
MEDICARE COVERAGE OF POWER-OPERATED VEHICLES



OFFICE OF INSPECTOR GENERAL
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MEDICARE COVERAGE OF POWER-OPERATED VEHICLES

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to determine the effects of beneficiary-oriented marketing of power-operated vehicles (POVs) on Medicare reimbursement and to review the appropriateness of Medicare payments.

BACKGROUND

Power-operated vehicles are three-wheeled battery operated vehicles that resemble small golf carts. Under its durable medical equipment provision, Medicare covers small, relatively light-weight POVs that have a short turning radius and are appropriate for home use.

To qualify for a POV, patients must be unable to operate a wheelchair manually, and would otherwise be confined to a bed or chair. Medicare requires that the prescribing physician be from one of four specialties, unless extenuating circumstances exist, and that carrier medical staff review all POV claims.

The Office of Inspector General (OIG) became concerned about POV reimbursement in 1987 when abuses were brought to its attention by a local Medicare carrier. This experience resulted in the issuance of an OIG Fraud Alert and conduct of this inspection.

METHODOLOGY

Two samples were utilized: the first was a national random sample of 102 beneficiaries who were contacted by phone to determine their responses to supplier advertising and their role in obtaining the POV. Some physicians of these patients were also contacted for related information. The second was a sample of eight Medicare carriers; these were visited to examine their policies and procedures for reviewing POV claims.

FINDINGS

Direct Marketing Of POVs To Beneficiaries Is Generating Demand.

- More than half of POV beneficiaries interviewed reported they learned about POVs through television and other advertising.
- Thirty-seven percent learned about POVs from family, friends, and neighbors.
- Three-quarters of the beneficiaries said it was their own or their family's idea, not that of a health care professional, to obtain a POV.
- Suppliers are aggressively marketing POVs. As an example, one-third of the beneficiaries claim they were told they would not have to pay anything for the POV.

- Physicians are playing a passive role in prescribing POVs. This includes “going along with it,” signing the authorizations after the POVs are delivered in one-third of the cases, and having little knowledge of Medicare coverage guidelines.

Medicare Should Not Have Paid For A Majority Of POVs In 1986.

- Sixty-two percent of the POV beneficiaries contacted apparently did not meet coverage requirements. They said they could operate a wheelchair manually when they obtained their POV, or they were using their POV exclusively outside their home.
- A review of carrier supporting documentation showed most claims fail to document appropriateness.
- Six of eight carriers failed to routinely utilize medical personnel to review POV claims as required.
- Thirty-one of 81 carrier cases showed no information as to the specialty of the authorizing physician.
- A loss of \$5.9 million for 1986 is projected.

RECOMMENDATIONS

To reduce inappropriate payments for POVs, HCFA should:

- 1. Evaluate and strengthen as needed carrier implementation of Medicare coverage requirements and the 1987 Omnibus Budget Reconciliation Act provisions to:***
 - a. use medical staff to review each submitted POV claim for medical necessity,
 - b. allow only certain specialists to authorize these claims or cite the reasons for exceptions to this rule,
 - c. ensure that payments are made only for beneficiaries whose medical and/or physical conditions render them unable to use a wheelchair manually and who need a POV for indoor use, and
 - d. prohibit payment for durable medical equipment unless suppliers receive a written order from a physicians before the delivery of the item to the patient.
- 2. Publicize Medicare coverage requirements to the medical community. This could be done by issuing instructions or letters to all physicians, citing Medicare restrictions on POVs.***
- 3. Advise carriers to develop and refer sanction recommendations to the OIG when carriers have identified physicians with patterns of excessive POV prescriptions.***

HCFA COMMENTS

The HCFA acknowledged the existence of inappropriate expenditures for POVs as reported in the study but did not agree to any specific dollar amount. The HCFA also agreed with our three recommendations by citing actions they have taken to resolve these problems. (See appendix B for text of comments and OIG's response.)

