

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ORDERING MEDICARE EQUIPMENT
AND SUPPLIES**

Physician Patient Relationship



**JUNE GIBBS BROWN
Inspector General**

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EXECUTIVE SUMMARY

PURPOSE

To determine whether the relationship between the physician and the patient affects the certification for Medicare medical equipment and supplies

BACKGROUND

We are undertaking two studies to look at the role of the physician in certifying non-physician services. The first report, “Ordering Medicare Equipment and Supplies, Physician Perspectives” OEI-02-97-00081 is about physicians’ perceptions of the certification process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). This second report looks at the relationship between the physician and the patient and its’ effect on the certification of medical equipment and supplies.

In general, Medicare recognizes the physician as the key figure in determining the appropriate utilization of all medical services. Accordingly, Medicare requires that payment for certain non-physician services, such as medical equipment and supplies are conditional on the existence of a physician’s order or certificate of medical necessity which must be kept on file by the supplier. This report is based on the analysis of questionnaires sent to physicians who certified a sample of 1,000 medical equipment or supply items, a review of claims histories and medical records associated with those 1,000 medical equipment and supply items, telephone interviews with a sub-sample of 200 patients, a review of the certificates of medical necessity or physician’s orders submitted by the suppliers and interviews with the 4 durable medical equipment regional carriers.

FINDINGS

Most Medical Equipment and Supplies are Prescribed by the Treating Physicians, But Some Problems Are Identified

The referring physicians for 89 percent of the items billed knew and treated the patients for whom they ordered medical equipment and supplies. Of the remaining 11 percent we determined that almost one half appear to be coding errors with the unique physician’s identifying number. In the remaining 6 percent of cases, the physician reported not knowing the patient without explanation. Additionally, 13 percent of physicians who say they knew the patient did not order the equipment or supplies. Ninety percent of patients

interviewed who received the medical equipment and supplies report being treated by the referring physician during the study period.

Medicare Payments Were Questionable for Fourteen Percent of the Sample Medical Equipment and Supplies

In nine percent of the medical records we received there was no documentation of the need for the equipment or supplies billed. In another four percent patients required the equipment when it was originally ordered but no longer needed it, patients receiving diabetic supplies were not insulin dependent as required by Medicare in 1996, billings were after the date of the patient's death, or equipment or supplies were inappropriately billed to skilled nursing facilities. In one percent of the records there was sufficient evidence to fully prove that the equipment or supplies were unnecessary.

Medical records are more often questioned when physicians report not ordering the equipment or supplies and less likely to be questioned when there was a recent encounter between the physician and patient.

The questionable records represent \$414 million of Medicare payments. This is a conservative amount because it is based on a review of the 530 of 1000 records we received. We did not receive an additional 470 records that we requested. The failure of providers to supply us with these records makes it likely that the payment error rates were at least equal to or may even have been greater than those we received. Thus the actual dollar amount of questionable Medicare payments is likely to be significantly higher than the amount we calculated.

Vulnerabilities Exist in the Medical Equipment and Supply Ordering Process

Currently Medicare regulations do not require the patient's diagnosis, the physician's name, identifying number, or speciality on the claim. Because there are diagnosis or physician speciality driven policies, the physician's name and identifying number are important in order to contact the referring physician for any information about the patient or to review a medical record for the appropriateness of equipment or supplies. The lack of an ongoing medical relationship between the durable medical equipment regional carriers and physicians hampers the educational efforts about supplies and equipment. The durable medical equipment carrier does not have physician information readily available, and is not responsible for educating the physicians about the Medicare requirements for medical equipment or supplies.

RECOMMENDATIONS

We found that when the referring physician knew the patient, more appropriate medical equipment and supplies were ordered. Therefore we support the Health Care Financing Administration in its' requirement that the referring physician be a physician who has treated the patient and recommend that:

- ▶ the physician who orders the equipment or supplies be required to treat the patient prior to the order and
- ▶ a systematic process be developed to assure that the supplier submits a new CMN or order to the DMERC when the physician changes, the equipment or supply or the medical need for the equipment or supply changes.

