DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 20 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson Daniel R. Levinson
Inspector General

SUBJECT: Review of Disaster-Related Medicare Claims Submitted by The Mobility Depot for Calendar Year 2005 (A-06-07-00079)

Attached is an advance copy of our final report on disaster-related Medicare claims submitted by The Mobility Depot (Mobility) in Baton Rouge, Louisiana, for calendar year 2005. We will issue this report to Mobility, a durable medical equipment (DME) supplier, within 5 business days. Mobility submitted claims to Palmetto GBA, a durable medical equipment regional carrier under contract with the Centers for Medicare & Medicaid Services (CMS).

As authorized by section 1135(b) of the Social Security Act (the Act) and in response to Hurricanes Katrina and Rita, the Secretary waived certain requirements of the Act to ensure that sufficient health care items and services were available to meet the needs of specified individuals, including Medicare beneficiaries, in emergency areas. The waivers also were intended to ensure that health care providers that furnished such items and services in good faith, but were unable to comply with certain program requirements because of the hurricanes, would be reimbursed and exempt from sanctions for noncompliance except in cases of fraud or abuse.

Our objective was to determine whether the beneficiaries identified on selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME.

We found that the beneficiaries identified on 40 selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME in accordance with Federal requirements and additional guidance described to us by CMS and Palmetto GBA as implementing the section 1135 waivers. Although we were not able to obtain documentation of CMS's DME replacement policies under the waivers, we determined that Mobility had complied with Federal requirements and the additional guidance described to us. We also determined that Mobility had established controls in an effort to ensure compliance with Federal policies.

Based on our sample results, we are not making recommendations for financial adjustments. Should CMS determine that Mobility did not correctly follow DME replacement policies in effect under the section 1135 waivers, it may wish to further examine Mobility's disaster-related claims.

This review was conducted in conjunction with the President's Council on Integrity and Efficiency (PCIE) as part of its examination of relief efforts provided by the Federal Government in the aftermath of Hurricanes Katrina and Rita. As such, a copy of the report has been forwarded to the PCIE Homeland Security Working Group, which is coordinating Inspectors General reviews of this important subject.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through e-mail at Gordon.Sato@oig.hhs.gov. Please refer to report number A-06-07-00079.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

JUN 26 2008

Report Number: A-06-07-00079

Mr. Keith Menville
Owner
The Mobility Depot
7931 Calais Avenue
Baton Rouge, Louisiana 70809

Dear Mr. Menville:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Disaster-Related Medicare Claims Submitted by The Mobility Depot for Calendar Year 2005." We will forward a copy of this report to the HHS action official noted below.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-06-07-00079 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. Tom Lenz
Consortium Administrator
Consortium for Financial Management and Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF DISASTER-RELATED MEDICARE CLAIMS SUBMITTED BY THE MOBILITY DEPOT FOR CALENDAR YEAR 2005

Daniel R. Levinson
Inspector General

June 2008
A-06-07-00079

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to section 1832(a)(2)(G) of the Social Security Act (the Act), Medicare Part B covers durable medical equipment (DME). The Centers for Medicare & Medicaid Services (CMS) defines DME as equipment that is primarily and customarily used to serve a medical purpose, is not useful in the absence of an illness or injury, can withstand repeated use, and is appropriate for use in the home. DME includes wheelchairs, scooters, hospital beds, walkers, and other medically necessary items. To receive Medicare reimbursement, a DME supplier must have a signed and dated order for the DME from the treating physician, as well as proof of delivery of the DME to the beneficiary. For certain DME items, the supplier also must have a signed certificate of medical necessity from the treating physician.

As authorized by section 1135(b) of the Act and in response to Hurricanes Katrina and Rita, the Secretary of the Department of Health and Human Services waived certain requirements of the Act in September 2005 to ensure that sufficient health care items and services were available to meet the needs of individuals in emergency areas who were enrolled in Medicare, Medicaid, and the State Children's Health Insurance Program. For Medicare DME suppliers, the waivers included certain conditions of participation, certification requirements, program participation requirements, and preapproval requirements, as determined to be necessary by CMS. The section 1135 waivers were intended to ensure that health care providers that furnished items and services in good faith, but were unable to comply with certain program requirements because of the hurricanes, would be reimbursed and exempt from sanctions for noncompliance except in cases of fraud or abuse.