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
INTRODUCTION	1
FINDINGS	4
<i>Direct Marketing Of POVs To Beneficiaries Is Generating Demand</i>	4
Beneficiaries are taking initiative to obtain POVs	4
Suppliers are aggressively marketing their product	4
Physicians are playing a passive role in prescribing POVs	5
<i>Medicare Should Not Have Paid For A Majority Of POVs In 1986</i>	6
Beneficiaries' phone responses apparently reveal most did not qualify for POVs	6
Carrier documents for most beneficiaries fail to justify appropriateness of reimbursement	7
Weakness noted in carrier claims review procedures	8
RECOMMENDATIONS	10
APPENDIX-A: Cost Savings Projections	12
APPENDIX-B: HCFA General Comments and OIG Response	13

A representative of one carrier spotted an elderly woman, accompanied by her daughter, maneuvering a power-operated vehicle through the aisles of a shopping mall in a western city. The cart had a basket filled with packages and a small sign on the rear announcing "Medicare paid for me," followed by the name and phone number of the local supplier of medical equipment. This is only one of many techniques being used by manufacturers or suppliers to market power-operated vehicles.

INTRODUCTION

PURPOSE

The purpose of this inspection was to determine the impact of beneficiary-oriented marketing of power-operated vehicles (POVs) on Medicare reimbursement and to review the appropriateness of Medicare payment.

BACKGROUND

Power-operated vehicles are three-wheeled battery operated vehicles that resemble small golf carts. Under its durable medical equipment provision, Medicare covers small, relatively light-weight POVs that have a short turning radius and are easily maneuverable in an individual's home. This easy maneuverability is the primary advantage over electric wheelchairs. Medicare will pay for electric wheelchairs prescribed by the physician instead of POVs when the severity of the patient's condition requires it for greater balance and safety.

Concerns in the Office of Inspector General (OIG) about Medicare's reimbursement of POVs emerged in 1987 when the OIG New York office was alerted by a Medicare carrier regarding some abusive practices. As a result two carriers in the New York area completed a special pre-payment review of POV claims during a 4-month period in 1987. The carrier developed questionnaires which were completed by physicians and made telephone calls to Medicare beneficiaries. Coverage denials resulted in most of these cases. In response to these findings the OIG sent an issuance to carriers, urging increased surveillance of POV reimbursements.

Medicare Coverage of POVs

Claims for POVs must meet the criteria that the Health Care Financing Administration (HCFA) has set for all durable medical equipment:

- can withstand repeated use,
- is primarily and customarily used to serve medical purposes,
- is generally not useful to a person in the absence of illness or injury, and
- is appropriate for use in the home.

All of these elements must be met in order for the equipment to be covered by Medicare.

The POV models covered by Medicare are small and relatively light-weight. Medicare does not cover the larger POV models which are much heavier and have a greater turning radius. The rationale is that such chairs are used primarily outside the home and are generally useful as a means of transportation in the absence of an illness or injury. Another explanation for not covering such vehicles was that "the cycle chair might actually increase program costs since beneficiaries might require one device for outside the home and another for use inside the home."

According to Medicare POV coverage requirements issued in 1978, a specialist in physical medicine, orthopedic surgery, and neurology, and since 1988 rheumatology "must provide an evaluation of the patient's medical and physical condition and prescribe the vehicle to assure that the patient requires the vehicle and is capable of using it safely." There is an exception to the four-specialty requirement that applies when a Medicare carrier "determines that such a specialist is not reasonably available, e.g., more than one day's round trip from the beneficiary's home, or the patient's condition precludes such travel." In these cases, a prescription from the beneficiary's physician (outside of the four specialty groups) can be accepted.

Medicare also requires that the patient be eligible for a wheelchair (i.e., the patient would otherwise be confined to a bed or chair) and that the patient be unable to operate a wheelchair manually. These coverage requirements are found in Section 60-5 of the Coverage Issues Appendix of the Medicare Carriers Manual, which also states that the carrier's "medical staff will review all claims for a power-operated vehicle, including the specialist's or other physician's prescriptions and evaluations of the patient's medical conditions to insure that all coverage requirements are met."

