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# MEDICARE COVERAGE OF SEAT LIFT CHAIRS

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**OFFICE OF INSPECTOR GENERAL**  
**OFFICE OF ANALYSIS AND INSPECTIONS**

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# MEDICARE COVERAGE OF SEAT LIFT CHAIRS

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## EXECUTIVE SUMMARY

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### PURPOSE

The purpose of this study was to review the Medicare program's experience in responding to the high volume of claims being received for seat lift chairs.

### BACKGROUND

A seat lift chair (SLC) is a mechanized chair, that assists a person in standing up and sitting down alone. The SLC has been covered by the Medicare program as durable medical equipment (DME) since 1978. The Health Care Financing Administration (HCFA) defines DME as: "... equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home." All elements of the definition must be met in order for the equipment to be covered by Medicare.

Prior to 1986, HCFA restricted Medicare coverage of SLCs to patients with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular diseases. In 1986, HCFA amended its policy to tie coverage of SLCs directly to medical necessity rather than diagnostic categories.

Nationally, in 1985, the number of SLC claims received tripled--from about 200,000 in 1984 to about 700,000--and allowed charges went from \$33.7 million to \$63.3 million. This experience revealed that the aggressive national marketing by suppliers of SLCs had given rise to a Medicare beneficiary "consumerism" in which beneficiaries were initiating requests for SLCs. It also raised questions about the adequacy of SLC coverage guidelines and the role of physicians in authorizing them.

### METHODOLOGY

Two samples were selected: 8 Medicare carriers; and 97 beneficiaries for whom a SLC claim was paid by Medicare in 1986. Site visits were made to the 8 carriers where discussions were held and case records for 161 selected 1987 paid claims were reviewed. In addition, telephone discussions were held with 107 respondents, including 61 seat lift chair beneficiaries, 7 family members of beneficiaries and 39 physicians who authorized chairs for some of the beneficiaries.

### FINDINGS

*There are strong indications that seat lift chairs do not qualify as durable medical equipment under the Medicare program.*

- Most beneficiaries' comments indicated that the SLCs were used primarily for non-medical purposes, such as personal comfort, and can be useful to persons in the absence of illness or injury. Between 31 percent and 44 percent did not require assistance in getting up from bed, table or toilet, and most of those said they were able to walk around their home, many without assistance. Most of the remaining beneficiaries were either unable to walk at all or went from the SLC to a wheelchair or power-operated vehicle in order to move about their homes. Since two of the four elements which define DME frequently are not met, there appears to be no basis for covering SLCs as DME under the Medicare program.
- Over 85 percent of the 61 beneficiaries contacted stated they initiated the request for seat lift chairs. Most said they learned about them through aggressive mass media marketing by suppliers.
- Sixty percent of the 61 beneficiaries said the supplier told them they would not have to pay anything, and 69 percent said they never made payments (i.e., for coinsurance or deductibles owed).
- Beneficiaries' physicians were often authorizing SLCs under pressure from both beneficiaries and suppliers, rather than as part of an existing course of treatment. In nearly half the 161 cases reviewed on-site, the SLCs were actually delivered before the chair was prescribed by a physician.

***The HCFA has recognized vulnerabilities related to SLC claims and has taken aggressive action; nevertheless, more effective payment safeguards need to be implemented.***

- More rigorous SLC claims review by Medicare carriers, in response to timely HCFA directives and guidance, resulted in significant reductions in SLC reimbursement after 1985.
- The question of carrier jurisdiction, already under review by HCFA, needs to be resolved to avoid out-of-service-area claims for which carriers lack beneficiary history data needed to prevent duplicate claims and to identify claims for contraindicated DME.
- Some carrier best practices for more effective evaluation of SLC claims need to be shared.

## RECOMMENDATIONS

### 1. Coverage of SLCs

In light of the strong evidence that most SLCs appear to be used primarily as furniture, HCFA should reconsider whether SLCs, in fact, meet the Medicare definition of DME.

### 2. Payment safeguards

- a) Immediate steps should be taken by HCFA to further improve the effectiveness of carrier processing of SLC claims. The HCFA should disseminate to its carriers best practices identified in this inspection which help to assure that current coverage requirements for SLCs are met. These include having carriers review beneficiaries' claims histories to:
  - determine whether the authorizing physician for the SLC had previously treated the beneficiary to help ascertain whether a course of treatment including a SLC was initiated prior to its authorization and delivery.
  - ascertain whether the beneficiary has a wheelchair and, if so, whether the SLC should also be covered.
- b) The HCFA should implement the OBRA 1987 provision prohibiting payment for DME unless the supplier has received a written order from the physician before delivery of the item to the patient.
- c) The HCFA should instruct carriers to develop and refer sanction recommendations to the OIG when carriers have identified physicians with patterns of unnecessarily prescribing SLCs.
- d) The HCFA should direct carriers to enforce the provisions of the Medicare Carriers Manual, section 5220, by allowing only those charges which the supplier expects to receive when they routinely waive collection of coinsurance and deductible payments. Suppliers found to have routinely advertised a general intention to waive such payments or to have failed to make reasonable collection efforts should be referred to the OIG for sanctions.
- e) The HCFA should also instruct carriers to refer to the OIG for civil money penalty action in which suppliers advertise SLCs as being "Medicare-approved" or "endorsed" or "authorized" in violation of the Medicare Catastrophic Coverage Act of 1988.