This report focuses on The Mobility Depot (Mobility), a DME supplier in Baton Rouge, Louisiana. We reviewed a sample of 40 of the 85 disaster-related Medicare claims submitted by Mobility to Palmetto GBA, a CMS durable medical equipment regional carrier. These claims had dates of service in calendar year 2005 and included power wheelchairs, scooters, or manual wheelchairs.

OBJECTIVE

Our objective was to determine whether the beneficiaries identified on selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME.

SUMMARY OF RESULTS

The beneficiaries identified on the 40 selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME in accordance with Federal requirements and additional guidance described to us by CMS and Palmetto GBA as implementing the section 1135 waivers. Although we were not able to obtain documentation of CMS's DME replacement policies under the waivers, we determined that Mobility had complied with Federal requirements and the additional guidance described to us.

We also determined that Mobility had established controls in an effort to ensure compliance with Federal policies.

Based on our sample results, we are not making recommendations for financial adjustments. Should CMS determine that Mobility did not correctly follow DME replacement policies in effect under the section 1135 waivers, it may wish to further examine Mobility's disaster-related claims.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program to provide health insurance to people age 65 and over, those suffering from permanent kidney failure, and certain people with disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Pursuant to section 1832(a)(2)(G) of the Act, Medicare Part B covers durable medical equipment (DME). CMS defines DME as equipment that is primarily and customarily used to serve a medical purpose, is not useful in the absence of an illness or injury, can withstand repeated use, and is appropriate for use in the home. DME includes wheelchairs, scooters, hospital beds, walkers, and other medically necessary items. CMS contracts with durable medical equipment regional carriers (DMERC) to process and pay claims from DME suppliers.

Supplier Documentation Requirements

Medicare regulations (42 CFR § 424.57) establish the conditions that a DME supplier must meet to be eligible to receive payment for a Medicare-covered item, including furnishing documentation required to process the claim. Chapter 5 of the "Medicare Program Integrity Manual" (the Manual) (Pub. No. 100-08), issued October 28, 2005, provides that a DME supplier must fulfill certain documentation requirements before submitting claims to Medicare. Pursuant to section 5.1.1 of the Manual, the supplier is required to keep a signed and dated order from the treating physician on file. The supplier also is required to maintain proof-of-delivery documentation in accordance with section 5.2.1 of the Manual.

For certain DME items, a certificate of medical necessity (certificate) signed by the treating physician also is required. However, Transmittal 128 to the Manual, issued October 28, 2005, stated that the use of certificates for power wheelchairs, manual wheelchairs, and scooters would be phased out for claims with dates of service on or after May 5, 2005, and that a partially completed, unsigned certificate was required for those claims until system changes could be fully implemented in April 2006.

Section 1135 Waivers

Section 1135(b) of the Act authorizes the Secretary of the Department of Health and Human Services to temporarily waive or modify certain requirements, to the extent necessary to accomplish the statutory purpose, with respect to health care items and services furnished in an emergency. Under that authority and in response to Hurricanes Katrina and Rita, the Secretary waived several requirements on September 1 and 23, 2005, respectively, to ensure that sufficient health care items and services were available to meet the needs of individuals in emergency areas who were enrolled in Medicare, Medicaid, and the State Children's Health Insurance Program. For Medicare DME suppliers, the waivers included certain conditions of participation, certification requirements, program participation requirements, and preapproval requirements, as

determined to be necessary by CMS.[1] The section 1135 waivers were intended to ensure that health care providers that furnished items and services in good faith, but were unable to comply with program requirements because of the hurricanes, would be reimbursed and exempt from sanctions for noncompliance absent any determination of fraud or abuse.

The section 1135 waivers were in effect during our audit period. For designated geographic areas of Louisiana, the Hurricane Katrina waiver was in effect from August 29, 2005, to January 31, 2006, and the Hurricane Rita waiver was in effect from September 25, 2005 (retroactive to September 20), to January 31, 2006.

Replacement Durable Medical Equipment

Under CMS policy guidance in Chapter 15, section 110.2, of the "Medicare Benefit Policy Manual" (Pub. No. 100-02), updated by Transmittal 30 on February 18, 2005, Medicare payment may be made for replacement of medically required DME. Section 110.2(C) states that replacement refers to the provision of an identical or nearly identical item and that "Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster . . . . A physician's order and/or new [certificate], when required, is needed to reaffirm the medical necessity of the item."