Reimbursement Trends

Claims submitted by suppliers under assignment are paid at 80 percent of the allowable charge recognized by Medicare. The beneficiary is then responsible for paying the 20 percent coinsurance to the supplier. Suppliers who do not accept assignment can charge the beneficiary the difference between their total charge and what Medicare allows.

Based on HCFA data for a 1 percent sample consisting of 102 beneficiaries, total Medicare allowed charges for POVs can be projected to \$13.6 million in 1986, with an average allowance of \$1,330 per beneficiary. The HCFA reported from its Medicare Part B procedure file that the total allowed charges for POVs were \$12.9 million in 1986 which is statistically comparable to the \$13.6 million projection. Additional information from the procedure file shows a gradual increase from \$9.7 million in 1985 to \$12.9 million in 1986 to \$13.3 million in 1987.

OBJECTIVES

1. Describe the nature of beneficiary and physician responses to the marketing of POVs by suppliers.
2. Identify types of POV beneficiaries for whom reimbursement may have been inappropriate.
3. Assess the carriers' procedures for implementing HCFA's requirements for POV coverage and claims review.

METHODOLOGY

This inspection was designed and carried out in conjunction with the recent OIG inspection, "*Medicare Coverage for Seat Lift Chairs*" (OAI-02-88-00100). The same methodology and sampling procedures were used for both studies. The first was a national random sample of 102 beneficiaries from all carriers, representing 1 percent of all Medicare payments for POVs in calendar year 1986. Seventy-one of these beneficiaries — or, in a few cases, their survivors — were reached by telephone to determine how and why they requested a POV. They were asked about their ability to use a wheelchair manually, their need for a POV and whether they had paid anything for it. Reasons for not contacting the remaining 31 individuals included the following: beneficiaries with no telephone listing did not respond to letters; others who were deceased had no available survivor, or their survivor was not contacted; and some requested records had been purged or billed electronically and the beneficiary was not contacted.

Telephone interviews were conducted with 28 of the physicians for the 71 beneficiaries, selected on the basis of availability, to ascertain their role in prescribing a POV for the patient.

The Medicare claims and physicians' authorizations for 62 of the 71 beneficiaries interviewed were also reviewed by a physical therapist to assess the adequacy of documentation of the diagnoses and conditions which might justify the need for a POV. Other analyses were made, including a comparison of POV delivery dates with physician authorization dates.

The second sample, consisting of eight Medicare carriers was originally selected for the study on seat lift chairs. It is a judgemental sample drawn from a universe of 53 carriers nationwide. Included were: Blue Cross and Blue Shield plans of Florida, Indiana, Massachusetts, Pennsylvania, and Rhode Island, Traveler's Insurance Company of Minnesota, General American Life of Missouri, and Prudential of New Jersey. The eight carriers accounted for 32 percent of all dollars allowed for POVs in 1986.

Discussions were held with 22 managers and staff personnel at the carrier level. To assess each carrier's POV claims review procedures, approximately 10 claims were randomly selected from 1987 paid claims and reviewed on site at seven carriers (one carrier had only one paid claim in 1986).

Discussions were also held with HCFA and carrier officials and non-sample beneficiaries, and other physicians and suppliers, bringing the total respondents contacted to 167.