- f) The HCFA should expedite its review of the carrier jurisdiction issue and resolve the problem of out-of-service-area claims which denies carriers data essential to assuring the integrity of SLC and other claims.

## COMMENTS ON DRAFT REPORT

Comments received from the Administrator of HCFA indicate essential agreement with the findings. The HCFA reports it has begun a number of actions to implement the OIG recommendations, including:

- development of a draft *Federal Register* notice that addresses coverage issues relating to SLCs (recommendation 1);
- disseminating best practices information to the carriers (recommendation 2a);
- preparing regulations to implement section 1834 of the Omnibus Budget Reconciliation Act of 1987. The regulations will include SLCs as one of the items for which the supplier must have received a physician's written order before the item is delivered to the patient (recommendation 2b);
- instructing carriers, effective for services rendered on or after January 1, 1989, to require that the suppliers have a written order in hand prior to delivery of the equipment to the beneficiary (recommendation 2b);
- instructing the carriers to conduct an indepth medical review of all SLC claims (recommendation 2c); and
- reviewing the issues of carriers' jurisdiction in order to look at ways to resolve the problems of out-of-service area claims (recommendation 2f).

The HCFA also suggested that the OIG take vigorous action to curb abuses regarding SLCs noted in the report. We have expanded our recommendations to reflect such concerns expressed by HCFA and the OIG's Office of Investigations. However, before the OIG can act, cases must be referred to it by HCFA and its carriers through increased diligence in identifying instances of routine waiver of coinsurance and of suppliers who misuse the word "Medicare" in advertisements.

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## INTRODUCTION

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### BACKGROUND

"When I saw the TV advertisement I felt that I wanted it (the seat lift chair) because it was getting to the point where I was having difficulty getting out of a chair by myself."

This statement, obtained during the research for this inspection, was made by a Medicare beneficiary who was able to walk unassisted around her apartment, had a home health aide daily and had ordered the chair through a national supplier of medical equipment. When her physician was interviewed he verified that he had not initiated the order for the seat lift chair (SLC): "I did not order the chair and I can't say that it's part of my course of treatment, but the chair has been helpful to her."

Numerous complaints about SLCs received and investigated by the OIG kindled concern over the rapidly growing number of claims being received for SLCs apparently in response to aggressive marketing efforts by suppliers. This concern prompted this inspection.

#### *Medicare coverage of seat lift chairs*

Durable medical equipment (DME) is defined by the Health Care Financing Administration (HCFA) as: "... equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home." All of the elements of the definition must be met in order for the equipment to be covered by Medicare.

A seat lift chair, or SLC, is a mechanized chair, that assists a person in standing up and sitting down unassisted. The HCFA's current coverage policy and contractor guidelines for the SLC are based in part on a June 1978 Public Health Service (PHS) assessment requested by HCFA. The PHS offered the opinion that the chair "seems to be equipment presumptively medical" similar to hospital beds and wheelchairs, and as such should be covered as DME. This is in contrast to items which HCFA has determined to be "presumptively nonmedical," i.e., items that basically serve a comfort or convenience purpose, such as stairway elevators, posture chairs, bathtub lifts and seats, lounge beds (power or manual) and raised toilet seats. Such items are not covered as DME.

Prior to 1986, Medicare coverage of SLCs was restricted to patients with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular diseases. In 1986, HCFA clarified its policy to tie coverage of SLCs directly to medical necessity rather than diagnostic categories.

In order for a SLC to be covered, it is required that:

- a physician determines that a patient can benefit therapeutically from its use;



- the SLC is included in the physician's course of treatment and is likely to effect improvement or arrest or retard deterioration in the patient's condition, and
- the severity of the condition is such that the alternative would be chair or bed confinement.

Medicare carriers are responsible to see that these coverage requirements are met before approving payment. Payments are most frequently made under assignment to the SLC supplier, who is paid 80 percent of the allowable charge. The beneficiary is then responsible for paying the 20 percent coinsurance to the supplier. The purchase allowance for a SLC, which varies by carrier, ranged from \$697 to \$1,795 in September 1987; the average allowance was \$906.41. At that time, the allowable monthly charge for renting a SLC ranged from \$40 to \$162.