We recognize that as a result of the Balanced Budget Act of 1997, physicians are required to provide diagnostic information to suppliers and the suppliers provide this information on claims for medical supplies and equipment when the DMERC has a medical review policy requiring such diagnostic information. We support this, but recommend that:

- ▶ the referring physician's name and specialty, the patient's related diagnostic information be required on all claims for medical equipment and supplies.

This report also supports the recommendation in our report entitled "Ordering Medicare Equipment and Supplies, Physician's Perspectives" OEI-02-97-0081. This report recommended that the Health Care Financing Administration strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies and suggested the following approaches:

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

physicians include the coverage and payment rules and cost of equipment for the specific equipment or supplies ordered.

We will refer all unnecessary and questionable cases and those where the physician did not see the patient or did not order the equipment or supplies to the appropriate Durable Medical Equipment Regional Carrier for further review.

COMMENTS

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

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

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INTRODUCTION

PURPOSE

To determine whether the relationship between the physician and the patient affects the certification for Medicare medical equipment and supplies.

BACKGROUND

We are undertaking two studies to look at the role of the physician in certifying non-physician services. The first report, “Ordering Medicare Equipment and Supplies, Physician Perspectives” OEI-02-97-00081 is about physicians’ perceptions of the certification process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). This includes: wheelchairs and hospital beds; prosthetics and orthotics; catheters, ostomy and wound care supplies, and enteral and parenteral nutrition. For the purposes of our reports we refer to DMEPOS as medical equipment and supplies. In the first report we found that physicians are generally satisfied with the process, but would like it to be easier and less time consuming. They would also like more detailed rules and specific criteria regarding Medicare coverage and eligibility for medical equipment and supplies. This second report looks at the relationship between the physician and the patient and its’ effect on the certification of medical equipment and supplies.

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

Medicare Expenditures for Medical Equipment and Supplies

According to published Health Care Financing Administration (HCFA) statistics, in 1996, Medicare paid an estimated \$4.8 billion for medical equipment and supplies under Part A and Part B of the program. Part A, hospital insurance, covers services which are furnished by hospitals, home health agencies, and skilled nursing facilities. Part B, supplementary medical insurance, covers a wide array of non-institutionalized care. These include

physicians services, medical equipment and supplies, outpatient hospital services, diagnostic laboratory tests, x-rays and ambulance services.

The HCFA administers Medicare and contracts with private insurance companies to process and pay claims. Contractors that process claims for Part A, such as those for home health agency services, are considered fiscal intermediaries. Contractors that process claims for Part B, such as physician visits are considered carriers. Intermediaries and carriers are also responsible to assure that Medicare coverage requirements are met before approving payment.

Medicare Durable Medical Equipment Regional Carriers (DMERCs)

In October 1993 HCFA began processing claims for medical equipment and supplies through 4 durable medical equipment regional carriers (DMERCs). These 4 carriers are responsible for all 50 States, the District of Columbia, and Puerto Rico. These entities are responsible for ensuring that coverage requirements for medical equipment and supplies are met before approving payment. Although fiscal intermediaries also process some claims for medical equipment and supplies through the Part A coverage of home health agency services, this report will focus only on medical equipment and supplies covered by Part B and processed by the DMERCs.

Certification of Durable Medical Equipment

Medicare pays for medical equipment and supplies that are ordered or prescribed by a treating physician and is appropriate for the patients' diagnosis and symptoms as determined by the DMERCs. Suppliers must obtain and keep on file a physician's order or prescription for all the medical equipment and supplies that they bill to Medicare. The supplier usually puts the name and unique physician identification number (UPIN) of the referring physician and the patient's diagnosis related to the equipment or supplies ordered on the claim, but the claim will be paid without this information.