FINDINGS

1. Direct Marketing of POVs to Beneficiaries is Generating Demand

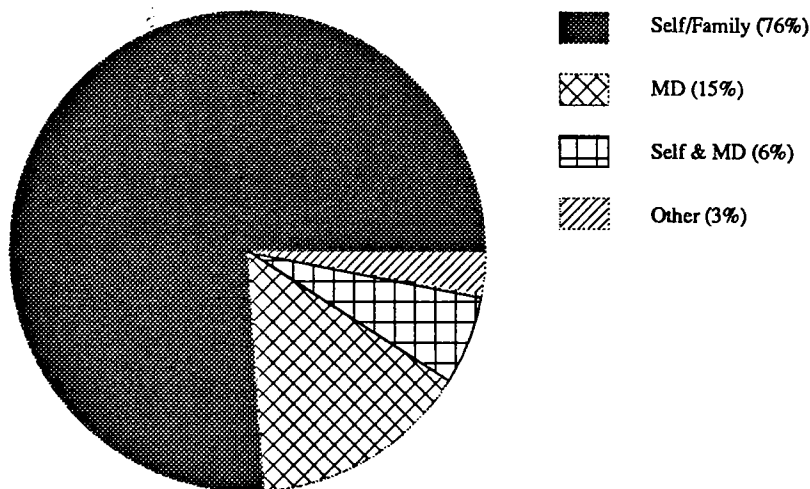
Beneficiaries are taking initiative to obtain POVs

Beneficiaries were initially asked how they first learned about POVs. More than half (57 percent) of the 71 POV beneficiaries contacted said they learned about POVs through television and other advertising, including magazines, salespersons, mail brochures and demonstrations at shopping malls. Thirty-seven percent were told about POVs by family, friends or neighbors. Only 6 percent said they learned about POVs from a doctor or other medical personnel.

Beneficiaries were next asked to indicate whose idea it was to obtain the POV. As shown in figure 1, three-quarters of the POV beneficiaries contacted said it was their own idea or their family's idea to get a POV. Another 6 percent said it was both their idea and their doctor's idea. Most of the remaining beneficiaries (15 percent) said it was the doctor's idea.

PATIENT RESPONSES: WHOSE IDEA WAS IT TO GET A POV?

FIGURE 1



Suppliers are aggressively marketing their product

Some beneficiaries describe suppliers' tactics as aggressive, such as salespersons showing up at the door within minutes of a phone call from a patient, the withholding of information about the difficulty of maneuvering or lifting the POV into a car, and implying that the POV would not cost anything.

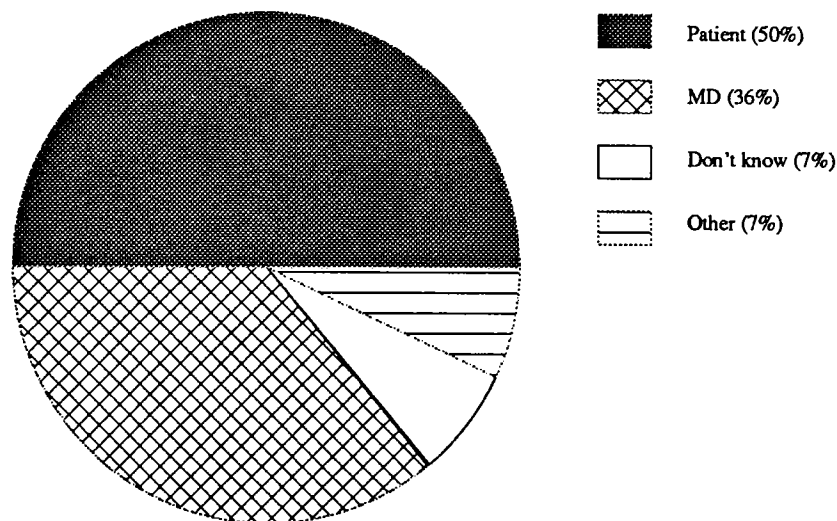
Thirty-four percent of the 71 beneficiaries contacted said they were told they would not have to pay anything for their POV.

Physicians are playing a passive role in prescribing POVs

A number of practices were noted which showed the physician's role to be a relatively passive one. These include a "go along with it" role in prescribing the POVs, signing authorizations after the vehicles have been delivered, feeling pressured by the patients or families to authorize a POV, not following-up on patients' use of the POVs and not having knowledge of Medicare guidelines. As shown below in figure 2, when the physicians contacted were asked whose idea it was to obtain a POV, half responded that the patients rather than the physician had suggested the POV. Only 36 percent of the physicians said it was their idea.