### *HCFA and OIG Concerns*

In May 1985, the HCFA Director of the Bureau of Eligibility, Reimbursement and Coverage issued a Medicare Coverage Alert on SLCs to HCFA Regional Administrators. The alert mentioned an extensive advertising campaign for "Medicare-approved" seat lift chairs that was resulting in numerous claims being submitted. Nationally, the number of SLC claims went from about 200,000 in 1984 to about 700,000 in 1985, and allowed charges went from \$33.7 million in 1984 to \$63.3 million in 1985.

In June 1985, the HCFA Bureau of Program Operations asked regional HCFA staff to conduct a survey of carriers' experiences in reimbursing claims for SLCs, "... so that, if necessary, more precise national procedures could be developed." The survey revealed that SLC coverage and reimbursement rules were being abused. Many more Medicare beneficiaries were obtaining SLCs than HCFA expected on the basis of existing guidelines and coverage criteria.

The OIG's Office of Investigations in New York, working with a large local carrier, helped devise a questionnaire to be completed by the prescribing physician after a SLC claim was submitted and before it was paid. This questionnaire solicited information for the carrier's medical staff on the medical necessity and appropriateness of the chair. This project resulted in a denial rate of 98.6 percent of the claims (1,198 of 1,215) submitted within an 8-week period in 1985 and a savings of \$910,480.

When later adopted by several other Region II carriers, the questionnaire again resulted in a very high rate of denials (82 percent) for 44,150 claims submitted for the first three quarters of Fiscal Year (FY) 1986 (a savings of nearly \$8.5 million). This encouraged HCFA and its carriers to implement similar claims development procedures. The use of a uniform national questionnaire was, however, not mandated and not every carrier followed the Region II example.

The experience of 1984 to 1986 showed that the aggressive national marketing of SLCs had given rise to a Medicare beneficiary "consumerism" in which beneficiaries were apparently initiating the medical authorization process for this equipment. It also raised questions about the adequacy of SLC coverage guidelines as well as the role of physicians in authorizing them.

## **OBJECTIVES**

- Describe the nature of beneficiary responses to the marketing by suppliers of seat lift chairs.
- Assess the role of physicians when their patients wish to obtain seat lift chairs under Medicare.
- Describe and characterize the nature of the response of HCFA and its carriers to the increase in the volume of seat lift chair claims.
- Identify those factors which raise particular concerns about SLC coverage and related Medicare policies and procedures.

## **METHODOLOGY**

### *Overview*

Site visits were made to 8 Medicare carriers where discussions were held with a total of 31 individuals and selected case records were reviewed. Respondents included 22 managers and supervisors and 9 staff members, among them claims examiners and Fair Hearing officers. Telephone discussions were held with 107 respondents, including 61 seat lift chair beneficiaries, 7 family members of beneficiaries and 39 physicians who had authorized chairs. Laws, regulations, HCFA correspondence, guidelines and special studies, as well as carrier and supplier forms and related materials were also reviewed.

### *Samples and respondents*

Two samples were drawn: a stratified purposive sample of carriers; and a random sample of beneficiaries for whom a SLC claim was paid by Medicare in 1986. More specifically, 8 Medicare carriers were selected from a universe of 35 carriers nationwide, stratified according to high, medium and low amounts of dollars allowed for SLCs. Two carriers were selected from the low group. Each of the of the sample carriers in turn provided a randomly selected group of 100 approved 1987 claims. From these, 161 claims (about 20 for each carrier) were randomly selected by the study team for on-site review while examining the carrier's SLC claims review procedures.

The second sample, consisting of 97 beneficiaries whose SLC claims were paid in 1986, was randomly selected from HCFA's Part B Medicare Annual Data base (BMAD) for all carriers.

Sample represented 25 from as many States around the country. Out of these 97 potential respondents, 68 contacts were made: 61 telephone discussions were held directly with beneficiaries and 7 with the spouses or children of deceased beneficiaries. From the initial sample of 97 beneficiaries, 50 beneficiaries were selected and an effort was made to contact the 50 physicians who authorized the SLCs for those beneficiaries. Thirty-nine were successfully contacted by telephone. These contacts resulted in 30 matched pairs of beneficiaries and their physicians with whom separate discussions were held.

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## FINDINGS

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*There are strong indications that seat lift chairs do not qualify as durable medical equipment under the Medicare program.*

**The SLC is used primarily as furniture.**

The fact that a SLC can serve a non-medical purpose as furniture is one characteristic which raises a question about its qualifying as DME under Medicare. The SLC can serve as a comfortable and attractive piece of furniture, much as a recliner. Its only distinguishing feature from an ordinary chair is that it has a mechanism which assists a person in sitting down and standing up. This circumstance appears to contradict one element of HCFA's definition of DME: that it would not be generally useful to a person in the absence of illness or injury.