According to a CMS official, physicians' orders and certificates were not required for replacement DME provided to individuals affected by the hurricanes if the CMS Common Working File (CWF) contained the certificates for the original equipment. Officials from Palmetto GBA, the DMERC for The Mobility Depot (Mobility), also stated that if a supplier submitted a disaster-related claim without a certificate but the CWF contained a certificate for the original DME, they would process the claim. CMS and Palmetto GBA could not provide documentation in support of this policy; therefore, we were unable to independently establish the guidance provided to Mobility during the emergency waiver period.

The Mobility Depot

Mobility is a Medicare-approved DME supplier in Baton Rouge, Louisiana.

In an effort to comply with Federal requirements under the section 1135 waivers, Mobility created a "Disaster Relief Equipment Replacement Form." The form was intended to ensure that individuals requesting replacement DME (1) were Medicare beneficiaries, (2) had DME prior to the hurricanes, (3) lived in designated emergency areas, and (4) were provided with replacement DME that was identical or nearly identical to the DME lost because of the hurricanes. The form provided Mobility with an internal control designed to comply with Federal requirements and guidelines that Mobility officials stated were posted on the CMS and Palmetto GBA Web sites following the hurricanes. In addition, Mobility submitted partially completed certificates for replacement DME as required by the Manual revision in Transmittal 128.

[1]The Secretary also waived other Medicare, Medicaid, and State Children's Health Insurance Program requirements that did not apply to DME suppliers.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the beneficiaries identified on selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME.

Scope

We selected Mobility for review because it received more Medicare reimbursement than any other supplier nationwide for DME claims that were designated as disaster related and that had dates of service in calendar year 2005. We limited our review to the 85 paid disaster-related claims that included power wheelchairs, scooters, or manual wheelchairs. From those claims, we selected a judgmental sample of 40 claims for review. For claims that contained multiple items, we reviewed only power wheelchairs and scooters because these items had the highest reimbursement amounts. We included manual wheelchairs in our review to ensure a representative selection of comparable mobility equipment.

We did not assess Mobility's overall internal control structure. We limited our review of internal controls to those related to ordering, delivering, and inventorying DME and maintaining beneficiary records before and after the hurricanes.

We performed our onsite work at Mobility in April 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, DMERC guidance, CMS manuals, and the section 1135 waivers;

- interviewed Mobility officials about policies and procedures for ordering, delivering, and inventorying DME and for maintaining beneficiary records before and after the hurricanes;

- interviewed CMS and DMERC officials about documentation requirements for hurricane-affected beneficiaries;

- reviewed the sample beneficiaries' records for physician orders, certificates, proof of delivery, and/or evidence that Mobility had contacted CMS if Mobility was not the original supplier to determine whether the beneficiaries were eligible for replacement DME;

- compared the sample beneficiaries' prehurricane addresses, as reported on the "Disaster Relief Equipment Replacement Form," with counties that the Federal Emergency

Management Agency had designated as emergency areas to determine whether the beneficiaries were eligible for replacement DME;

- compared the DME documented on invoice records and disaster-related claims with proof-of-delivery documentation to determine whether the replacement DME provided by Mobility and reimbursed by Medicare was delivered to the sample beneficiaries;

- contacted 25 of the 40 sample beneficiaries to determine whether they had received replacement DME from Mobility after the hurricanes;[2]

- reviewed the sample beneficiaries' DME claim histories in the CWF to determine whether the replacement DME received by the beneficiaries after the hurricanes was identical or nearly identical to the DME provided before the hurricanes; and

- discussed the results of our audit with Mobility officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

SUMMARY OF RESULTS

The beneficiaries identified on the 40 selected disaster-related Medicare claims submitted by Mobility were eligible for replacement DME and provided with allowable replacement DME in accordance with Federal requirements and additional guidance described to us by CMS and Palmetto GBA as implementing the section 1135 waivers. Although we were not able to obtain documentation of CMS's DME replacement policies under the waivers, we determined that Mobility had complied with Federal requirements and the additional guidance described to us. We also determined that Mobility had established controls in an effort to ensure compliance with Federal policies.

Based on our sample results, we chose not to review the remaining 45 disaster-related claims submitted by Mobility, and we are not making recommendations for financial adjustments. Should CMS determine that Mobility did not correctly follow DME replacement policies in effect under the section 1135 waivers, it may wish to further examine Mobility's disaster-related claims.

[2]We were unable to contact the remaining 15 beneficiaries because they (1) died after the date of the service claimed, (2) had disconnected or incorrectly listed phone numbers, or (3) did not return our calls.