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

Some of the items within the following 14 groups require a CMN:

- | | | | |
|---|------------------|---|--------------------------|
| ! | hospital beds | ! | motorized wheelchairs |
| ! | support surfaces | ! | manual wheelchairs |
| ! | lymphedema pumps | ! | osteogenesis stimulators |

- | | |
|--|--|
| ! Transcutaneous Electrical Nerve Stimulators (TENS) | ! Continuous Positive Airway Pressure (CPAP) devices |
| ! seat lift mechanisms | ! power operated vehicles |
| ! parenteral nutrition | ! enteral nutrition |
| ! home oxygen therapy | ! infusion pumps |

The CMNs were revised in October of 1995. They were standardized and reformatted by HCFA and the DMERCs. Each of the aforementioned equipment and supply groups now have their own CMN form.

CMNs now have four sections: A-D. Section A is to be filled out by suppliers. Section B lists the clinical justifications or the medical necessity of the device. This section is not to be filled out by suppliers. The Durable Medical Equipment Regional Carriers prefer that a clinician fills out Section B, but there is no specific requirement to that effect. Section C contains a narrative description of all items ordered, the supplier's charge and the Medicare fee schedule allowance. Section D must be signed by the physician certifying the medical necessity of the device. This certifying physician cannot have any financial or contractual relationship with the supplier of the item.

The Omnibus Budget Reconciliation Act (OBRA) of 1990 prohibited suppliers from filling out the CMNs themselves. The HCFA interpreted this to mean that suppliers could fill out only the administrative portion of the CMN. In addition, in instances where the supplier initiates the process by filling out the administrative portion, HCFA requires that they must also send a letter to the physician indicating what their charge and Medicare's allowed amount for the item is.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 requires that when an item is ordered by a physician, but furnished by another entity such as a supplier, the entity furnishing the item, that is the supplier, must provide diagnostic or other medical information in order for payment to be made to the supplier. The physician must provide this information to the supplier when the item is ordered. This is effective January 1, 1998. Physicians are required to provide this diagnostic information when ordering supplies when the carrier has put in place a local medical review policy requiring such diagnostic information from the supplier.

OIG Activities

There have been many OIG efforts related to the utilization of non-physician services. The following two studies have addressed the role of physician authorization in the provision of these services. An OIG study entitled "The Physician's Role in Home Health Care" (OEI-02-94-00170) found that at least 91 percent of the physicians who certified

the plan of home health care had a pre-existing relationship with the patient for whom the plan was designed.

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

METHODOLOGY

Using a 1 percent sample of HCFA's 1996 National Claims History (NCH) data, we selected a stratified, random sample of 1000 medical equipment and supply items. We stratified our sample between codes that require a CMN and codes that have no such requirement. We then further stratified the CMN codes between oxygen and non-oxygen items. This ensured that oxygen related items were not over-represented in our sample.

Within the non-CMN stratum, we selected medical equipment and supply items from the procedure codes used for billing (HCPCS) where each item cost was more than \$103 or where HCFA allowed more than \$260,000 in 1996. These codes accounted for 96 percent of all the medical equipment and supply items in 1996 and 99 percent of the total monetary amount allowed by HCFA in 1996. We further divided the 724 non-CMN codes into three separate groups: one containing five codes which account for 30 percent of all non-CMN line items; another with 20 codes which account for an additional 30 percent; and, finally, one with the remaining non-CMN codes. This prevented any over representation in our non-CMN stratum. We randomly selected 200 line items from each of the 5 stratum for a total of 1000 items.

From this sampling, we identified the beneficiary, his/her diagnosis, the supplier, the place of service, the certifying physician, and his/her specialty.

Beneficiary Histories

Using the appropriate codes for physician visits and other medical equipment and supplies in the beneficiary billing histories, we determined whether the referring physician identified from our sampling had billed Medicare for any physician encounters in a 6 month period prior to date of the claim. We used this information as one source of the physician's prior treating relationship with the beneficiary.

Physician Survey and Medical Record Review

We mailed a questionnaire to the 983 physicians certifying the equipment for the 1000 line items in our sample and asked them: if they have ever treated and how long they have known the beneficiaries for whom they certified these services; the date of their last visit with that beneficiary; and if they ordered the equipment or supplies. We received 695 completed questionnaires from sample physicians.