As far back as 1984, a question was raised by a carrier's associate medical director on whether the SLC was primarily a therapeutically beneficial piece of medical equipment or a convenient piece of furniture. In a July 1984 letter to a member of Congress, he argued that the therapeutic value of the SLC does not meet HCFA's requirements that the patient can benefit therapeutically from use of the device:

"In my opinion, the key word here is therapeutic. I see no way that a chair of any kind can be said to have a part in the therapy or treatment of a patient's disease or disorder. No matter how I look at it, the seat lift chair is still an item of furniture. It may be handy; it may be convenient; and it may be desirable, but I do not view this as a part of *a course of treatment prescribed by a physician* for any named disorder, disease or disability. It seems to me that if we provide a seat lift for all of aged people who are crippled up with arthritis and others who are simply too old and weak to get out of a chair alone or at least without considerable trouble, that we are going to be spending an awful lot of money for some expensive equipment that really was not intended to be a part of the Medicare Program, which so greatly benefits our aged population. The more money we spend on things like this, the less there is going to be available for really necessary, truly medical care services and equipment."

In 1987 this physician wrote again to HCFA regarding SLCs and complained about the marketing techniques of suppliers and their effect on physician practice:

"I write this time over my personal private practice letterhead and personal signature to make a strong complaint as a practicing physician and as a tax-paying citizen of this country about the possibility of the Medicare Program providing reimbursement for this item of durable equipment. This is almost fraud, if not fraud, the way these people solicit our beneficiaries and the way they fill out all these forms in a way that no really practical practicing physician would complete them. You will notice that the language is almost exactly, if not exactly, that of the printed regulations. They have obviously constructed a piece of paper here and a completed form deliberately patterned after the

regulations and not after the facts in any particular case.... They send them to the physicians, and naturally most of the busy physicians, even if they are fairly alert and even if they are fairly experienced, will believe that the Congress intended their patient to have the benefit of this kind of device.... I doubt if any particular physician ... has any idea how much is being spent on durable medical equipment and how much of that is indeed strictly a luxury or buying furniture and not *medically* necessary.... I was hopeful that after our last session on this subject the regulation of authorizing the payment for these chairs would be substantially modified and clarified or even eliminated all together."

The following comments by some beneficiaries provide insights into the SLC's function as furniture:

"The chair is fine but it's too big for my living room. It's beautiful, like a piece of furniture."

"It's a very wonderful piece of furniture."

"It is very beautiful, but I regret not having one that reclines as well as lifts up."

"The seat lift chair is a good, sturdy chair and comes in handy."

"It's very handy and is very comfortable. It also has nice material."

One of the physicians who acknowledged that a chair was not part of his course of treatment for his patient said, "It's more of a convenience."

### **Some beneficiaries did not appear to be benefitting therapeutically from their SLC.**

The therapeutic value of a SLC ostensibly consists in helping a patient stand up in order to walk, so as to correct or stabilize the patient's condition and prevent confinement to bed or hospitalization. However, 18 percent of the 68 beneficiaries contacted said they were not able to walk around their home, even with assistance. Further, as many as 44 percent said that they didn't need assistance, either in standing when getting up from the table or when getting up from the toilet. Thirty-one percent said they didn't need help to stand when getting out of bed.

Some beneficiaries told us of the carriers of cases where the chair was not used or was not considered useful after delivery:

"I've never been satisfied with [it]," one beneficiary said. "My hips hurt me worst when I'm just sitting in it than when I sit in my recliner. I have been waiting for a letter from Medicare so I could tell my story.... I really hate the chair."

Another beneficiary wrote to the Medicare carrier:

"I'd like you to send someone to pick the chair up. It's very hard, and I can't put my left foot up. I used the chair about 15 minutes. It's new, I kept it covered."

There is little in what we learned from beneficiaries and physicians that supports any distinction between SLCs and, for example, posture chairs and lounge beds, items judged by HCFA to be "presumptively nonmedical" and not covered as DME by Medicare. On the contrary, there is compelling evidence that SLCs are not primarily serving a medical purpose and can be useful to a person in the absence of illness or injury; hence, there appears to be no basis for SLCs to be considered DME under Medicare provisions.

### **Beneficiaries learn about SLCs from advertisements and take the initiative to obtain chairs.**

When the 61 beneficiaries were asked, "How did you first learn about the seat lift chair you obtained?" 73 percent said they heard about it through supplier advertising; most mentioned television as a source with a smaller number mentioning suppliers' salespersons. Of those not mentioning advertising, 15 percent said they learned through family or friends; only 12 percent said they learned about the SLCs from a doctor.

