therapy and speech language pathology, medical social services, medical supplies (other than drugs and biologicals), and DME.

As a condition for payment, Medicare requires a patient's treating physician to certify initially and recertify at least every 62 days (2 months) that:

- # the patient is confined to the home;
- # the individual needs or needed (i) intermittent skilled nursing care; (ii) speech or physical therapy or speech-language pathology services; or (iii) occupational therapy or a continued need for occupational therapy (payment for occupational therapy will be made only upon an initial certification that includes care under (i) or (ii) or a recertification where the initial certification included care under (i) or (ii));
- # a plan of care has been established and periodically reviewed by the physician; and
- # the services are (were) furnished while the patient is (was) under the care of a physician.

The physician must order the home health services, either orally or in writing, prior to the services being furnished. The physician certification must be obtained at the time the plan of treatment is established or as soon thereafter as possible. The physician certification must be signed and dated prior to the submission of the claim to Medicare. If a physician has any questions as to the application of these requirements to specific facts, the physician should contact the appropriate Medicare Fiscal Intermediary or Carrier.

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## **PHYSICIAN ORDERS AND CERTIFICATES OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES FOR HOME USE**

DME is equipment that can withstand repeated use, is primarily used for a medical purpose, and is not generally used in the absence of illness or injury. Examples include hospital beds, wheelchairs, and oxygen delivery systems. Medicare will cover medical supplies that are necessary for the effective use of DME, as well as surgical dressings, catheters, and ostomy bags. However, Medicare will only cover DME and supplies that have been ordered or prescribed by a physician. The order or prescription

must be personally signed and dated by the patient's treating physician.

DME suppliers that submit bills to Medicare are required to maintain the physician's original written order or prescription in their files. The order or prescription must include:

- # the beneficiary's name and full address;
- # the physician's signature;
- # the date the physician signed the prescription or order;
- # a description of the items needed;
- # the start date of the order (if appropriate); and
- # the diagnosis (if required by Medicare program policies) and a realistic estimate of the total length of time the equipment will be needed (in months or years).

For certain items or supplies, including supplies provided on a periodic basis and drugs, additional information may be required. For supplies provided on a periodic basis, appropriate information on the quantity used, the frequency of change, and the duration of need should be included. If drugs are included in the order, the dosage, frequency of administration, and, if applicable, the duration of infusion and concentration should be included.

Medicare further requires claims for payment for certain kinds of DME to be accompanied by a CMN signed by a treating physician (unless the DME is prescribed as part of a plan of care for home health services). When a CMN is required, the provider or supplier must keep the CMN containing the treating physician's original signature and date on file.

Generally, a CMN has four sections:

- # Section A contains general information on the patient, supplier, and physician. **Section A may be completed by the supplier.**
- # Section B contains the medical necessity justification for DME. This cannot be filled out by the supplier. **Section B must be completed by the physician, a non-physician clinician involved in the care of the patient, or a physician employee.** If the physician did not personally complete section B, the name of the person who did complete section B and his or her title and employer must be specified.
- # Section C contains a description of the equipment and its cost. **Section C is**

**completed by the supplier.**

- # Section D is the treating physician's attestation and signature, which certifies that the physician has reviewed sections A, B, and C of the CMN and that the information in section B is true, accurate, and complete. **Section D must be signed by the treating physician.** Signature stamps and date stamps are not acceptable.

By signing the CMN, the physician represents that:

- # he or she is the patient's treating physician and the information regarding the physician's address and unique physician identification number (UPIN) is correct;
- # the entire CMN, including the sections filled out by the supplier, was completed **prior** to the physician's signature; and
- # the information in section B relating to medical necessity is true, accurate, and complete to the best of the physician's knowledge.

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## **IMPROPER PHYSICIAN CERTIFICATIONS FOSTER FRAUD**

**U**nscrupulous suppliers and providers may steer physicians into signing or authorizing improper certifications of medical necessity. In some instances, the certification forms or statements are completed by DME suppliers or home health agencies and presented to the physician, who then signs the forms without verifying the actual need for the items or services. In many cases, the physician may obtain no personal benefit when signing these unverified orders and is only accommodating the supplier or provider. While a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be facilitating the perpetration of fraud on Medicare by suppliers or providers. When the physician knows the information is false or acts with reckless disregard as to the truth of the statement, such physician risks criminal, civil, and administrative penalties.

Sometimes, a physician may receive compensation in exchange for his or her signature. Compensation can take the form of cash payments, free goods, or any other thing of value. Such cases may trigger additional criminal and civil penalties under the anti-kickback statute.

The following are examples of inappropriate certifications uncovered by the OIG in the course of its investigations of fraud in the provision of home health services and medical equipment and supplies:

- # A physician knowingly signs a number of forms provided by a home health agency that falsely represent that skilled nursing services are medically necessary in order to qualify the patient for home health services.
- # A physician certifies that a patient is confined to the home and qualifies for home health services, even though the patient tells the physician that her only restrictions are due to arthritis in her hands, and she has no restrictions on her routine activities, such as grocery shopping.
- # At the prompting of a DME supplier, a physician signs a stack of blank CMNs for transcutaneous electrical nerve stimulators (TENS) units. The CMNs are later completed with false information in support of fraudulent claims for the equipment. The false information purports to show that the physician ordered and certified to the medical necessity for the TENS units for which the supplier has submitted claims.
- # A physician signs CMNs for respiratory medical equipment falsely representing that the equipment was medically necessary.
- # A physician signs CMNs for wheelchairs and hospital beds without seeing the patients, then falsifies his medical charts to indicate that he treated them.
- # A physician accepts anywhere from \$50 to \$400 from a DME supplier for each prescription he signs for oxygen concentrators and nebulizers.