We also requested the 1000 relevant medical records for each of the 985 beneficiaries in our sample. We received 530 of the 1000 medical records requested from the physicians or from the facility where the physician told us the medical record was kept. We developed a screening instrument to review the medical records to determine whether the information provided supported the need for the medical equipment or supplies that was provided to the beneficiary. We used the HCFA requirements for reimbursing the particular equipment or supplies being reviewed to develop the screening instrument. This instrument was reviewed by the DMERCs and changed according to their suggestions. The screening was done by a registered nurse on the inspection team to determine whether information provided by the physician in the medical record supported the need for the medical equipment or supplies provided. The questionable medical records were referred to a DMERC and reviewed by their medical staff.

We conducted a second and third mailing to non-respondents and **782 physicians** responded to us in some form. Seven hundred and fifty-one physicians either sent in the questionnaire, a medical record, or both. Of the remaining 31 physicians, 20 notified us they are retired, and 11 directed us to a nursing home for the relevant patient information. The remaining physicians are non-respondents who we were either unable to locate or failed to respond. We were able to gather information in some form on **all but 32 sample physicians**.

Suppliers

We identified the suppliers for each of the beneficiaries in our sample and requested copies of the CMNs and/or physician orders for items supplied to those beneficiaries. We examined these forms to determine when they were signed and whether the physician who signed the CMN or ordered the item is also the referring physician in our sample. We received 920 returns from the suppliers.

Durable Medical Equipment Regional Carrier (DMERC) Interviews

We interviewed by telephone and on-site the appropriate carrier staff to determine how the physician certification requirements are overseen. We asked them to identify any existing prepayment screens and/or edits regarding physician authorization. We also

discussed their post-payment efforts in this area. Finally, we obtained and reviewed any policies or educational materials the carriers might have which address this issue.

Beneficiary Survey

We selected a random sub-sample of 200 beneficiaries for telephone interviews. These interviews included questions regarding: who initiated the provision of the service; whether, and how recently, the physician who had certified the service had treated the beneficiary; and whether the beneficiary had received and was satisfied with the overall process of obtaining the equipment. We contacted and interviewed 145 beneficiaries in the sub-sample.

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

FINDINGS

Most medical equipment and supplies are prescribed by the treating physician, but some problems are identified

Almost all physicians know the patient

The referring physicians for 89 percent of the items billed knew and treated the patient for whom they ordered durable medical equipment and supplies. Of the remaining 11 percent we determined that almost half appear to be coding errors with the unique physician identification number (UPIN). Some of these UPIN problems include transposed numbers or numbers with the wrong prefix in the claim information. Often, the name of a completely different physician and an inappropriate specialty appear on the claim.

With regard to the remaining cases (6 percent) the claim and the certificate of medical necessity or order have the physician's name and signature but the physician reports not knowing the patient. This could occur for a number of reasons. The physician may not remember a patient who is seen in a location other than their office, such as a nursing home, because the records would be kept at the other site. It may have been a patient whom they treated years ago and ordered equipment or supplies that do not require re-certification or the supplier may have signed the physician's name to complete the form.

Over one-half (52 percent) of the physicians who did not know the patient reside in California, Florida, and New York compared to 23 percent for all other States. Eighteen percent of these physicians are general surgeons, although this physician specialty comprises only 4 percent in the sample. There is no pattern relative to the kinds of supplies and equipment billed.

Additionally, thirteen percent of physicians who say they knew the patient did not order the equipment or supplies. However, a review of the certificates of medical necessity or orders show that the physician's name was the same in three out of four cases. This may occur for a number of reasons. The doctor may not remember the patient or another physician in the office or an office assistant may have ordered the equipment or supplies. Another possibility is that the supplier signed the CMN or order.

Almost all patients know the physicians

Ninety percent of the patients receiving medical equipment and supplies report being treated by the referring physician during the study period. The doctor was usually their regular physician (72 percent) who had treated them for several years. In many cases the patient continues to be treated by the physician. Ninety-six percent of the patients

confirmed receiving the medical equipment or supplies ordered in our sample. More than three-fourths (79 percent) of beneficiaries who received medical equipment or supplies continue to use them.