Respondent comments, as well as study observations of television and brochure advertisements reveal that the ads commonly refer to the SLC as "Medicare-approved" and imply there may be no cost to the beneficiary. Indeed, 60 percent of the 67 beneficiaries who dealt with the suppliers, usually on a toll-free telephone number displayed in the ad, reported that the suppliers said they wouldn't have to pay anything for a SLC, suggesting the suppliers would be willing to forego the 20 percent coinsurance. One carrier's claims review supervisor told of seeing a television ad recently in which the announcer said that all one needed to do was call and order the chair if one had Medicare; no mention was made of the need for medical authorization.

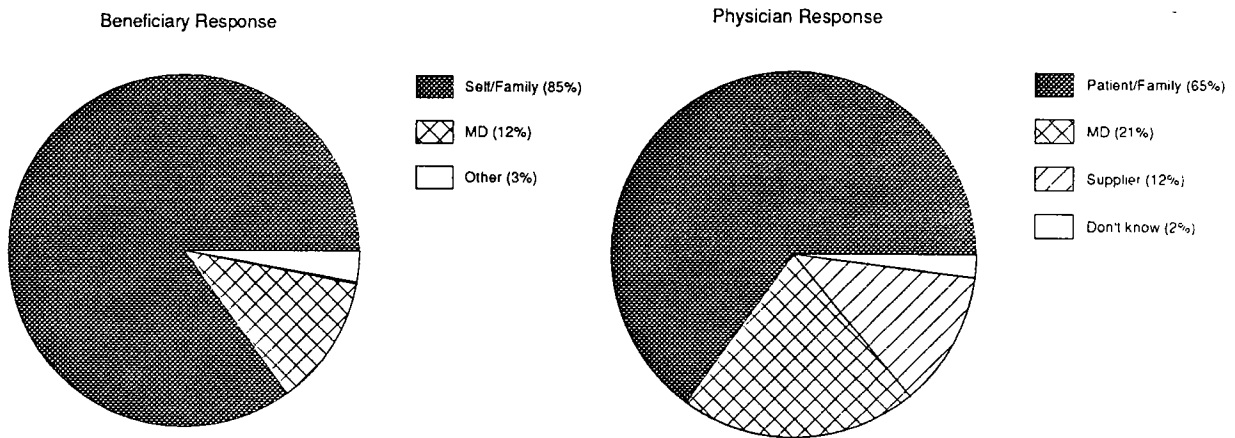
The degree to which suppliers are aggressively marketing seat lift chairs is reflected in the statement of one doctor: "There have been chair companies calling people and telling them all they have to do is buy the chair and then have the doctor okay it and Medicare will pay." One beneficiary said she ordered a chair through a television ad and, before she could contact her doctor, the chair was delivered to her home (within a few hours).

It should be noted that the Medicare Catastrophic Coverage Act of 1988, effective after the field work for this study was completed, prohibits the "use, in connection with any item constituting an advertisement ... the (word) 'Medicare'... in a manner which such person knows or should know would carry the false impression that such item is approved, endorsed, or authorized by the ... Health Care Financing Administration." Civil money penalties can be levied against violators.

**Most patients say getting the chair was their idea.**

Unlike most ordering of medicines or other DME, requests for SLCs tend to be initiated by the patient and subsequently authorized by the doctor. As shown in figure 1, 85 percent of the contacted beneficiaries said it was either their own idea or their family's idea to get a SLC. Only 12 percent stated it was their doctor's idea.

**Figure 1  
Whose Idea Was It to Get a Seat Lift Chair?**



One woman stated: "My mother and I were together when we saw the announcement (about the SLC) on television. We made the decision to purchase the chair and ordered it."

The physician responses in figure 1 confirm this reversal of roles - 65 percent of the 39 physicians confirmed it was their patient's idea.

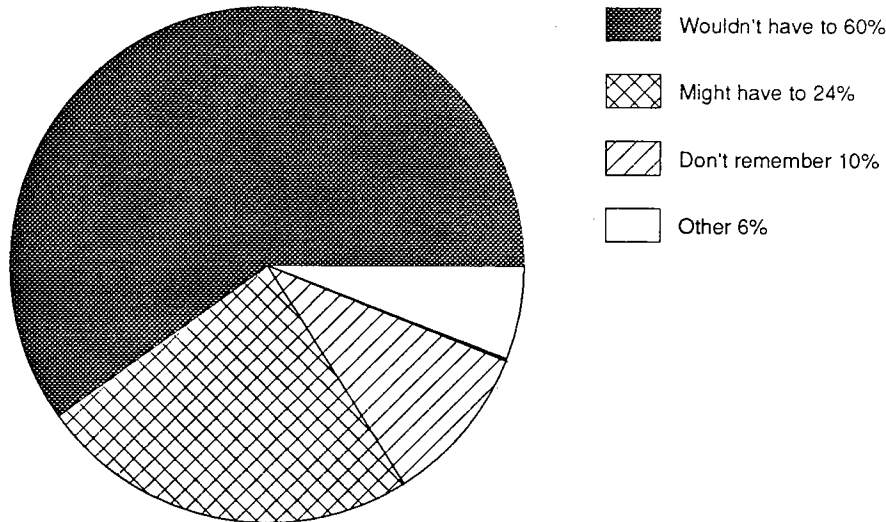
**Most beneficiaries were told they would not have to pay for SLCs.**

Eighty-four percent of the beneficiaries contacted said they were told they would not, or might or might not have to pay anything for their SLC; and 69 percent of them said they did not pay anything.