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## POTENTIAL CONSEQUENCES FOR UNLAWFUL ACTS

A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence. However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties including:

- # criminal prosecution;
- # fines as high as \$10,000 per false claim plus treble damages; or
- # administrative sanctions including: exclusion from participation in Federal health care programs, withholding or recovery of payments, and loss of license or disciplinary actions by state regulatory agencies.

Physicians may violate these laws when, for example:

- # they sign a certification as a “courtesy” to a patient, service provider, or DME



supplier when they have not first made a determination of medical necessity;

# they knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted to a Federal health care program; or

# they receive any financial benefit for signing the certification (including free or reduced rent, patient referrals, supplies, equipment, or free labor).

Even if they do not receive any financial or other benefit from providers or suppliers, physicians may be liable for making false or misleading certifications.

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## **WHAT TO DO IF YOU HAVE INFORMATION ABOUT FRAUD AND ABUSE AGAINST MEDICARE OR MEDICAID PROGRAMS**

If you have information about physicians, home health agencies, or medical equipment and supply companies engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

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<b>Field Offices</b>	<b>States Served</b>	<b>Telephone</b>
Boston	MA, VT ,NH, ME, RI, CT	617-565-2664
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	215-861-4586
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago	IL, MN, WI, MI, IN, OH, IA, MO	312-353-2740
Dallas	TX, NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS	214-767-8406

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Los Angeles

AZ, NV, So. CA

714-246-8302

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San Francisco

No. CA, AK, HI  
OR, ID, WA

415-437-7961

## **Comments on the Draft Report**

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In this appendix, we present in full the comments from the Health Care Financing Administration.



Memorandum

DEC 30 11:12  
DEC 29 1998

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EAIG	<input type="checkbox"/>
SAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
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DIG-EI	<input type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
AIG-LC	<input type="checkbox"/>
OGC/IG	<input checked="" type="checkbox"/>
ExecSec	<input type="checkbox"/>
Date Sent	12-30

DATE: DEC 29 1998

TO: June Gibbs Brown  
Inspector General

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*  
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Ordering Medicare Equipment and Supplies: Physicians' Perspectives" (OEI-02-97-00081), and "Ordering Medicare Equipment and Supplies: Physician Patient Relationship" (OEI-02-97-00080)

The OIG undertook two studies to look at the role of the physician in certifying non-physician services. The first report is about physicians' perceptions of the certification process for durable medical equipment, prosthetics, orthotics, and supplies. The second report examines the relationship between the physician and the patient and its effect on the certification of medical equipment and supplies.

We concur with the report recommendations and offer the following comments:

Ordering Medicare Equipment and Supplies: Physicians' Perspectives (OEI-02-97-00081)

OIG Recommendation

OIG recommends that HCFA strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies.

HCFA Response

HCFA concurs with this recommendation. We will take steps to ensure that durable medical equipment regional carriers' (DMERCs) procedures and policies are published in all Part B Carrier Quarterly Bulletins. The DMERCs currently publish changes in their policies and procedures on their web sites and in quarterly bulletins. We will ask that all carriers work more closely with their physician community to ensure that they know where to find information regarding the ordering and referring of medical equipment and supplies. One approach involves directing the carriers to provide new physician providers with information about ordering medical equipment and supplies. In addition

to providing new physicians with this information, we believe it would be beneficial for all participating physicians to receive this information.

Ordering Medicare Equipment and Supplies: Physician Patient Relationship (OEI-02-97-00080)

OIG Recommendation

OIG recommends that the physician who orders the equipment or supplies be required to treat the patient prior to the order and a systematic process be developed to assure that the supplier submits a new certificate of medical necessity (CMN) or order to the durable medical equipment regional carrier when the physician changes, the equipment or supply or the medical need for the equipment or supply changes; and that the referring physician's name and specialty, as well as the patient's related diagnostic information be required on all claims for medical equipment and supplies.

HCFA Response

We generally concur with your recommendation that whenever a physician orders medical equipment he or she must treat the patient prior to the order. In fact, the new version of the CMN, revised in May 1997, specifically states that the treating physician must certify and attest to the medical necessity of the item being ordered on behalf of the beneficiary. However, there are instances when it is appropriate for a physician to order an item based on a telephone call from a patient, such as for a cane or walker for a patient with a history of problems walking. Nevertheless, we do believe that there should be a relationship between the physician and beneficiary before an item of durable medical equipment, orthotics, prosthetics, or supplies is ordered for the beneficiary.

We generally concur with your recommendation to assure that the supplier submits a new CMN to the DMERC when the physician changes, the equipment changes, and/or the medical need changes. However, for some single purchase items, like lymphedema pumps, wheelchairs, or hospital beds, a change in physician would have no impact on the need for that item. For some rental items, such as oxygen, a change in physician does not usually mean there will be a need for a change in equipment.

We concur with your recommendation that a new CMN be required every time there is a change in equipment, or if the beneficiary's condition worsens and he or she needs to upgrade the equipment. Our current policy reflects this position.

Page 3 - June Gibbs Brown

We concur with your recommendation that the CMN include the name, address, and UPIN of the referring physician. Our current form requires all of that information. However, we do not currently request information on the physician's specialty because Medicare does not make payment determinations based on specialty. We will consider capturing this information on future versions of these forms.

We concur with your recommendation that diagnostic information be required on all claims for medical equipment and supplies. Preferably this information would be in the form of an ICD-9 code so we can automate this process. The DMERCs have put the requirement for an ICD-9 code in certain regional medical review policies, as they recognize the value of this information.