Many physicians did not treat the patient within 6 months of receiving the equipment

A review of Medicare data showed that 39 percent of physicians did not bill Medicare for a physician visit 6 months prior to the claim. Those physicians who had no encounter in the billing history were less likely to submit medical records than those with an encounter. Sixty-seven percent of those physicians who did not show an encounter sent in medical records compared to 85 percent who had an encounter.

We attempted to contact those patients whose billing history showed no prior physician encounter and whose physician did not send in a medical record or questionnaire. We will refer to this group as non-respondents. While only 19 of 51 patients were contacted, 18 out of 19 reported knowing the physician on the claim. Only one patient reported not knowing the physician on the claim. While wheelchairs and wheelchair accessories represent 12 percent of our total sample, they comprise 18 percent of the non-respondent group. Hospital beds represent 5 percent of our sample and 13 percent of the non-respondent group.

Medicare payments were questionable for fourteen percent of the sample medical equipment and supplies

In 9 percent of the medical records we received there was no documentation of the need for the equipment or supplies billed. There was no diagnosis or indication in the medical record that the item was ordered or received, although the diagnosis on the claim might have been appropriate. In many cases the documentation was scanty, seemed incomplete, or was sometimes difficult to read.

In another 4 percent of records that were questionable the patient required the equipment when it was originally ordered, but according to the medical record the patient no longer had a need for it. An example is a patient who had a fractured hip and needed a wheelchair when she first came home from the hospital in 1995, but at the time of our sample billing the patient was walking independently on all surfaces according to the record. Nevertheless Medicare continued to pay a monthly rental for a wheelchair for her. Other patients were receiving diabetic supplies and were not insulin dependent as required by Medicare in 1996. Some items were billed after the date of the patient's death, and some were inappropriately billed to patients in skilled nursing facilities. See Appendix B for further analysis.

Despite a high non-response rate, wheelchairs and hospital beds represented a large proportion of questionable medical records. While wheelchairs and wheelchair accessories represent 12 percent of our total sample, they are 27 percent of the questionable medical records. Hospital beds represent 5 percent of our sample and 13 percent of the questionable records. Both wheelchairs and hospital beds are expensive items and are usually rented. They do not require re-certification unless the physician or the need for the equipment changes. There appears to be no established notification process when a patient may no longer fulfill the Medicare requirements for the item.

In 1 percent of the medical records there was sufficient evidence to fully prove that the equipment or supplies were unnecessary. All but one of the medically unnecessary records involved oxygen. In these cases there was no indication in the medical records that the patients had any breathing problems or that oxygen was being used. The equipment in the remaining case was determined unnecessary because the physician informed us that the air pressure mattress was never ordered by him and the patient has no history of bedsores. The medical record read, "Patient up and about as necessary." According to the record, the only equipment ordered was a four pronged cane.

Questionable records represent \$414 million in Medicare payments

The 14 percent of medical records that were questionable project to \$414 million. Sixty million of the \$414 million represent the 1 percent of the records where there was sufficient evidence to fully prove that the equipment or supplies were unnecessary. The \$414 million is a conservative amount because it is based on a review of only those 530 of 1000 records we received. We did not receive an additional 470 records that we requested. The failure of providers to supply us with these records makes it likely that the payment error rates were at least equal to or may even have been greater than those we received. Thus the actual dollar amount of questionable Medicare payments is likely to be significantly higher than the amount we calculated.

Medical records are more likely to be questioned for physicians who report not ordering the equipment or supplies

Of the physicians who said that they know the patient but did not order the equipment or supplies, 22 percent of the records were questionable or unnecessary. Of the physicians who report ordering the equipment, only 11 percent were questioned. This difference is significant at the 90 percent level of confidence.

Medical records are less likely to be questioned when there was a recent encounter between the physician and patient

Only 12 percent of the medical records were questioned when the physician saw the patient in 1996 or later. Twenty-seven percent of the records were questionable or

unnecessary when the physician reported not seeing the patient since 1995 or earlier. This difference is significant at the 90 percent level of confidence.