As shown in figure 2, 60 percent of the beneficiaries reported that the suppliers advised them they would not have to pay anything; another 24 percent were told they might or might not have to pay anything, 10 percent could not remember what they were told; and 6 percent gave other responses, e.g., their children had taken care of their finances for them.

Figure 2

**What Supplier Told Beneficiaries About Whether They Would Have to Pay for SLC**



When beneficiaries were asked whether they actually paid anything for their chair, 69 percent said no; a quarter said they paid something and 6 percent could not remember.

While a few beneficiaries said the supplier kept billing them, the great majority did not report any supplier efforts to collect coinsurance or deductible payments. While nearly two-thirds of the beneficiaries said their policy paid something for their SLC and 30 percent said they did not know. The majority, 58 percent, said their insurance did not pay anything.

The HCFA had given specific instructions to its regional offices in a May 1985 memorandum concerning SLCs to have carriers "enforce vigorously the ground rules in MCM (Medicare Carriers Manual) section 5220 when suppliers, including suppliers of seat lift chairs, routinely waive the collection of coinsurance or deductible amounts." The appropriate carrier action in response to such instances was to assure that:

"(1) the amount allowed on current claims should not exceed the amount the supplier actually expects to receive; and (2) the correct actual charges should be recorded and accumulated for use in future updates of the supplier's customary charge profile. The supplier should, of course, be notified."

The beneficiary responses indicate that some such action by carriers may have been warranted.

**Many physicians authorize SLCs in response to beneficiary or supplier requests.**

The physician interviews indicated that SLC approvals are often responses to patient or family requests rather than professional treatment decisions of the physician. One doctor, when



asked if he initiated the authorization for the seat lift chair, said: "The chair was her request and I authorized it to help her get up and watch television."

While most physicians contacted did not report being pressured into prescribing the chair, nearly one-fifth did admit pressure from the patient or the family. One said:

"This is a small town and everyone knows me. I have been treating Mrs. "X" for 5 years. When the supplier called to say he needed an authorized form for the chair Mrs. "X" had ordered, I was very uncomfortable. Then her daughter called to say her mother needed the chair and I should give it to her. I signed."

Another physician spoke of pressure from both patients and suppliers:

"The supplier tells the beneficiary that if their doctor fills in the right information on related illnesses, coverable by the Medicare program, they can get a seat lift chair. The patient pressures the doctor as does the supplier, putting the doctor in the middle."

Other physicians, however, noted that they sometimes turn down requests for chairs. One doctor, for example, said: "I've turned down patients who ask for them because I felt they didn't need them."

Suppliers frequently provide authorization forms for doctors to sign. Most (58 percent) of the physicians contacted reported that suppliers provided forms or suggested the words to use. Another 32 percent said both they and the suppliers play a part in completing the forms. Only 8 percent wrote an authorization without any supplier involvement.

Suppliers have been accused, by some physicians interviewed, of soliciting SLC business from Medicare beneficiaries and then sending authorization forms to the beneficiaries' physicians without the knowledge or permission of the beneficiaries.

**Including a SLC in beneficiary's course of treatment often appears to be a physician justification after the fact.**

An important requirement for SLC coverage is that the SLC be part of the physician's course of treatment. Five physicians (13 percent) of those contacted acknowledged that the SLC was not part of their course of treatment. When they were asked if the SLC was intended as part of the patients course of treatment, several remarked as follows:

"No, the patient is not ambulatory but the alternative would be a nursing home."

"The patient wanted the chair and her daughter felt it would help when mom is in the living room watching T.V."

"It (the authorization form) does look like my signature but I have no records regarding authorizing a chair and I wouldn't."

Eighty-four percent of the physicians said the chair was intended for use as part of their course of treatment for their patients. However, a comparison of the date the physician authorized the chair with the date of service, i.e., the date the chair was delivered, showed that in nearly half (48 percent) of 141 cases reviewed on-site, for which both dates were available, the date of delivery occurred before the chair was authorized. The course of treatment in these cases, rather than preceding the ordering of the SLC, may not have been developed until after the chair was ordered.

One physician expressed the view that "doctors should not be put in a position to rubber stamp an authorization because DME has been ordered by a patient and already delivered, and now the patient states that Medicare will pay 80 percent if the doctor would just sign."