PHYSICIAN RESPONSES: WHOSE IDEA WAS IT TO ORDER A POV?

FIGURE 2



A review of the 1986 claims and authorization data showed that in one-third of the claims the POV was delivered to the beneficiary before the authorization for it was signed by the physician. Since then, the Omnibus Budget Reconciliation Act (OBRA) of 1987 was enacted. It includes a provision prohibiting Medicare payment for durable medical equipment unless the supplier has received a written order from the physician before delivery of the item to the patient.

Several physicians in this study indicated that they received pressure from patients or their families to prescribe the POV. One physician said:

"The patient asked me twice during appointments and kept insisting how useful it would be for him ...and then I conceded! Patients see these advertisements and pressure you to get the equipment. If you don't sign the form, the patient moves on to another doctor."

Over half (53 percent) of the 28 physicians contacted said they did not know the Medicare guidelines for POVs. Of special note: while 38 percent of the physicians outside the four specialties said they did not know the guidelines, 54 percent of the *approved* specialty physicians said they did not know them. One physician, who did not know the POV guidelines, made the following suggestion:

“Medicare criteria should be clearly explained more to the medical population by carriers so the basis of ordering equipment could be better understood.”

2. Medicare Should Not Have Paid for a Majority of POVs in 1986.

Beneficiaries’ phone responses apparently reveal most did not qualify for POVs

Forty-four (62 percent) of the 71 beneficiaries interviewed seem to have been inappropriately reimbursed by Medicare for their POVs. This resulted in estimated overpayments totaling \$59,162 (see appendix). Projecting this to the entire Medicare program in 1986 yields estimated overpayments of \$5.9 million. The responses of these individuals indicated that they did not qualify for reimbursement since they failed to meet either one or both of the two primary criteria, namely that the beneficiary cannot operate a wheelchair manually and the POV must be appropriate for home use. Table 1 summarizes the results of these interviews.

Table 1
Reasons Why Reimbursement Appears Inappropriate*

Reasons Why Reimbursement Appears Inappropriate	Number of Beneficiaries
(a) Beneficiaries could operate a wheelchair manually	22
(b) Beneficiaries used the POV outdoors exclusively	30**
(c) Either (a) or (b)	44 (=62% of 71 beneficiaries)

**Based on a total of 71 beneficiaries contacted*

*** These 30 cases include 8 beneficiaries who did both (a) and (b).*

Twenty-two beneficiaries told us that they had a wheelchair in their home which they could operate manually, when the POV was obtained. They did not mention any pain or difficulty in using it. In 6 of these 22 cases, prescribing physician certification documents cited an inability to operate a wheelchair manually. The carrier had no apparent reason to question the validity of the physician’s statement, absent conflicting information in carrier files. Thirty beneficiaries said that their POVs were used exclusively outdoors. Eight of these 30 beneficiaries told us that they could both operate a wheelchair manually and used their POV outdoors exclusively.

As some of the beneficiaries noted, the POVs were too big or too heavy to use indoors. The following are beneficiary responses on when and how they used their POVs (also called scooters).

*"I used the (standard) wheelchair in the house. If I go to the Mall, I use the scooter."
"The scooter was better — it would allow her to go downtown. However, it was too heavy. She used the wheelchair up until a week before she died."
"The wheelchair was worn out. It was the reason I asked for a POV...I used the wheelchair inside and the scooter outside."*

Only one carrier had an authorization form signed by the physician which included a question on whether the POV was for outside use only.

Ten beneficiaries, at the time of the telephone interviews in the summer of 1988, said they could walk without any assistance or with the assistance of a cane, a walker or crutches.