Vulnerabilities exist in the medical equipment and supply ordering process

Lack of patient's diagnosis on the claim

Currently Medicare regulations do not require that the patient's diagnosis be included on the claim, although certain items do have diagnosis requirements to determine eligibility. In 1996, diabetic supplies required a diagnosis of insulin dependent diabetes in order to be paid, although as of January 1998 the insulin dependency has been removed. They also note that there are policies that require a patient diagnosis of obstructive sleep apnea before a continuous airway pressure device is eligible for payment.

Some of the DMERCs suggested the use of more diagnosis driven claims. This would facilitate more accurate claims processing. In addition to the diagnosis on the claim, one DMERC medical director would like to see more preauthorization or approval prior to supplying the item especially in the area of wheelchairs and wheelchair accessories.

Referring physician's name or identifying number is not always on the claim

There is no requirement that the referring physician's name or identifying number (UPIN) appear on the claim and no systematic procedure exists to verify them. The DMERCs report that if the claim has the correct number of digits and a letter in the referring physician section, the number will be accepted and the claim processed. We found a number of different problems with the UPIN in our review. These include claims without any number so the referring physician could not be identified, the same number on both the claim and the CMN with different physicians' names, transposed numbers or a prefix that gives us the name of a physician different from the patient's physician, or a generic number that appears to indicate a hospital intern or resident. In all of these cases it is impossible to contact the referring physician for any information about the patient. One of the DMERCs indicated that if a physician is under sanctions, claims could be suspended by checking the UPIN number. In order to review a medical record for the appropriateness of the equipment or supplies ordered, the proper physician needs to be identified on the claim.

It is also important to capture the referring physician's specialty on the claim because Medicare only pays for some medical equipment and supplies when referred by certain physician specialties. For example, power-operated vehicles may be used as an electric wheelchair when prescribed by specialists in physical medicine, orthopedics, rheumatology or neurology.

Difficulty identifying patient place of residence

The DMERCs indicated that there is no way to verify the place of service on the claim because the name of the facility is not required by Medicare. Certain medical equipment and supplies are not paid for in a skilled nursing facility. The medical review in this report indicated that some items were inappropriately billed to beneficiaries in skilled nursing facilities. These included wheelchairs and IV poles. The prospective payment system's implementation in skilled nursing facilities in July of 1998 will include some supplies and equipment. It will be essential to know if a patient is in a skilled nursing facility in order to process claims correctly.

Lack of ongoing medical relationship between DMERCS and physicians hampers educational efforts

The DMERCs usually have no ongoing relationship with the referring physicians who sign the orders or CMNs. The suppliers have the responsibility to maintain the order or CMN on file and make them available to the DMERC for review. The DMERC does not have physician data readily available, and is not responsible for educating the physician about the criteria and eligibility requirements for medical equipment and supplies. One medical director indicated that the weak link in the process is the physician. One suggestion made by the DMERC medical staff is to have the criteria and eligibility requirements on the CMN which the physician would then review before signing the form. One DMERC attempted to use suppliers to distribute new policies to physicians but it did not work. Without direct access to the individual physicians, DMERCs must occasionally contact the appropriate Part B carriers to include new policies about supplies and equipment in their bulletins. Other DMERCs have used seminars, contacts with State Medical Societies, articles, and individual phone calls and letters to educate the physicians about medical equipment and supplies.

RECOMMENDATIONS

We found that when the referring physician knew the patient, more appropriate medical equipment and supplies were ordered. Therefore we support the Health Care Financing Administration in its' requirement that the referring physician be a physician who has treated the patient and recommend that:

- ▶ the physician who orders the equipment or supplies be required to treat the patient prior to the order and
- ▶ a systematic process be developed to assure that the supplier submits a new CMN or order to the DMERC when the physician changes, the equipment or supply or the medical need for the equipment or supply changes.