Some physicians also play a passive role in following up on the patient's use of a SLC and on any therapeutic value the chair may have had. After an interval of 1 1/2 to 2 1/2 years following their authorization of a SLC, 44 percent of physicians contacted said they had not spoken to their patient about whether the seat lift chair was helpful. Another 10 percent did not remember whether they had or not. Although 84 percent of the physicians had seen their patient subsequent to authorizing the SLC, 27 percent did not know whether the chair had any effect on the patient's condition. A large number of physicians profess ignorance of what Medicare coverage guidelines are for SLCs. As a matter of fact, when asked whether they felt this authorization of a SLC for their patients met Medicare guidelines, nearly half (46 percent) said they did not know the guidelines.

### **Medicare is the most prominent payer for SLCs.**

Commercial insurance members of the National Health Insurance Association of America do not ordinarily offer coverage for DME, particularly SLCs. In order to provide such coverage, a rider would be added to policies if subscribers were willing to pay substantially higher premiums. The National Association of Blue Cross and Blue Shield reported that its plans do not cover SLCs for private policy holders. The Veterans Administration (VA) does cover SLCs under very stringent controls. All prescriptions are reviewed by a VA physician and the VA's Chief of Prosthetics to assure that like other types of medical equipment, SLCs will be "furnished when it is medically necessary and not for the convenience of life outside the hospital." The volume of SLCs approved by the VA for 1987, primarily for patients with prosthetic limbs, was only 200. A survey of the nation's eight largest State Medicaid plans revealed that only two cover SLCs. In those States, prior approval under stringent medical necessity guidelines is required.

*The HCFA has recognized vulnerabilities related to SLC claims and has taken aggressive action; nevertheless, more effective payment safeguards need to be implemented.*

#### **Carriers alerted by HCFA to take action.**

Coverage of SLCs was not seen as a serious problem by HCFA until early 1985, when a remarkable increase in SLC claims and reimbursement was noted: SLC claims rose 240 percent from 205,800 in 1984 to 700,600 in 1985. The amounts allowed for SLCs rose 94 percent from \$33,750,653 in 1984 to \$63,360,201 in 1985.

In June 1985, HCFA notified its regional offices to have carriers review SLC claims more closely. The HCFA also surveyed carriers to learn how SLC claims were being handled. The survey results, reflected in a November 1985 memorandum, indicated "... this coverage area continues to be a source of potential program abuse although current coverage policy indicates seat lifts are to be covered only in very limited situations." Regional offices were advised to encourage carriers to develop a "... special purpose claims development and certification form when requesting additional information from physicians." Such a form was already in use by 11 carriers and a model was attached to the memorandum for carrier use. A list of "Claims Review Criteria for High Cost Durable Medical Equipment Claims" was also provided.

#### **Carrier review efforts reduced amounts allowed by 1986 and carriers continue to apply coverage guidelines.**

Nationally, the timely actions taken by HCFA and carriers in 1985 and 1986 were largely responsible for the 66 percent drop in volume of SLC claims to 236,013 in 1986 and the 55 percent drop in allowances in 1986 to \$28,304,558. The dollar amounts allowed illustrate how effective the actions by HCFA and carriers have apparently been. Nationally, more than half (56 percent) of the carriers reduced the amounts allowed in 1986. The eight sample carriers showed allowances for SLCs dropping in 1986 to \$4,488,000 from \$25,175,000 in 1985.

The results of the eight carrier site visits show that carriers continue to apply SLC coverage guidelines, although the efforts of some are more rigorous than others. Three carriers use medical staff personnel to review SLC claims to determine their appropriateness; five use non-medical staff personnel, usually a claims examiners. One medical director said that "the non-medical staff are capable of making coverage decisions and the carrier couldn't afford to pay [the medical director's] salary to review such claims." However, seven carriers use medical personnel to review questionable claims including denied SLC claims going to fair hearings.

A best practice was seen at six carriers where claims examiners check beneficiaries' claims histories to determine whether the beneficiaries also have wheelchairs. The possession of a wheelchair and a SLC, from the carriers' perspective, is generally contraindicated, based on the reasoning that the therapeutic benefit of the chair, if any, resides only in its ability to get the patient into a standing position so he or she can ambulate (with or without assistance). If the patient is helped to a standing position only to sit down again in a wheelchair, that patient

would be chair-ridden even with the SLC. At best, the SLC would have limited value in allowing the brief stretching of the patient's legs before the patient is again chair-ridden.

Of the 68 patients or family members contacted in 1988, 9 percent volunteered that the beneficiary also had a wheelchair. When their Medicare claims histories were reviewed for 1986 (the year they received their SLC), we found that an additional three percent obtained wheelchairs in that year alone. A recent postpayment audit conducted by a sample carrier of one supplier found that 56 of 72 beneficiaries with SLCs also had wheelchairs. As a consequence of this study the carrier expanded the audit and reviewed a sample of 257 beneficiaries who reside within the State or in several neighboring States. Forty-five percent of the SLCs were denied as not medically necessary and a refund of over half a million dollars was established.