Carrier documents for most beneficiaries fail to justify appropriateness of reimbursement

The appropriateness of reimbursement for the sample beneficiaries was also assessed by reviewing supplier claims and all documents signed by physicians including authorization forms, medical necessity forms, letters and prescription pad notations. Such claims or physician documents were available for 62 of the 71 beneficiaries interviewed. We looked specifically at documentation concerning diagnoses and condition to determine whether the patient could propel a standard wheelchair manually, or had a need for a POV. Only some forms signed by physicians addressed the patient's ability to operate a wheelchair manually. Thirty-nine of the 62 cases (63 percent) had a physician-signed document, indicating that the patient could not manually operate a wheelchair. However, as noted above, only 6 of these 39 cases had been judged as inappropriately reimbursed based just on the beneficiary's reported ability to use a wheelchair manually. In four of the six cases, where there was a contradiction between physician and beneficiary response, the evidence clearly supported the beneficiary's statement.

Some carriers' authorization forms requested information from the physician in areas such as upper and lower extremity strength, or ability to ambulate with or without assistance.

Many beneficiaries in our sample were diagnosed with the following diseases or conditions:

multiple sclerosis	muscular dystrophy
rheumatoid arthritis	osteoarthritis
cerebral vascular accident	peripheral neuropathy
paraplegia	quadriplegia
arteriosclerotic heart disease	congestive heart failure
diabetes	cancer
chronic obstructive pulmonary disease	below-knee amputation

The records were reviewed by a physical therapist who was a member of the inspection team and experienced in rehabilitation and evaluating patients for wheelchairs. Based on her review, the 62 cases were divided into three categories, depending on the adequacy of documentation.

The first category, with nine cases, dealt with those containing adequate information to support the need for the POV. One patient, a bilateral below-knee amputee with severe peripheral vascular disease and poor upper body strength clearly would appear to require a POV.

The second category included patients for whom it was likely that there was a need for a POV, but where more information was needed to support a positive decision (14 cases). Several of these were multiple sclerosis patients, who by the nature of the disease have weakness and poor endurance and would likely benefit from a POV. However, there was no additional information to indicate where and how much weakness the person had or whether a wheelchair could be manually operated. One case showed a person with diagnoses of polymyalgia rheumatica, rheumatoid arthritis, and diabetes. An attached medical note cited "*limited ability to propel a wheelchair*" and indicated that the physician wanted the POV to enable community access. More documentation might clarify this claim's appropriateness. It should be noted that only one of these 14 cases was judged inappropriate based solely on the beneficiary's statement that he continued to use a wheelchair manually.

The third category consisted of those patients whose need was not clearly indicated from the less than adequate information available and more compelling evidence was necessary (39 cases). Several of these cases were patients who had a cerebral vascular accident with resulting hemiplegia. Additional evidence would be necessary to show that the person could not propel a wheelchair with the unaffected hand and foot as is often done by hemiplegic patients. Indication of perceptual and cognitive disability would also be helpful to show whether the person could manually propel a wheelchair and also whether a POV could be safely used. Some of the other diagnoses, such as low back pain, arthritis, paraplegia or hip fracture would not in themselves indicate inability either to ambulate or to propel a wheelchair manually. However, in some of these cases additional information from the physician might support a need for a POV.

The results of this record review matched our findings based on the responses of these beneficiaries that reimbursement for a majority of beneficiaries studied was likely to have been inappropriate.

Weakness Noted In Carrier Claims Review Procedures

The key problem noted during the on-site visits to carriers was the failure of most carriers (six of eight) to routinely utilize medical personnel to review all POV claims as required by the Medicare Carriers Manual.

Another problem noted was the lack of information in the carriers' files for the claims OIG reviewed on site concerning the specialty of the prescribing physician. The authorizing physician must be practicing in one of four specialties or specific exception requirements must be

met. In 60 percent of these claims information was lacking on whether the prescribing physician met the specialty requirement and/or whether the exception criteria applied.

There was also no documentation in the files of any of the carriers visited that they had checked to see if the physician specialty exception applied because the beneficiary was unable to leave home, or because the specialist is more than 1 day's round trip from the beneficiary's home.