We recognize that as a result of the Balanced Budget Act of 1997, physicians are required to provide diagnostic information to suppliers and the suppliers provide this information on claims for medical supplies and equipment when the DMERC has a medical review policy requiring such diagnostic information. We support this, but recommend that:

- ▶ the referring physician's name and specialty, the patient's related diagnostic information be required on all claims for medical equipment and supplies.

This report also supports the recommendation in our report entitled "Ordering Medicare Equipment and Supplies, Physician's Perspectives" OEI-02-97-0081. This report recommended that the Health Care Financing Administration strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies and suggested the following approaches:

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

- ▶ assuring that all certificates of medical necessity sent from the suppliers to physicians include the coverage and payment rules and cost of equipment for the specific equipment or supplies ordered.

We will refer all unnecessary and questionable cases and those where the physician did not see the patient or did not order the equipment or supplies to the appropriate Durable Medical Equipment Regional Carrier for further review.

COMMENTS

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

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

Confidence Intervals for Key Survey Questions

We calculated confidence intervals for 12 key questions from the physician questionnaires, beneficiary telephone surveys, medical records, certificates of medical necessity or orders, and beneficiary histories. The response estimate and 95 percent confidence interval are given for each of the following:

Physician survey questions

1. Is the patient referred to in the enclosed letter someone that you have ever treated?
“Yes” response estimate: 89%
Lower interval: 87%
Upper interval: 92%
2. Approximately when did you last treat this patient in person?
“1996” or “1997” response estimate: 88%
Lower interval: 85%
Upper interval: 91%
3. Approximately how long have you treated this patient?
“More than one year” response estimate: 87%
Lower interval: 84%
Upper interval: 90%
4. Did you order the equipment or supplies referred to in the enclosed letter?
“Yes” response estimate: 82%
Lower interval: 79%
Upper interval: 86%

Beneficiary survey questions

5. Have you ever been examined by this physician?
“Yes” response estimate: 90%
Lower interval: 96%
Upper interval: 85%

6. Did you receive the equipment or supplies?
“Yes” response estimate: 96%
Lower interval: 93%
Upper interval: 100%

7. Is the physician your regular doctor or specialist you saw for a particular reason?
“Regular doctor” response estimate: 72%
Lower interval: 64%
Upper interval: 81%

8. Did you see the physician in 1996?
“Yes” response estimate: 94%
Lower interval: 89%
Upper interval: 99%

Medical record information

9. Overall were the equipment/supplies reasonable and necessary according to Medicare guidelines?
“No” response estimate: 14%
Lower interval: 11%
Upper interval: 17%

Certificate of medical necessity/physician’s order information

10. Is the claim physician the same as the ordering physician?
“Yes” response estimate: 83%
Lower interval: 80%
Upper interval: 85%

11. Is the date on the Certificate of Medical Necessity/Order before the claimed date?
“Yes” response estimate: 70%
Lower interval: 67%
Upper interval: 73%

Beneficiary history information

12. Was there billing by the referring physician in the six month period prior to the date the equipment was ordered?
“Yes” response estimate: 61%
Lower interval: 58%
Upper interval: 64%

Medical Review Dollar Projections

We used the HCFA requirements for reimbursement and a screening instrument to determine whether information provided by the physician in the medical record supported the need for the medical equipment or supplies provided. A registered nurse on the team completed a medical review screening instrument. Questionable cases were referred to and reviewed by a DMERC medical staff. Fourteen percent of medical equipment and supplies in our sample are medically unnecessary or questionable. The weighted allowable monetary amount projects to \$414,396,000 + or - \$120,326,900 at the 95 percent confidence level. See Table I below.

Table I
Medically Unnecessary or Questionable Dollar Projections

Sample Size	530 medical record responses
Weighted Size	487,200
Total	\$414,396,000
Standard Error Total	\$61,391,200
95% Confidence Interval	\$120,326,900
Lower limit	\$294,069,100
Upper limit	\$534,722,900

Seventy-nine medical equipment or supply items were deemed questionable or medically unnecessary. Wheelchairs and wheelchair accessories comprised over one-quarter of all questionable records. Additionally, oxygen and oxygen accessories comprised 22 percent of all questionable records. Table II below illustrates the breakdown of all questionable or medically unnecessary equipment or supplies.