An emergent problem, however, is that the prepayment checking of beneficiary claims histories is difficult when the beneficiary resides outside the carrier's service area, a frequent circumstance. Six of the carriers who review beneficiary claims histories in-house do not obtain out-of-area claims histories from other carriers. Their reason is they cannot wait for the information on an otherwise "clean" SLC claim which must be processed under stringent payment cycle standards.

There is concern over carrier claims jurisdictional issues and the problems they generate, particularly when SLCs are involved. Extensive supplier national media advertising frequently results in carriers paying SLC claims for beneficiaries out of their service area for whom they have no claims histories, possibly resulting in unidentified duplicate claims. In addition, carrier reasonable charge allowances are sometimes higher for out-of-area beneficiaries whose claims would have been reimbursed less by a carrier serving their community. Among the 97 beneficiaries included in the 1986 SLC paid claims sample, 26 (27 percent) did not reside in the area serviced by the carrier paying the claim. The HCFA is currently reviewing the area of carrier claims jurisdiction.

Another carrier best practice involves reviews of beneficiaries' claims histories to determine whether the authorizing physician for the SLC has previously treated the beneficiary, a likely indicator that a course of treatment preceded the prescribing of the SLC.

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## RECOMMENDATIONS

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### 1. *Coverage of SLCs*

In light of the strong evidence that SLCs appear to be used primarily as furniture, HCFA should reconsider whether SLCs, in fact, meet the Medicare definition of DME.

### 2. *Payment safeguards*

- a) Immediate steps should be taken by HCFA to further improve the effectiveness of carrier processing of SLC claims. The HCFA should disseminate to its carriers the best practices identified in the inspection which help to assure that current coverage requirements for SLCs are met. These include having carriers review beneficiaries' claims histories to:
  - determine whether the authorizing physician for the SLC had previously treated the beneficiary. This would indicate whether a course of treatment including a SLC was initiated prior to its authorization and delivery; and
  - ascertain whether the beneficiary has a wheelchair or power-operated vehicle and, if so, whether the SLC should also be covered.
- b) The HCFA should implement the OBRA 1987 provision of PL 100-203, section 1834, which prohibits payment for DME unless the supplier has received a written order from the physician before delivery of the item to the patient.
- c) The HCFA should instruct carriers to develop and refer sanction recommendations to the OIG when carriers have identified physicians with patterns of unnecessarily prescribing SLCs.
- d) The HCFA should direct carriers to enforce the provisions of the Medicare Carriers Manual section 5220 by allowing only those charges which the supplier expects to receive when they routinely waive collection of coinsurance and deductible payments. Suppliers found to have routinely advertised a general intention to waive such payments or to have failed to make reasonable collection efforts should be referred to the OIG for sanctions.
- e) The HCFA should also instruct carriers to refer to OIG for civil money penalty cases in which suppliers advertise SLCs as being "Medicare-approved" or "endorsed" or "authorized" in violation of the Medicare Catastrophic Coverage Act of 1988;

- f) The HCFA should expedite its review of the carrier jurisdiction issue and resolve the problem of out-of-service-area claims which denies carriers data essential to assuring the integrity of SLC and other claims.

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## APPENDIX

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### COMMENTS ON DRAFT REPORT

Comments received from the Administrator of Health Care Financing Administration indicate essential agreement with the findings. The HCFA reports it has begun a number of actions to implement the OIG recommendations, including:

- development of draft *Federal Register* notice that addresses coverage issues relating to SLCs (recommendation 1);
- disseminating best practices information to the carriers (recommendation 2a);
- preparing regulations to implement section 1834 of the Omnibus Budget Reconciliation Act of 1987. The regulations will include SLCs as one of the items for which the supplier must have received a physician's written order before the item is delivered to the patient (recommendation 2b);
- instructing carriers, effective for services rendered on or after January 1, 1989, to require that the suppliers have a written order in hand prior to delivery of the equipment to the beneficiary (recommendation 2b);
- instructing the carriers to conduct an indepth medical review of all SLC claims (recommendation 2c); and
- reviewing the issues of carriers jurisdiction in order to look at ways to resolve the problems of out-of-service area claims (recommendation 2f).

The HCFA also suggested that the OIG take vigorous action to curb abuses regarding SLCs noted in the report. We have expanded our recommendations to reflect such concerns expressed by HCFA and the OIG's Office of Investigations. However, before the OIG can act, cases must be referred to it by HCFA and its carriers through increased diligence in identifying instances of routine waiver of coinsurance and of suppliers who misuse the word "Medicare" in advertisements.