RECOMMENDATIONS

TO REDUCE INAPPROPRIATE PAYMENTS FOR POVs, HCFA SHOULD:

- 1. Evaluate, and strengthen as needed, carrier implementation of Medicare coverage requirements and OBRA 1987 provisions to:**
 - a. use medical staff to review each submitted POV claim for medical necessity,
 - b. allow only certain specialists to authorize these claims or cite the reasons for exceptions to this rule,
 - c. ensure that payments are made only for beneficiaries whose medical and/or physical conditions render them unable to use a wheelchair manually and who need a POV for indoor use, and
 - d. prohibit payment for durable medical equipment unless suppliers receive a written order from a physician before the delivery of the item to the patient.

HCFA COMMENTS

Medicare Coverage Issues Manual, Part 3, Section 60-5 released in February 1988 and Medicare Carriers Manual, Part 3, Section 4107.6 released in December 1988 already provide for each of these recommendations.

OIG RESPONSE

We question HCFA's citing Medicare Coverage Issues Manual, Part 3, Section 60-5, as a response to our recommendation that HCFA evaluate and strengthen as needed carrier implementation of Medicare coverage requirements. It was because these Manual guidelines were not being adequately followed by carriers visited, that we made this recommendation.

- 2. Publicize Medicare coverage requirements to the medical community. This could be done by issuing instructions or letters to all physicians, citing Medicare restrictions on POVs.**

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APPENDIX A

COST SAVINGS PROJECTIONS

The data for this inspection were pulled from the 1986 HCFA Annual Data Base (BMAD) and represent a 1 percent sample of all POV records for that year. One hundred and eighty-two records were found. These records represented bills for 102 individuals. According to an analysis of these bills, 44 of the beneficiaries had overpayment charges totalling \$59,162. This is an average of \$580 per beneficiary reviewed (standard error of \$79.48). The number of beneficiaries in the universe with bills for POVs is estimated at 10,200. With this information, it is estimated that there is approximately \$5,916,204 (standard error of \$810,699) in allowed overpayments in this population of beneficiaries. At the 90 percent confidence level, the lower cutoff point of this estimate is \$4,582,603 and the upper cutoff point is \$7,249,805. The overall precision of this estimate is 22.5 percent.

APPENDIX B

HCFA GENERAL COMMENTS AND OIG RESPONSE

The HCFA provided the following general comments on the draft report:

The OIG's findings of inappropriate Medicare expenditures was based largely on telephone interviews with beneficiaries not on claims reviewed, developed and, where appropriate, denied by carriers. We do not believe that an evaluation which focuses on information solicited from beneficiaries provides an accurate assessment of carrier claims processing effectiveness.

The OIG acknowledged that in 6 of 22 cases where beneficiaries reported they could operate a wheelchair manually when the power operated vehicle was obtained, physician documentation cited an inability to manually operate a wheelchair. In these situations, carrier medical review staff would have had no reason to question the physicians's statement assuming other documentation relating to the claim was consistent with the physician's certification statement.

We acknowledge that the OIG's study identified the existence of inappropriate expenditures for power operated vehicles. However, based on the focus of the review, we cannot agree to any specific dollar amount of unnecessary expenditures that would be projected nationally for the period in question.

OIG RESPONSE

In response to HCFA's comments that our review "was based largely on telephone interviews with beneficiaries not on claims reviewed, developed and, where appropriate denied by carriers," we would note that our statistically valid random sample of claims included a review of all documentation as well as the conduct of telephone interviews. In the six cases cited by HCFA where beneficiaries reported they could operate a wheelchair manually when the POV was obtained, even though the physician documentation stated otherwise, we assigned greater probative value to the beneficiaries' information in four cases based on our consideration of all available information and documentation.

We are satisfied that our projection of inappropriate expenditures is based on proper sampling techniques. We also do not believe that our projection of loss should be limited only to those cases where the carriers would have had reason to question physician statements, assuming other documentation relating to the claim was consistent with the physician's certification statement.