Table II
Unnecessary or Questionable Medical Equipment and Supplies

Equipment or Supply	Number	Percent of Questionable
Wheelchairs and accessories	21	27%
Oxygen and accessories	17	22%
Diabetic supplies	10	13%
Hospital beds	10	13%
Other	7	9%
Enteral feeding supplies	5	6%
IV poles	3	4%
Alternating pressure mattress	2	3%
Commode chair	2	3%
Ostomy supplies	2	3%
Total	79	100%

Statistical Tests for Key Findings

We computed Chi-square values for three key findings. All variables were analyzed at the 90 percent level of confidence. As shown in Table I below, all variables demonstrate statistically significant differences. The direction of the differences below are discussed in the findings of this report.

Table I
Chi-Square Values for Testing Significant Differences

Variables	Degrees of Freedom	Chi-Square	Significant Difference
Beneficiary History vs Medical Records Received	2	23.95	*Yes
Questionable Items vs When Did the Physician Last See the Patient	1	3.34	Yes
Questionable Items vs Did the Physician Order	1	3.26	Yes

*There is a significant difference at the 95 percent level of confidence

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

January 1999

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections, and investigations.

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

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

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

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

THE IMPORTANCE OF PHYSICIAN CERTIFICATION FOR MEDICARE

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

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

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

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

PHYSICIAN CERTIFICATION FOR HOME HEALTH SERVICES

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

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

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

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

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

DME is equipment that can withstand repeated use, is primarily used for a medical purpose, and is not generally used in the absence of illness or injury. Examples include hospital beds, wheelchairs, and oxygen delivery systems. Medicare will cover

medical supplies that are necessary for the effective use of DME, as well as surgical dressings, catheters, and ostomy bags. However, Medicare will only cover DME and supplies that have been ordered or prescribed by a physician. The order or prescription must be personally signed and dated by the patient's treating physician.

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

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

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

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

Generally, a CMN has four sections:

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

- did complete section B and his or her title and employer must be specified.
- # Section C contains a description of the equipment and its cost. **Section C is completed by the supplier.**
 - # Section D is the treating physician's attestation and signature, which certifies that the physician has reviewed sections A, B, and C of the CMN and that the information in section B is true, accurate, and complete. **Section D must be signed by the treating physician.** Signature stamps and date stamps are not acceptable.

By signing the CMN, the physician represents that:

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

IMPROPER PHYSICIAN CERTIFICATIONS FOSTER FRAUD

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

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

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

equipment and supplies:

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

POTENTIAL CONSEQUENCES FOR UNLAWFUL ACTS

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

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

Physicians may violate these laws when, for example:

- # they sign a certification as a “courtesy” to a patient, service provider, or DME supplier when they have not first made a determination of medical necessity;
- # they knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted to a Federal health care program; or
- # they receive any financial benefit for signing the certification (including free or reduced rent, patient referrals, supplies, equipment, or free labor).

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

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

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

Field Offices	States Served	Telephone
Boston	MA, VT ,NH, ME, RI, CT	617-565-2664
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	215-861-4586
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago	IL, MN, WI, MI,	312-353-2740

Dallas	TX, NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS	214-767-8406
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Los Angeles	AZ, NV, So. CA	714-246-8302
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San Francisco	No. CA, AK, HI OR, ID, WA	415-437-7961
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Comments on the Draft Report

We received comments from the draft report from HCFA. They concur with our recommendations.



Memorandum

DEC 29 11:12

IG	✓
EAIG	✓
SAIG	✓
PDIG	✓
DIG-AS	✓
DIG-EC	✓
DIG-EI	✓
DIG-OI	✓
DIG-MP	✓
AIG-LC	✓
OGC/IG	✓
Exec/Spe	✓
Date Sent	12-30

DATE: DEC 29 1998

TO: June Gibbs Brown
Inspector General

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

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

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

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

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

OIG Recommendation

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

HCFA Response

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

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

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

OIG Recommendation

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

HCFA Response

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

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

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

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

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